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Socio-Cultural Factors Influencing Access to Reproductive Health Service Information among the Youth in Korogocho Slum of Nairobi, Kenya

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Abstract

Access to reproductive health services information by the youth has received the minimal attention given that reproductive health service information for many years has been tailored to meet the needs of the adult population. The youths have therefore been neglected partly due to cultural sensitivity that dictates what, when and how reproductive health information is transmitted to the youth. This study investigated selected socio-cultural factors influencing access to reproductive health service information in Korogocho slum in Nairobi Kenya. A descriptive survey design was employed; questionnaires, focus group discussion guides and key informant interview schedules were administered on 164 with youths and 5 health facility officials (key informants) to collect data, the response rate was 91.46. The reliability and validity of research instruments was ensured by pre-testing. With a R^2 value of 0.98 the study found out that 98% of the independent variables explained access to Reproductive Health Service Information with the remaining 2% explained by other factors. The study revealed that the youth in Korogocho had inadequate and inaccurate Reproductive Health Service information mostly received from the media and/or their peers. The major socio-cultural factors that were found to influence the RHS included; family, religion and peer influence. The study therefore concludes that the above selected socio-cultural factors had influence on access to Reproductive Health Service information among the youths in Korogocho slum.

Key Words: adolescent health, youth in slum areas, health information accessibility

1.Introduction

There is variation in the age definitions of youth as a transitional .For instance, adolescence (10-19 years), youths (15-25 years), young people (10-25 years) and young adults (20-25). (Senderswotz, 1998). The focus age bracket for this study is 18 – 25 years. Family Health International (FHI, 2010) and National AIDS Control council (NACC, 2005) observe that this age bracket is the most vulnerable to HIV/AIDS which is a major reproductive health (RH) issue. Dire consequences may await youths who engage in risky sexual behavior. STIs, HIV, early childbearing, marriage, and unsafe abortion can all have irreversible impacts on the lives of youths affecting their current and future health, wellbeing, productivity and early childbearing that in some cases may lead to the death of mother and the child (NACC, 2005).
Focus on the youth is informed by the fact that youths under the age of 25 are close to 50% of the world's population (World Population Council [WPC], 2008) and 63 percent of Kenya's population (Kenya National Bureau of Statistics [KNBS], 2010). Seventy two percent of Nairobi's population is youth, majority of who live in the slums (Kenya Demographic Health Survey [KDHS], 2009).This gives them a powerful role in the world's health and future.

According to Family Care International(2008), by the age of 20, at least eighty percent of sub-Saharan African youth are sexually active. It also observes that in Kenya, about 64 percent of youths have various reproductive health related problems varying from unwanted pregnancies to HIV and STI's. The Kenyan Government has in place, a Youth Reproductive Health and Development Policy Plan 2005-2015. The policy notes that the reproductive health needs and rights of the youth have received relatively little attention and it aims at improving the quality of life and wellbeing of the Kenya's young people by integrating their reproductive health concerns into the national development process and enhancing their participation in the process (Family Health International [FHI], 2006).

There are factors characterizing the relationships and activities of the population of a specific region or operational environment. Socio-cultural structures and processes influence reproductive health information by increasing exposure and vulnerability to diseases, risk-taking behaviors, the effectiveness of health promotion

efforts, and access to, availability of, and quality of reproductive health service information (Bongaarts and Watkins, 1996; Ikamba, 2003). These factors contribute to understanding societal and population processes such as current and changing rates of morbidity, survival, and mortality. In the study, the selected socio-cultural factors are as discussed below:

Peer pressure refers to the influence exerted by a peer group in encouraging a person to change his or her attitude, values or behavior in order to conform to group norms (Allen, Porter & McElhaney , 2005).Youth peer pressure is one of the most frequently referred to forms of negative peer pressure. It is particularly common because most young people spend large amount of time in fixed groups regardless of their opinion of those groups and they lack the maturity to handle pressure from their friends. Ikamba (2003) says that youths are forced into having sexual intercourse by peer pressure. Peers play a role in initiating sexual activities, which frequently ends in unwanted and or early pregnancies. Young people however, are willing to behave positively towards those who are not members of their own peer groups (Steinberg and Monahan, 2007). These include but not limited to their mentors, religious leaders, and parents among others.

Religion holds unique importance in people's lives, and has been cited as an important factor in reproductive health. Some reproductive health policies and activities of international development organizations continue to be criticized by some religious groups such as Muslims (Islamic Relief Worldwide, 2009). Such criticisms can be serious obstacles in the provision of reproductive health and rights information and services to the youths. Conformity to religious norms and principles are prerequisites to the youths' loyalty to the religion, should they be asked to take on any form of reproductive health information. The religious groups are extra keen on organizations who come in to offer reproductive health service information, to establish their background, and the program that they want to do and the reasons for doing the program to the youths (Thumbi, 2003).

1.2 Statement of the Problem

Lack of access to reproductive health services and information contributes to high levels of morbidity and mortality for largely preventable reproductive health problems particularly in developing. These may be attributed to lack of adequate information and knowledge on reproductive health service due to hash cultural and or religious practices that may in one way or the other discourage access to RHSI for various reasons. Though some religions and societal values and practices permit access to RHSI, in most of them the elderly discourage the youth access to modern RHSI and information on family planning that includes but not limited to contraceptive use. Such socio-cultural practices hinder to a great extent, access to RHSI. The most common youth reproductive health problems in Kenya are early child bearing, STIs/HIV/AIDS and unsafe abortion (Thumbi, 2003). Despite the government's efforts to operationalize youth reproductive health and development policies, the youth still have problems accessing information on reproductive health issues (African Population and Health Research Center [APHRC], 2010). Korogocho slum has been singled out by the Kenyan government officials to be in dire need of reproductive health services information (Korogocho Slums Upgrading Program [KSUP], 2009).

Access to reproductive health services information that would help the youth to make responsible health decisions is further hampered by social norms and cultural taboos against discussing reproductive health issues (Gribble and Haffey, 2003: Tavadze, Bartel and Rubardt, 2009). The big question of this study was: what are the selected socio-cultural factors which influence access to reproductive health services information among the youth in Korogocho?

1.3 Objectives

1. To examine the influence of selected socio-cultural factors on accessibility to reproductive health services information.
2. To asses information dissemination on reproductive health services by health providers in Korogocho.

1.4 Hypotheses

$H_{01:}$ Selected socio-cultural factors do not influence Reproductive Health Service Information among the youth in Korogocho.

$H_{02:}$ Reproductive Health Service Information is not being disseminated by health providers in Korogocho.

2.0 Findings of the study

2.1 Socio-cultural Factors Influencing Access to RHS Information

The need for RHS information for the youth ought to be satisfied if they are to access the right information and to protect themselves against unwanted pregnancies and infections when they have sex (MoH, 2004). The strategies by which such information and services are provided to youths will need to be acceptable to even the most conservative groups in Kenyan society, and in a way that those providing the information and services feel comfortable (MoH, 2004). The study sought to examine the influence of selected socio-cultural factors on accessibility to RHS information. The respondents chose from a scale of 1-4 and the findings were summarized using frequencies and percentages.

2.2.1 Peer Influence and Access to RHS Information

Youth peer influence is one of the most frequently referred to forms of negative peer influence. However, this influence can also have positive influence (Steinberg and Monahan, 2007). In view of this, the study sought to find out if the RHS information obtained by youth was influenced by their peers. The respondents were also asked the personal reproductive health information they would share with their peers. The findings are presented in Table 1.1

Table 1.1: Peer Influence and Access to RHS Information

Statement		SA	A	D	SD	Total
Youth's learn about reproductive health from peers.	f	45	63	18	24	150
	%	30	42	12	16	100
Peers were first to give information on sex	F	61	42	30	17	150
	%	41	28	20	11	100
Learnt about contraceptive from friends	F	39	40	40	31	150
	%	26	27	27	20	100
First seek help from friends if realize I'm pregnant	F	22	22	7	7	58
	%	38	38	12	12	100
Would go for a HIV test if friends decided to do the same	F	47	57	27	19	150
	%	31	38	18	13	100

The study established that 108 respondents of which, 45 (30%) strongly agreed that they learnt about RHS information from peers with 63 (42%) agreeing. This implies that peer influence was the main source of RHS information. Secondly, 61 (41%) of the respondents strongly agreed that peers were the first to give them information on sex as 42 (28%) of the respondents agreed. Fther, the findings illuminated that of the 39 (26%) respondents strongly agreed that they learnt about contraceptives from friends with 40 (27%) agreeing.

However 47% either disagreed or strongly disagreed as they learnt about the same from other sources, this implies that friends act as source of contraceptive information for the youths. 22 (38%) of the females as well strongly agreed that they would seek help from friends if they realized they were pregnant as 22 (38%) agreeing. Lastly, 57 (38%) agreed while 47 (31%) strongly agreeing that they would go for a HIV test if their friends decide to do the same. It is important to note though that some of the youths were not drawn to RHSI because of their peers but by other factors. This implies that some important decisions made by the youths' are influenced by the peers and friends.

This conclusion is in tandem with Rutenberg and Watkins (2000) who observe that an individual's health behaviour is influenced by how a person thinks others view their behaviour. This was supported by the analysis of the data on a t-table at 0.05 significance table with 1 df, giving a t- value of -1.659 which is greater than the upper and lower bounds of -.175 and .015 in absolute terms respectively. As shown in table 1.2

Table 1.2: T- table on pear influence and Access to RHSI

Model	Un-standardized Coefficients		T	95.0% Confidence Interval for B	
	B	Std. Error		Lower Bound	Upper Bound
(Constant)	2.813	0.127	22.092	2.561	3.064
Learnt about contraceptive from friends	-0.08	0.048	-1.659	-0.175	0.015

Therefore the Peer Influence is statistically significant and had an influence on the reproductive health service information among the target group in Korogocho slums.

2.2.2 Religion and access to RHS Information

The study sought to further establish if the youth's religion approved access to general and specific RHS information. Contraception, safe abortion, abstinence and VCT were the specific RHS information the study considered. The results are tabulated on table 1.3

Table 1.3: Religion and Reproductive Health

	Statement		**SA**	**A**	**D**	**SD**	**Total**
1	My religion approves youth seeking RHS information.	f	45	61	20	24	150
		%	30	41	13	16	100
2	Contraceptive use is against God's teaching	f	51	24	39	35	149
		%	34	16	26	24	100
3	Contraception is killing	f	50	26	38	36	150
		%	33	17	26	24	100
4	Contraception encourages promiscuity	f	67	36	27	20	150
		%	45	24	18	13	100
5	Youth can access contraception	f	19	25	47	59	150
		%	13	17	31	39	100
6	Youth can access safe abortion	f	13	28	24	85	150
		%	8.7	19	16	57	100
7	Single youth can have safe sex	f	9	10	51	80	150
		%	6	7	34	53	100
8	Single youth must practice abstinence.	f	93	40	10	7	150
		%	62	27	7	4.6	100
9	Youth should go for VCT	f	103	39	3	5	150
		%	69	26	2	3.3	100

The study findings indicated that 45 (30%) of the respondents strongly agreed that their religion approves for them to seek RHS information. 61 (41%) agreed that their religion approves for them to seek RHS information. 13% and 16% disagreed and strongly disagreed respectively. This implies that religious institutions in Korogocho generally approved of RHS information teachings. The findings indicated that 51 (34%) strongly agreed that contraceptive use is against God's teaching while 24 (16%) agreed, the remaining 40% were to the contrary opinion; this implies that contraception is generally discouraged among youths in Korogocho by their religion.

Moreover, the findings indicated that contraception is considered as killing by 50 (33%) of the respondents strongly agreeing and 26 (17%) agreeing. On the other hand, 26% disagreed and 24% strongly disagreed, this implies that some of the youth's religion forbade contraception while others did not since they belonged to different religious groups and denomination. A further, 67 (45%) strongly agreed that contraception encourages promiscuity as 36 (24%) agreeing implying that the youths who used contraceptives were viewed as being immoral. In addition, 45 (19%) of the respondents strongly agreed that youths can access contraceptives while 24 (25%) agreed, 31% disagreed and 39 % strongly disagreed. This implies that some religious institutions discouraged access to contraceptives as others allowed.

The findings on Table 1.4 of the study also indicates that 85 (57%) of the respondents strongly disagreed that youths can access safe abortion and a further 24 (16%) disagreeing; this implies that religion discouraged access to safe abortion. In addition, 51 (34%) of the respondents strongly disagreed that single youths can have safe sex and 80 (53%) disagreed; this implies that the religions outlaw sex for single youths, nevertheless, 11% either agreed or strongly agreed that their religion did not condemn safe sex among the youth. An overwhelming 93 (62%) of the respondents strongly agreed that single youths should practice abstinence with 40 (27%) agreeing; being the safest RHSI, religions endorsed abstinence for the youths.

Table 1.4: Information Family gives on Reproductive Health Services.

	Family information on		**SA**	**A**	**D**	**SD**	**Total**
1	Contraceptives	f	29	40	45	36	150
		%	19	27	30	24	100
2	Safe/unsafe sex.	f	44	39	31	36	150
		%	29	26	21	24	100
3	Abortion	f	42	27	20	61	150
		%	28	18	13	41	100
4	HIV/AIDS	f	69	46	15	20	150
		%	46	31	10	13	100
5	STIs	f	32	26	55	37	150
		%	21	17	37	25	100
6	Pregnancy	f	75	37	15	23	150
		%	50	25	10	15	100

Finally, 103 (69%) of the respondents strongly agreed that youths should go for VCT as 39 (26%) agreed; the religions in this case motivated the youths to know their HIV and AIDS status in order to live positively. The data above shows that though religions generally approved the youth's access to RHS information, they negatively viewed most of the RHSI apart from abstinence and VCT. The findings are in agreement with (Wanyeki, 1996) as the population of youths in Kenya increases, the debates about youth sexuality, youth pregnancy and its consequences become fierce in the medical and lay press.

2.2.3 Family Values and Access to RHS Information

Parents and family members are an influential source of knowledge, beliefs and attitudes for youths. They are role models who shape young people's perceptions and influence the choices that youth make about their sexual behaviour. According (Senderowitz, 1999) navigating the transition to adulthood can be hazardous for the youth in Kenya. In the traditional culture, this transition consisted of a process of socialization with rites of passage; nowadays this transition is more difficult without this initial guidance. Indeed the process of modernization has changed the norms of the society, particularly regarding the relationship between youth and their family. Youth were trying to get education, find a job, find a partner, and establish their identities and place in society. Throughout this transition, the lives and situations of girls and boys differ greatly. As part of this transition period, youth typically have unmet needs for RHS information.

There are many barriers to youths' reproductive health knowledge and use of services in Kenya (MoH, 2004). In view of the above, the research extensively sought to find out how family values affected accessibility to RHS information. The research measured the frequency of family discussions of the reproductive health issues with the youth, the family sources of the RHS information and the type of RHS information provided in the family circles. The relevant data is presented in percentages and frequencies as follows.

2.2.4 Frequency of Family Discussions on RHS Information

The respondents were asked to indicate how frequently their families talked about the RHS information. The information given in a four-point Likert scale is summarized in Figure 1.1

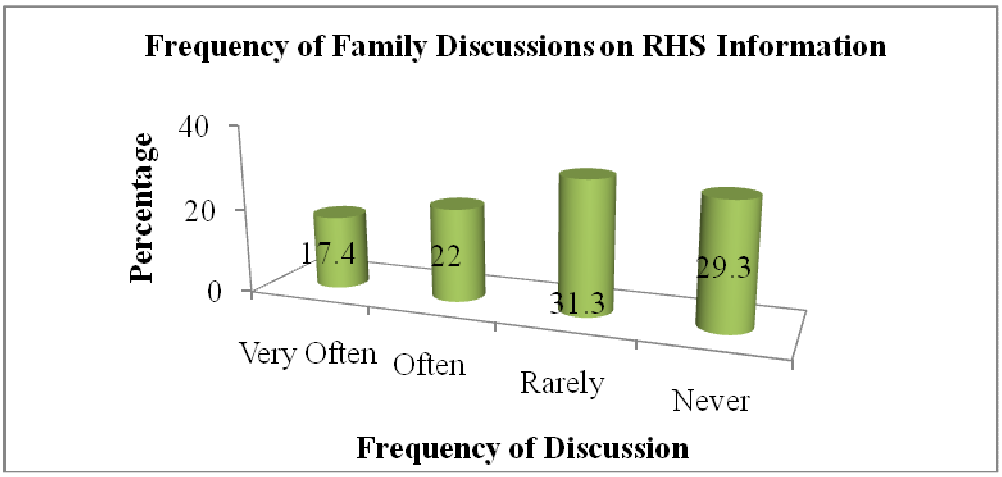

Figure 1.1: Family Members and Reproductive Health

The study findings above indicate that of the youth who were living with either a parent or a relative in a family set up, majority of them did not frequently have family discussions on RHS information at 31.3% and 29.3% for 'Rarely' and 'Never' respectively. This could be as a result of traditional and religious norms that consider reproductive health issues as taboo topics. These findings are reflected in an earlier study by (RamaRao & Naflissatou, 2003) which indicated that lack of communication between parents and their youth was a major problem. Parents think that they should serve as role models for their youths, but that role does not include providing sexual information. There remains a strong undercurrent of skepticism or opposition to strategies that address the reproductive health needs of youth.

2.2.5 Family Sources of RHS Information to the Youth

The study further sought to find out who in the family was bestowed with the responsibility of advising the youths. The findings are summarized in Figure 1.2

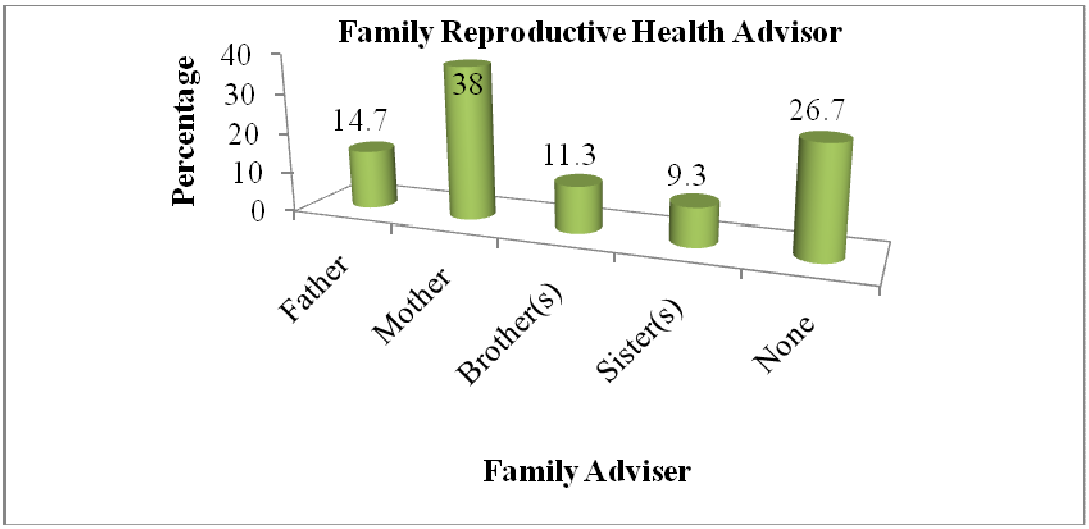

Figure 4.1: Source of RHS Information in the Family

This could be attributed to a closer bond between mothers and their children or probably the conservative nature of most fathers. It was interesting to note that 26.7% of the respondents said that they had no one to guide them on RHS information within the family set up. This implies that youths were seriously lacking the desired information and the family role models in this area were failing. In almost all societies educating youths about reproductive health is not a task that parents and other family members find easy.

Many feel uncomfortable talking with the youth about the subject – they are probably reluctant to expose their own lack of reproductive health knowledge and worry about how much information to give at what age based on the unfounded belief that this information will lead young people to experimenting with sex. They therefore shy away from actively educating the youth about issues related to reproductive health (Planned Parenthood Federation of America (PPFA, 1997).

3.0 The RHS Information Disseminated by Health Providers

This objective aimed at investigating information access of RHS from the health providers in Korogocho. To achieve this, the researcher sought to find out the reproductive health services available, the RH services tailored for the youth, the effective strategies for motivating the youth to access RHS information, challenges and factors affecting the youth's access to RHS information in the health facilities.

3.1.1 Services Offered by Health Facilities

Services offered by the health facilities under the study locality were investigated and the findings are tabulated in Table 1.5

Table 1.5: Services Offered by Health Facility

Services offered by health facility	Health facilities offering RHSI	%
Deliveries	3	60
General treatment	5	100
Antenatal clinic	1	20
Training of nursing AIDs	2	40
Family planning	3	60
Counseling	2	40
Health talk	4	80

It is worth noting that the most common services offered by the health facilities were general treatment (severe ailments referred to hospitals of higher levels), health talk, deliveries, family planning and counseling. Of these, the services that relate to reproductive health concerns addressed by the study are family planning and counseling which were offered by three and two health facilities respectively. In the study, health talks covered both general and reproductive health service information. This implies that reproductive health service information, unlike general treatment (100%), is not considered as a basic health service in the study area.

The study findings established that four out of the five health facilities advocated for abstinence from sex, use of condom and No to unsafe sex, on the other hand only three of the five health facilities advocated for VCT access. In some parts of the study area however, there were no health facilities and consequently no reproductive health service information offered. This mismatch of availability and access of RHS information in health facilities was confirmed by the FGD which reported that there were no health facilities in the area; *".....as far as I am aware there are no reproductive services provided in Kisumu Ndogo what we have in rare times are condoms sold in small chemists and kiosks…"*
(FGD 05/05/2011. Korogocho Nairobi).

Working with youth clubs was found to be the most effective strategy of reaching the youth with RHS information. In this aspect of the youth clubs, the study further sought to find out specific strategies tailored to effectively reach them with RHS information. Eight strategies were isolated and the health officers in charge asked to choose the most effective. The results of the findings are summarized in Table 1.6

Table 1.6: Tailored Youth Strategies

Tailored Youth Strategies.	Frequency out of 5	%
Fashion show	3	60
Rap contest	4	80
Music festival	2	40
Drama festival	3	60
Dance contest	1	20
Sport Days	5	100
Tee-shirt and cap messages	4	80
Wall and street posters and banners	1	20

Multiple responses was allowed

3.2 Dissemination of information

Sport days (100%), Rap contest and T-shirt messages (80%), Fashion shows and drama festival (60%) were found to be the most effective information dissemination strategies, in that order. It was also in the interest of the study to find out that the least effective information dissemination strategies that could be used to reach the youths with RHS. The findings are presented in Table 1.7

Table 1.7: Least Effective Dissemination Strategies

Strategy	**Frequency out of 5**	**%**
Public barazas	4	80
Using community health workers	1	20
Dance contest	1	20
Wall and street posters and banners	1	20

Disseminating RHS information in public barazas was reportedly the least effective strategy. This could be attributed to the fact that RHS information may be considered inappropriate for the youth since public barazas are attended by mostly older people.

Dissemination of information was of statistical significance as indicated by the regression analysis having a t-value of 2.646 which is greater than (0.052 and 0.360) upper and lower bound in their absolute terms respectively. In this case therefore, the null hypothesis was rejected to imply that reproductive health service information is was being disseminated by health providers in Korogocho.

4.0 Conclusion

From the foregoing findings, the study made conclusions with regard to the study objectives:

The Majority of the youth have heard of RHS information with the sources being the peer, health facilities, community leaders, media, parents, relatives and religious leaders, though some of the sources were unreliable especially the peers. The study rejected the null hypothesis and concludes that the youth in Korogocho slum had information on ways of HIV and AIDS prevention, contraceptives and ways of preventing early pregnancies. Information on counseling, testing and abstinence were known as ways of HIV and AIDS prevention. The contraceptives best known were condom, emergency pills, while the least known was tube illigation and vasectomy. Among ways of preventing early pregnancies, abstinence was the highest, followed by use of condoms and e-pills with least sought way of avoiding early pregnancy being guidance and counseling. This study therefore concluded that there is Reproductive Health Service Information available to the youth in Korogocho.

The socio-cultural factors selected in the study were peer influence, education, family values and religion. Access to RHS information was found to be influenced by all the factors. The peers influenced learning about sex, contraception, how to deal with pregnancy and HIV and AIDS. Educational level of the respondents was also found to influence the access to RHSI. It was noted that those with higher level of education accessed RHS information with a greater percentage compared to respondents with lower levels of education. Family values as a factor influenced access to RHS information both positively and negatively. The family readily volunteered information on HIV and AIDS and safe sex but did not give RHS information access especially on contraception and abortion. Religion influenced access by providing the respondents with adequate information on VCT and abstinence information. Religion was reported to negatively view contraception, abortion and safe sex access. The selected socio cultural factors were of statistical significance to the access of the RHSI having a t-value of 0.387 < (-0.092 and 1.09). the study therefore, rejects the null hypothesis which implies that selected socio cultural factors had influence on access to RHSI among the youths in Korogocho slum.

The study found out that information was being disseminated by health providers in Korogocho which were family planning, counseling and health talks. The information availed covered abstinence, VCT and condom use. Dissemination strategies identified in the study were working closely with the youth clubs, making the centers youth-friendly and having free medical camps while the strategies that could effectively reach the youth with information included Sports days, Rap contests and T-shirt/cap messages. The least effective forum for disseminating RHS information to the youth was public barazas. The study therefore concludes that information was being disseminated to the youth in Korogocho slum.

5.0 Recommendations

. 5.1.1 Policy recommendations

i. There is need for the society to devote time and resources to ensure that the youth acquires the desired information from trained personnel to assist make informed decision on RHSI.
ii. Curriculums should be developed by the ministry of education in collaboration with relevant stakeholders that covers RHSI in learning institutions nationwide and be taught stating from upper primary school to secondary school.
iii. There is need for development of policies to incorporate youth health sessions in health facilities to motivate the youth by adopting the most effective methods to train youths on how to acquire RHS information.
iv. There is need to implement and enact youth reproductive health policies by organizations concerned with the youth such APHYA II Kenya and the Ministry of Sports and Youth Affairs.

5.1.2 Practice recommendations

i. There is need for the youths to seek for alternative sources of information such as counselors and other trained personnel on RHSI matters, rather than relying solely on peer influence.
ii. Religious leaders should also devote their precious moments with the youth in disseminating RHS information without discriminating on other issues concerning the same.
iii. There is need for continuous efforts from the central government and the relevant NGOs to make RHSI accessible and youth-friendly.

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