

**SELECTED SOCIO-CULTURAL FACTORS INFLUENCING ACCESS TO
REPRODUCTIVE HEALTH SERVICE INFORMATION AMONG THE
YOUTH IN KOROGOCHO SLUM OF NAIROBI, KENYA.**

BY

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DECLARATION

STUDENTS DECLARATION

This thesis is my own work and has not been presented for the award of degree, diploma or any other certificate in any university.

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DEDICATION

To my family members for their love, care and understanding during the entire study period. To my husband, James Ombasa Omweno, for his tireless support and encouragement especially during the times I felt like giving up. To my mum, Maria, for her constant and unwavering prayers that kept me strong and going. To my children Isaac, Lucky and Victor who have been a constant joy in my life.

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ACRONYMS & ABBREVIATIONS

APHRC African Population and Health Research Centre

AIDS Acquired Immune Deficiency Syndrome

FHI Family Health International

FLE Family Life Education

HIV Human Immune Deficiency Syndrome

KSUP Korogocho Slum Upgrading Program

MDGs Millennium Development Goals

MoE Ministry of Education

MSM Men having Sex with Men

NASCOP National AIDS / STD Control Program

NCAPD National Coordinating Agency for Population and Development

NCPD National coordinating agency for population and development

NGO Non-Governmental Organization

NPPSD National population planning survey and Development

RHS Reproductive Health Service

RHSI Reproduction Health Service Information

RTI's Reproductive Tract Infections.

STIs: Sexually Transmitted Infections

UNAIDS Joint United Nations Program on HIV/AIDS

UNESCO United Nations Education, Scientific and Cultural Organization

UNFPA United Nations Population Fund

WCTU Women's Christian Temperance Union

WHO World Health Organization

WPC World Population Council

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. The objectives of the study were to establish the availability of reproductive health service information to the youth, to determine the information the youths have on reproductive health services, to examine the influence of selected socio-cultural factors on accessibility to reproductive health services information and to assess information dissemination on reproductive health services by health providers in Korogocho slum. A descriptive survey design was employed; questionnaires, focused 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%. Purposive sampling was also used to include youth groups whose members were exclusively within the study's age bracket (18 – 25) and to select the facilities which offer reproductive health services information. Five youth groups met this criterion. Twenty percent of the respondents from each group were sampled using stratified random sampling. The members of the selected youth groups were divided into two strata: female (320) and male (502). This ensured desired proportionate inclusion of each stratum in the sample. Systematic random sampling of the second member per every ten members from each group in every stratum was done. This gave rise to a total of 164 youths (64 females and 100 males). The reliability and validity of research instruments was ensured by pre-testing and thoughtful discussions with the researcher's supervisors respectively. The study findings were presented in prose, tables, graphs and charts. Descriptive statistics of percentage and frequencies were used to describe the population characteristics such as demographic information, education and religion. Inferential analysis involved the use of Chi-square to cross tabulate selected independent variables to the dependent variable. Regression analysis was used to analyze the relationship between the independent variables (Information the Korogocho youth have on RHSI; The influence of socio-cultural factors on accessibility to RHSI and Dissemination of RHSI) and the dependent variables (Access to reproductive health services information). With a R^2 value of 0.98 the study found out that 98% of the independent variables explained access to RHSI with the remaining 2% explained by other factors. The study revealed that the youth in Korogocho had inadequate and inaccurate RHS information mostly received from the media and/or their peers. The major socio-cultural factors influencing the youth's access to RHS information were found to be family, religion and peer influence. The study therefore concludes that the above selected socio-cultural factors had influence on access to RHSI among the youths in Korogocho slum. The study recommended that, there is need for the youth to seek for an alternative source of information rather than relying mainly on the peers and the media. The government and non-governmental organizations should develop, implement and operationalize youth RHSI policies. The findings of this study are hoped to be useful to policy makers in the public health sector, religious and non-governmental organizations concerned with the welfare and development of youth in Kenya.

CHAPTER ONE: INTRODUCTION

1.0 Introduction

This chapter presents the background information, statement of the problem, purpose of the study, objectives, and research questions. It also contains significance of the study, assumptions, theoretical and conceptual frameworks as well as the definition of terms.

1.1 Background Information

Reproductive Health (RH) is a state of complete physical, mental and social well-being. It's not merely the absence of disease or infirmity in all matters relating to reproductive system, its functions and processes (World Health Organization (WHO), 2011). Such matters include prevention and management of Sexually Transmitted Infections, Reproductive Tract Infections and Human Immune Virus/Acquired Immune Deficiency Syndrome, issues of contraception and prevention of abortion and management of complications resulting from unsafe abortion.

Although reproductive health information, counseling and delivery have been identified as necessary for adults for decades and have become increasingly accessible, the knowledge and availability of such services have just been recently endorsed for the youth (Senderowitz, 1999). The International Conference on Population and Development (ICPD) held in Cairo in 1994 and the Fourth International Conference on Women, in Beijing in 1995, endorsed the right of young people to reproductive health information and services. Later, at the 2005 World Health Summit, world leaders recognized that Reproductive Health was critical to the achievement of the MDGs.

They resolved to make universal access to reproductive health a reality by 2015 giving priority to providing basic reproductive health services information to the young people (United Nations Population Funds [UNFPA], 2009). According to Senderowitz (1998), youth is a transient stage between childhood and adulthood and a formative period during which many life patterns are learnt and established. Although the pronounced risk-taking associated with the youth abates with age, it has lasting consequences. Acquiring knowledge, skills and behavioral habits, therefore, sets the stage for adult expectations and outcomes. However, Senderowitz (1998) further observes that young people are not receiving adequate information and knowledge they need to manage their reproductive lives at the time they need it. This is compounded by modernization and urban migration, which have broken down some of the traditional means of information transmissions and guidance and have made intra-family communication on the subject less likely.

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).

Studies carried out on the world youth reproductive health reveal that offering young people access to reproductive health information and services has been challenging not only because the programming is new and ground breaking but also because the issues and actions involve matters of great cultural sensitivity regarding what is expected and allowed. Consequently, many societies customarily withhold information from the youth until it is felt necessary to impart it (UNFPA, 2000). In

this study, selected socio-cultural factors that influence the youths' accessibility to reproductive health services information are considered.

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 countries (Institute of Development Studies [IDS], 2010). 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 Purpose of the Study

The purpose of this study was to investigate the influence of selected socio-cultural factors on youths' access to reproductive health services information, in Korogocho slum of Nairobi.

1.4 Objectives of the study

The study addressed the following specific objectives.

- i. To establish the availability of reproductive health services information to the youth in Korogocho slum.
- ii. To determine the information the youths in Korogocho have on reproductive health services.
- iii. To examine the influence of selected socio-cultural factors on accessibility to reproductive health services information.
- iv. To assess information dissemination on reproductive health services by health providers in Korogocho.

1.5 Research Questions

- i. What Reproductive Health Service Information is available to youth in Korogocho?
- ii. What information about Reproductive Health Services do the youth in Korogocho have?

- iii. How do selected socio-cultural factors influence reproductive health service information among the youth in Korogocho?
- iv. How is Reproductive Health Service Information disseminated by health providers in Korogocho?

1.6 Hypothesis of the Study

H₀₁: There is no relationship between availability of Reproductive Health Service Information and access to reproductive health service information by the youth in Korogocho.

H₀₂: There is no relationship between information on reproductive health Services possessed by the youth and access to reproductive health service information by the youth in Korogocho .

H₀₃: Selected socio-cultural factors do not influence Reproductive Health Service Information among the youth in Korogocho.

H₀₄: Reproductive Health Service Information is not being disseminated by health providers in Korogocho.

1.7 Significance of the Study

Being able to provide youth friendly services information will be the most important step towards achieving the Millennium Development Goal on universal access to reproductive health by 2015 (Senderowitz, 1999). Other than improving access to RHS information and making them more youth friendly, there is need to create demand for these services and improve health seeking behavior among the youth. The findings of this study will be valuable to service providers; policy and program developers since by generating new knowledge and information on accessibility to

reproductive health services information which in turn, will help them improve the existing ones and implement new programs to enhance reproductive health services information among the youths. It was envisaged that the findings of this study will enable service providers to come up with viable mechanisms to make their services youth friendly and readily accessible to the youths.

1.8 Delimitations of the study

The scope of the study encompasses selected socio-cultural factors that influence accessibility to information on reproductive services. Whether or not the recipients of this information act on it is outside the study's scope. The study concerns itself with the expected behavioral and health promotion aspects of information on reproductive health services.

1.9 Limitations of the study

The study is limited to the youth and health officials in Korogocho slum in Nairobi. The youths under study were within 18-25 years given that half of Kenya's population comprises of the youth aged below 25 years of which, 66% are between the ages of 18 and 25 years (KDHS, 2009). Implications and generalizations to other slum areas in Kenya should be done with caution since situations and condition are different in other slums in other cities.

1.10 Theoretical Framework

The research was guided by the Social Ecological model. Founded by Binder, Stokols and Catalano (1972), developed by the founder together with Stokols (1992) and distinctively defined as the social ecological model postulates 'the application of

multiple levels and methods of analysis and theoretical perspectives to social problems, recognizing the dynamic and active nature of human-environment interactions and the social, historical, cultural and institutional contexts of people's lives'.

Applied in this study is the Social Ecology Model, also called Social Ecological Perspective. It enabled the study to examine the multiple effects and interrelatedness of social elements in the study environment (Binder, 1972).; in particular, it helped the study to determine the influence of selected socio-cultural factors on accessibility to reproductive health services information. The theory was applied to determine how the social ecological perspective can be used to determine the information the youths in Korogocho have on reproductive health services and how that affected the problem of health promotion. It also enabled the study to capture the dynamic and active nature of human-environment interactions and the social, historical, cultural and institutional contexts of people's lives and how they affect access to RHSI among the youth.

Using the underlying principles of this theory the study was able to establish the major socio-cultural factors influencing the youth's access to RHS information which were the family, religion, education and peer influence. This enabled the study to identify lack of access to RHSI phenomenon as a social problem that has enormous influence to reproductive health of the youth. The theory enabled the study also to view the problem from multiple levels and diverse theoretical perspective making the study finding fairly objective since human-environment interactions are dynamic and active processes. The theory also enabled the study to consider the social context of

people in Korogocho and their cultural values, beliefs and expectations in order to identify how they influence availability and access to RHSI to the youth. The theory also enabled the study to assess information dissemination on reproductive health services by health providers in Korogocho.

1.11 Conceptual Framework

The conceptual framework shows the various sources of RHSI available to the youth and variables that affect availability of RHSI information to the youth. The sources of RHSI include the peers, health personnel and mass media. The schematic representation also illustrates the variable that determine the access to RHSI by the youth which include socio-cultural factors such as peer influence, family values, religion, education and availability of finances to health personnel to access the youth in various parts of the study locale.

Peer influence had influence on access to RHSI on abstain from sex, use of VCT services, and use of contraceptives like condoms, emergency pills, tube ligation and vasectomy. Access to RHSI was also determined by one's educational level i.e. the higher the level of education the greater the access to RHSI while those with low levels of knowledge had the least access to RHSI.

Family values had both positive and negative influence to access to RHSI though, only to a smaller percentage did the family member discuss about RHSI. Family members never shared sensitive information regarding issues of abortion and use of contraceptives with the youth unless it was on issues of HIV and AIDS and safe sex. In the family contexts, mothers were more active than fathers in provision of RHSI to

the youth. All the factors determined access to RHSI by the youth as shown in figure 1.

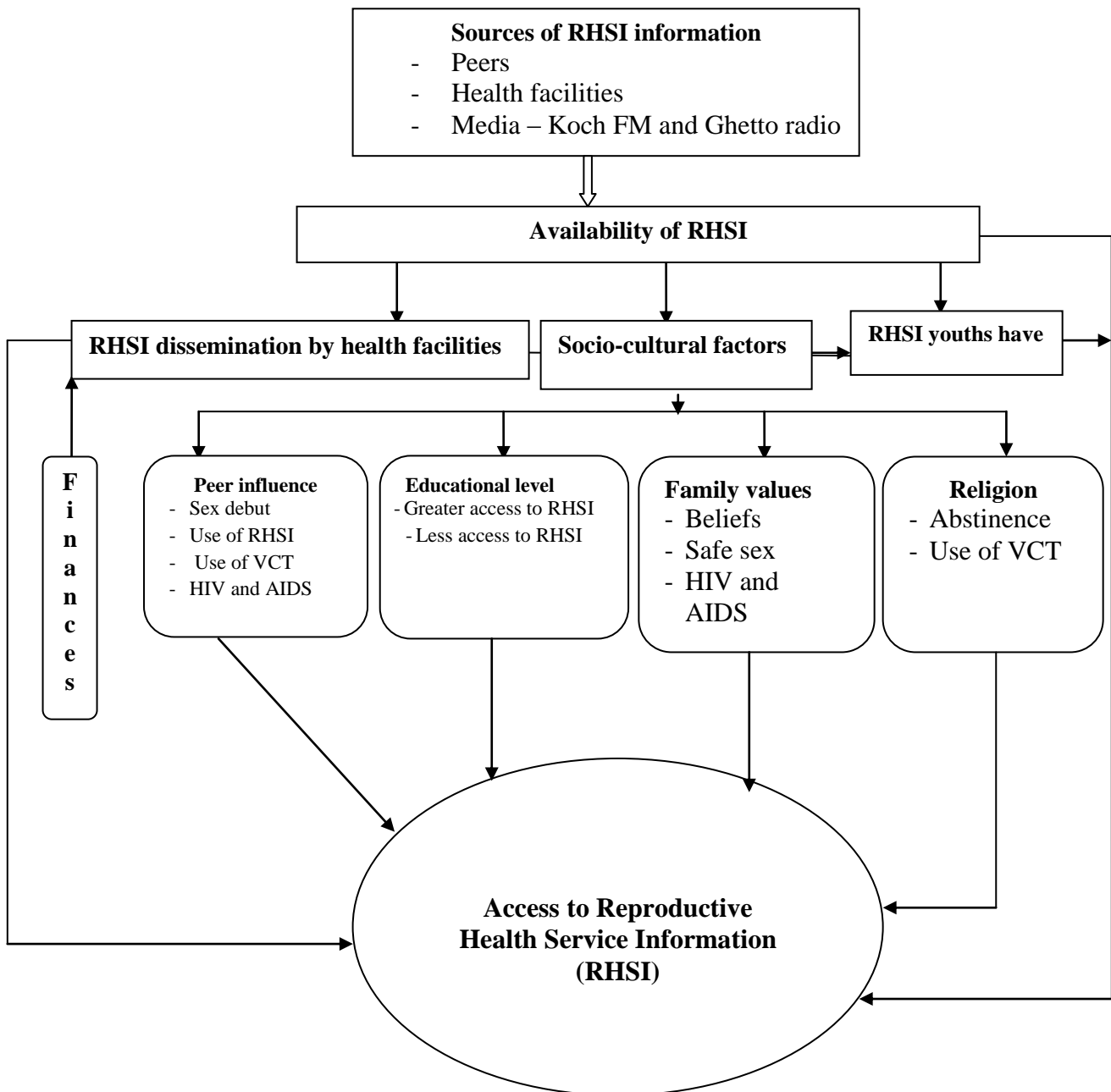


Figure 1.1: The Conceptual Framework
Source: Researcher, 2012

1.12 Operational Definition of Terms

Access – The extent to which services are available freely or at a cost and effort that is acceptable for those who need them.

Adolescence – The transition between childhood and adulthood defined to include ages 10 – 19. A distinction was drawn between early adolescence (10-14 years) and late adolescence (15-19 years)

Contexts -The social environment of an individual, the culture that he or she was educated and/or lives in, and the people and institutions with whom the person interacts with

Counseling – The process of providing professional guidance or advice to an individual or a group of individuals.

Health facility – Established health institutions that offer curative and reproductive health services.

Peer – A person who is of equal standing to another, often of same age, economic background and education level.

Reproductive health services information – information on contraceptives, unsafe abortion and prevention/counseling/testing of HIV/AIDS and STIs.

Socio-cultural factors –peer influence, religion, gender roles and family values.

Social networks – Include extended family, friends, neighbors, political groups, church groups, youth groups, and other formal and informal associations.

Youth – Individuals between ages 18 and 25 years old.

Cultural sensitivity – Societal traditions defining what is expected and allowed regarding reproductive health issues among the youth and ways of transmitting information on the same.

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

This section reviews relevant literature related to socio-cultural factors influencing access to reproductive health service information among the youth. Literature reviewed includes: Government policies and youth Reproductive Health Service Information, Reproductive Health Service Information, Youth level of education and reproductive health service information, Socio-Cultural factors and Youth Reproductive Health service information, Youth level of Education and reproductive health service information, HIV/AIDS/STIs and reproductive health service information. Early pregnancies and reproductive health service information.

2.1 Government Policies and Youth Reproductive Health service information

The Kenyan government has developed a number of policies that directly or indirectly supports youth Reproductive Health and HIV/AIDS and STIs awareness in Kenya. The Kenya National Youth Policy provides a broad framework within which civil society, private and public sectors among other players contribute to youth development. The policy aims to provide a comprehensive multi-sectoral response with the objective of integrating youth into national development. The policy promotes youth participation in community and civic affairs. The aim of youth reproductive health service information and development policy is to contribute to improving the quality of life and well-being of Kenya's young people by integrating their health and development concerns into the national development process and hence enhancing their participation in that process. It examines the consequences of prevailing social, economic, cultural and demographic issues in the context of youth reproductive health (USAID, 2006). Any government has role to play in provision of

reproductive health service information to it is citizens on the level of accessibility and service delivery. With majority of the reproductive health service information beneficiaries being the female, it is wise to as well to make policies skewed to the females in the society such as safety of birth and pregnancy. Heather (2008) in his article on the impact of government programs on reproductive health disparities states that the Pregnancy Discrimination Act in the United States of America played a major role in ensuring that those with private insurance had coverage for pregnancy-related care, but left a gap in coverage for the lowest income Americans.

In Kenya, according to Ministry of Public Health and Sanitation, the Nation Health Sector Strategic Plan phase II (MOH - NHSSP, 2010) had, as its goal to contribute to the reduction of health inequalities and to reverse the downward trend in health related impact and outcome indicators' with objectives such as to increase equitable access to health service information, Improve quality and the responsiveness of services and information in the sector, Improve the efficiency and effectiveness of service delivery; foster partnerships in improving health and delivering services and information; and to improve financing of the health sector.

The Kenya National Reproductive Health Policy (NRHP, 2007) serves as the overall RHSI policy with a goal to enhance the reproductive health status of all Kenyans by increasing equitable access to reproductive health service and information; improving quality, efficiency and effectiveness of service and information delivery; and improving responsiveness to the client needs. The priority area of this policy includes identifying several crucial areas such as - safe motherhood; family planning; youth sexual and reproductive health information. For convenience of users, and

streamlining of management, reproductive health service information should be integrated within a system that offers primary health care and referrals for more specialized needs. According to the National Coordinating Agency for Population and Development (NACDP, 2010), reproductive health service and information policies should be skewed more to the youth than to adults, since youth are at higher risk of illness and death from reproductive causes, including early pregnancy, unsafely performed abortion, and HIV and other sexually transmitted infections (STIs). Their greater vulnerability is due to a combination of physiological and behavioural factors. Young girls, whose bodies are still growing and developing, are more vulnerable to infection during intercourse and are at greater risk for pregnancy-related cases (CEDPA, 2000).

The Ministry of public health (2010) states that developing a Master Facility List which is a simple database that captures basic information about every health facility in Kenya (both public and private) made reproductive health service information access easier to most of the Kenyan population. The Master Facility List has an internal site that is accessible only to approved Ministry of Health staff who using the web-based system, logs in and rapidly modify facility information about existing and or new health facilities and the services they offer. This allows users to search for health facilities by location, information and services provided, facility types, and owners. This government policy in essence is to increase accessibility of reproductive health service information and other health related issues to the general public but more so benefit the youth who are the larger information technology users by numbers in the nation.

2.2 Reproductive Health Services Information

In Kenya as and other parts of Africa, young people face severe threats to their health and general well being. They are vulnerable to sexual assault and prostitution, early pregnancy and childbearing, unsafe abortion, malnutrition, Female Genital Mutilation, infertility, anemia and Reproductive Tract Infections (RTI`s) including STI`s and HIV/AIDS (Republic of Kenya, 2009).

Although government and private sectors provide reproductive services and information, most are not designed to take into account the special needs of young people. That is why service providers lack capacity to deal effectively with youth reproductive health issues and the range of services provided is not sufficient (NCPD, 2010).

Kenya youth initiative project on reviewing the existing laws, policies and Session papers on youth access to reproductive health service discovered that policies on youth reproductive health service were based on laws written to address either children or the population (Republic of Kenya, 2009). Existing laws on youth reproductive health were vague, misleading and contradictory and included inadequate definition of youth. Access to reproductive health information and care is crucial for adolescents in crisis-affected settings. Most youth in Kenya do not believe that they are at high risk of contracting sexually transmitted diseases or unwanted pregnancies due to lack of adequate reproductive health service information, thus leading them to engage risky sexual behaviors (KDHS, 2009) . Youth should be made aware of their right to access these services, and so should parents and community leaders. Although adolescents make up a large proportion of the population in the

developing world, where most humanitarian emergencies occur, they have low reproductive health information base and consequently their reproductive health needs are largely unmet.

According to Felogene (2010), most young people lack the information and resources necessary to make healthy choices, including protection against HIV/AIDS, other sexually transmitted infections (STIs), and the development of healthy relationships. The health and social-economic consequences of teenage pregnancy are enormous. Early parenthood is likely to affect educational achievements with significant employment and socio-economic ramifications, while health complications for both the mother and her unborn child or infant child are very high. UNFPA (2000) gives priority to providing basic reproductive health services to expanding access to information, education, counseling and services to pregnant women, and hard-to-reach populations, including those displaced by humanitarian crisis.

2.3 Socio-Cultural Factors and Youth Reproductive Health Service Information

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:

2.3.1 Peer Influence

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.

Everybody belongs to informal social networks that influence the behavior to some degree (Dixon, 1999; Montgomery, 2000). Individual health behavior is influenced by how a person thinks that others view their behavior (Stash, 2000). Peer-led interventions in reproductive health service information are able to reach larger numbers of youth when they are delivered at a scale designed for such reach (Susan and Wilson, 2006). Trained peer educators are more credible source of information for some youth than are adult educators because they communicate in readily understandable way and serve as positive role models (Hillary, 2003). The peer to peer approach is natural and effective especially in increasing levels of knowledge (UNESCO, 2003). Youths (ages 13 to 18) report that they are most likely to get information about sexual health issues from their peers (Kaiser Foundation, 2000).

Peer group is an important factor in youth development and has some bearing on the teenagers' decision about sex (Mkangi, 2000).

When young people are surrounded by good reasons to protect their health, it is much easier for them to adopt and sustain positive behaviors. It is therefore important to foster an environment where young people find it rewarding to make positive decisions about their reproductive health (Cristina, 2005). She observes that responsible behaviour, particularly that which relates to sexual and reproductive health, is cool and that it is possible to behave responsibly and still have fun with friends without one feeling discriminated against by this or her fellows. To this extent, autonomy in decision making with regard to reproductive life is exercised by the youth. Hillary (2003) observes that not every person your age is having sex. Even if sometimes it feels like everyone is "doing it," it is important to realize that this is not true. People often talk about sex in a casual manner, but this doesn't mean they are actually having sex.

However, it is important to note, that most of the youths may be easily swayed into sexual activities without taking into consideration the consequences on their behaviour due to lack of adequate information on reproductive health and or lack of access to reproductive health service information. UNFPA (2000) observes that lack of adequate privacy, confidentiality and judgmental attitudes of service providers, who often lack counselling skills, are barriers that limit youth access to reproductive health service information, and recommends that a package of training modules for youth in reproductive health service information. This can be of a greater impact on

the youth access to reproductive health service information since the youths themselves may deliver RHSI access in a way acceptable by his or he fellows.

According to (Hodzic, 2002), Initiating youth training sessions in health facilities has improved access by youths to reproductive health service information as well as services such as condom supply, these health facilities operated by youth groups to provide youth friendly services and information access. The youth can avoid being victims of lack of reproductive health service information and consequences such as unwanted pregnancies by hanging out with friends who also believe that it is ok not to be ready for sex yet, going out with a group of friends rather than only self date, always carrying money for a telephone call or cab in case one feels uncomfortable in a peer outing (Maria, 2005). The impact of peer influence increases during periods of uncertainty and can either be positive or negative with unknown consequences (Vladas, 2008). It is therefore advisable for the youth to take precautions in their dealings.

2.3.2 Religion

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).

Studies concerning reproductive health beliefs of religious leaders are rare and when conducted, have typically relied on small samples. Margaret and Thomas (2005) in his work on religion, reproductive health and access to service states that American women believe that Catholic religious teachings should not be allowed to influence the kind of services available in community and college clinical settings. They see this as discrimination to other religious groups. He argues that almost identically, women said they would disapprove (68%) of circumstances in which a Catholic hospital became the only medical institution in the community. On the contrary to the above, some religious leaders hold more conservative attitudes than the general population about reproductive health information. They hold dear the subject and prefer that youths should make reproductive health decisions as couples rather than singly. This could be mainly to discourage premarital sex, which is a sin according to some religious teachings. In fact, for the couple, they have attended many workshops on reproductive health in order to advocate publicly for reproductive health and make it socially acceptable Adumchak, (2002). It is therefore important to note that the religious affiliation of a person has effect on the accessibility of the RHSI either in a positive or in a negative way.

Many young adults encounter conflicts between religious values and decision-making surrounding contraception, premarital sex, unintended pregnancy, abortion, and marriage (Mkangi, 2000). Religious teaching often view most reproductive health

service information such as contraceptive use and information of the same to the unmarried as a sin. Muslim sexual ethics forbid sex outside marriage, so its teachings about birth control should be understood within the context of husband and wife (Islamic Relief Worldwide, 2009). There is no single attitude to contraceptive information use and dissemination within Islam. More conservative Islamic leaders have openly campaigned against such information access and use. For this reason, the youth are hindered from accessing and using such RHSI.

2.3.5 Family Values

In some cultures, parents and the extended family members like aunts, uncles and grandparents are an influential source of knowledge, beliefs, attitudes and values for youth. They are role models who shape young people's perception of gender roles and influence the choices that youth make about their own sexual behavior. Parents and other family members often have the responsibility to guide children develop positively towards healthy sexuality, normal and progressive experience within the life cycle (Hodzic, 2002). Parents can help their children develop and practice responsible sexual behaviour and personal decision making. When the father is present in the household, girls are less likely to be pregnant, to have ever had sex, to be sexually active, and to have experienced unwanted pregnancies, as compared to youths whose fathers do not live in the same household (Anon, 2006: Gupta, 2000).

To this extent youths who live in stable families and are close to their parents are more likely to remain sexually abstinent, postpone intercourse, have fewer partners and adapt reproductive health services information (WHO, 2003). Parents play an important role in dissemination of reproductive health service information and access

of the same. According to Anon (2006) youths with their mothers present, exhibit better reproductive health information indicators if such a presence is doubled with that of the youths' father. To this extent, there is need for both parents presence to give reproductive health service information to the youth.

There continues to be a significant gap in creating supportive environment for young people to maintain behaviour change. Both parents and community need to be targeted with programmes that build their knowledge and skills to talk with young people about their sexual behaviours and bridge the generation gap between old and young people. Most parents are unprepared to talk with their children about RH and HIV/AIDS, because they themselves do not possess the information and skills needed to do so. Communication between families needs to be opened and that communities need to have greater dialogue on Youth RHSI. Parents, extended families and communities are critical in guiding and supporting young people to make choices about their sexual and health seeking behaviours.

Studies have shown that consistent positive emotional connection with caring adults help young people to feel safe and secure and allow them to develop the resiliency needed to make the challenges they face especially as they transition into adulthood. Because African culture is changing so rapidly due to influence by westernization, there has been a significant shift in lifestyle and traditional support systems for young Kenyans. Today, the upbringing of children is frequently left in the hands of teachers and institutions that deal with youth as most parents pay more attention to their careers and jobs leaving them with little and or no time to be with their family members (USAID, 2006). At the household level, the responsibility of raising

children is commonly left in the hands of women who often lack the time and resources required for responsible parenting. Conflicts among spouses and broken marriages also have adversely affected youth upbringing (USAID, 2006).

2.4 Youth Level of Education and Reproductive Health information

The link between education and reproductive health is two dimensional. Education is closely related to improvement in family health and family fertility rates. Education delays marriage, improves health and lowers fertility. It is also the most influential factor in improved child health and reduction of infant mortality. Regardless of religion, culture or level of development, better educated youth are more likely to use contraceptives, bear fewer children and raise healthier children, making better decisions and greater contribution to the household (UNESCO, 2008).

Education helps in developing capacity of youths to understand their sexuality in the context of biological, psychological, socio-cultural, reproductive dimensions and also to acquire skills and knowledge in managing responsible decisions and actions with regard to sexual and reproductive health behaviour (WHO, 2008).

The first step to avoid maternal deaths is to ensure that the youth have access to adequate information and use of modern contraceptives and the ability to plan their families (World Bank, 2010). In addition to expanding information based on family planning and avoiding HIV/AIDS and sexually transmitted infections, motivation of young people to stay in school and acquire life skills before starting their families is an essential role of education (World Bank, 2010). Medical clinics specializing in reproductive health care should offer education for men and women that covers the

range of health issues related to the human reproductive system (Sandi, 2011). These facilities should teach the basics about pregnancy, sexually transmitted diseases (STDs) and urinary tract infections. Improving educational opportunities for female youth, helps them develop skills in decision making and influence community change in key areas. In turn, such educational opportunities have a positive impact on some of the most profound issues of our time, population growth, HIV and AIDS and the entire reproductive health at large (Sandi, 2011).

Early reproductive health service information and education from both parental and formal sources is associated with reduced sexual risk among the youth (Ancheta, 2005). High birth rates are closely allied with fragile health, little or no education. Demographic and health surveys analysis has always shown that women with secondary or higher education have fewer children than women with primary or no education. (World Bank, 2010)

Growing evidence in Kenya shows that keeping young people in school, especially girls, dramatically lowers their vulnerability to unplanned pregnancies, STIs and HIV (KDHS, (2007). Education empowers young people to think critically and positively and increase their confidence to communicate and solve problems. This is especially true for girls, who with each additional year of education, gain greater independence and are better equipped to make decisions affecting their reproductive health and have higher income earning potential all of which help them stay safe from unplanned pregnancy, STI's and HIV (Garret, Odede and Shaban, 2006).

2.5 HIV/AIDS/STI's and Reproductive Health Information

According to the National AIDS Control Council (NACC, 2005) the peak ages for AIDS cases are 25-29 years for females and 30-34 years for males. There is no significant difference between infection rates in rural and urban settings. Youths are more vulnerable to HIV and AIDS infection. NACC reports that about 20 percent of all reported AIDS patients are young people of age 15-25 years whose sexual contact accounts for 80-90 percent of all infections. Sexually transmitted infections, especially those that cause ulceration to the genital area, significantly increase HIV transmission rate. In Kenya, there are internal and local agencies looking in to youth reproductive health and HIV and AIDS issues, which need to put proper mechanisms in place for coordinating the multiple youth reproductive health and HIV and AIDS (USAID, 2006). Reaching young people, including married youth with reproductive health and HIV information and service represents a critical challenge. They have poor access to confidential and affordable reproductive health information and HIV services (Janet, 2006).

The gender gap in basic education increases women and girl's vulnerability to HIV and AIDS. They are less likely to have information and education on reproductive health especially in cultures where such information is synonymous with promoting promiscuity and spoiling girls (Elizabeth, 2003). Addressing HIV and AIDS in reproductive health services information can provide a broader outreach to underserved groups including youth and men. Women who deliver without prior antenatal care have a higher HIV prevalence than booked patients. In response, voluntary counselling and testing should be initiated for them (Maria, 2005).

2.6 Early Pregnancies and Reproductive Health Service Information

“About 16 million youths between 15 and 19 years of age give birth each year. Babies born to youthful mothers account for roughly 11% of all births worldwide. In addition, 95% of these occur in developing countries. Majority of these cases are unplanned, unexpected and unwanted”. (WHO, 2011). The youths who become pregnant are less likely than adults to be able to obtain legal and safe abortions to terminate their pregnancies due to lack of adequate reproductive health service information and rights. According to Family Care International, (FCI, 2008) in the mid-1990s, Family Care International partners of WHO in Africa identified a strong need to focus on the sexual and reproductive health and rights of young people, prevent and manage unintended pregnancy, and to slow the spread of HIV and increase access to reproductive health service information in Africa. Early pregnancies lead to unsafe abortion, maternal deaths, infant deaths, poor maternal health and that of the child, lack of education among other issues. According to (Lawlor, 2004) in low- and middle-income countries, complications from pregnancy and childbirth are the leading causes of death among girls aged 15 to 19.

In 2008, there was an estimated three million unsafe abortions among girls in this age group. World Health Organization (WHO, 2011) observed that, every day in 2009, about 800 women, majority being youths, died due to complications of pregnancy and child birth, including severe bleeding after childbirth, infections, hypertensive disorders, and unsafe abortions. Out of the 800, 440 deaths occurred in sub-Saharan Africa. The risk of a woman in a developing country dying from a pregnancy-related cause during her lifetime is about 25 times higher compared to a woman living in a developed country (WHO, 2011). Maternal mortality is a health indicator that shows

lack of adequate reproductive health service information in a society. “Early pregnancy among the youth has several health risks. Some of these health risks include: (1) Prolonged or obstructed labour, (2) Pre-eclampsia (hypertension in pregnancy) that is if it is left uncontrolled, it can progress to extreme hypertension. This condition could lead to the death of both the young mother and the baby. (3) Premature birth and still birth: infants born are more likely to be premature, of low birth weight, and suffer consequences of retarded fetal growth (Lawlor, 2004). Higher rates of gestational hypertension, anemia, prematurity, low birth weight, and neonatal mortality have been observed among youths when compared to pregnancies in adults. (Irene, 2000). Early pregnancies and associated reproductive health complications can be reduced by improving the level of reproductive health service information and accessibility to the girl child. This can be done in learning institutions. As a remedy, (FCI, 2008) suggest that working closely with government ministries to create ,develop and test new curricula for training health care workers to provide comprehensive reproductive health service information for the youth can as well help reduce cases of early and unwanted pregnancies.

2.7 Summary of Literature Review

Related literature has been reviewed on factors influencing access to reproductive health service information among the youth. The youth have been put on the spotlight and it is evident that there is rampant lack of access to information of key elements in sound reproductive health service information. Despite the government’s effort to intervene through developing new policies, there are still some factors that impede access to reproductive health services information. They include family values, information dissemination, level of education, religion and peer influence. Failure to

tackle these issues will risk plunging the youth into social problems and consequently degrading the social fabric in the target area.

Public and private reproductive health services providers lack capacity to deal effectively with youth reproductive health issues since most are not designed to take into account the special needs of the youth (NCAPD, 2010). With the current health reproductive services in Kenya described as not being youth friendly, the Ministry of Youth Affairs recommends that information on reproductive health services should be made available to the youth (MOYA, 2010). There continues to be a significant gap in creating supportive environment for young people to maintain behaviour change. It is therefore necessary to consider the factors that influence the youth's access to such information. This study endeavored to investigate selected socio-cultural factors which influence access to reproductive health services information among the youth in Korogocho.

CHAPTER THREE: METHODOLOGY

3.0 Introduction

This chapter gives a description of the research design, location of the study area, target population, sampling technique, pre-testing of research instruments, data collection techniques, data analysis techniques, presentation and dissemination as well as the logistical and ethical consideration.

3.1 Research Design

The research design that was used in this study was descriptive survey. Descriptive survey is a method of collecting information by interviewing or administering a questionnaire to a sample of individuals (Mugenda & Mugenda, 2003). Descriptive survey was chosen as it determines and reports things as they are. The major purpose of descriptive research was to describe the state of affairs as they existed (Orodho, 2005). The design not only enabled the study to report the findings but suggested solutions to significant problems. It enabled the study to collect valuable information about people's attitudes, opinions and feelings about various socio-cultural factors that determine access to RHSI by the youth in the study locale. The design allowed for the collection of information from respondents on the access to reproductive health service information. Information on the influence of the selected socio-cultural factors on access to reproductive health services information among the youth in Korogocho was also sought.

3.2 Location of the Study

The study was carried out in Korogocho slum. Korogocho is one of the 200 slum areas of Nairobi. It is the fourth largest slum in Nairobi (Kenya) after Kibera, Mathare

Valley and Mkuru Kwa Njenga. It started as an illegal settlement in early 1980`s. It is located 11 kilometers North East of Nairobi. It covers 1.5 square kilometers with a population of about 200,000 inhabitants with 70% being young people, who are less than 30 years old.(Demographic Health Survey Surveillance [DSS], 2009). Korogocho slum is divided into seven villages namely; Highridge, Grogan, Ngomongo, Ngunyumu, Githaturu, Kisumu Ndogo/ Nyayo and Korogocho. There is poor infrastructure with no system of street lighting, central sewerage system, piped fresh water and high crime rates. The youths here are confronted by myriad social problems like prostitution, unemployment, drug addiction, alcoholism, rapes and domestic violence. This made the study locale a fairly ideal site to study the influence of socio-cultural factors and how they influence access to RHSI among the youth. The slum is multi-ethnic with some 30 ethnic groups and serves as a hideout for young people who escape from police round ups in the city. It has been singled out by Kenya government officials to be in dire need of public services (KUSP, 2009). Korogocho has ten legally registered youth groups. The study area has no Government health facility but has six privately owned health facilities namely: Maendeleo Afya Kwa Wote Korogocho (MAKWK), Bidii, Vision, Provide, Tumaini Nursing Home and Comboni Mission.

3.3 Target Population

The target population in the study comprised of all the youth in Korogocho slum. The accessible population comprised of selected youth from the ages 18-25 years from youth groups within the seven villages in Korogocho slum. In Korogocho there are organized registered youth groups with a total population of one thousand, three hundred and ninety (1390) youths. The youth groups draw their membership from

across the seven villages. Youth groups include: St. John's Sports Society with 230 youths, Mukuru Recycle with 110, Pro-life with 105, Napenda Kuishi with 95, Jungle Africa with 108, Korogocho Entertainment Group with 141, Yes We Can with 112, Bidii Yetu with 119, Bega and Bega with 250 and Mwamko wa Vijana with 120 youths. Health facilities officials in the area helped in verifying the information given by the youth.

3.4 Sampling Technique and Procedure

Korogocho slum was purposively selected because of the unique characteristics of its youth population which comprises seventy percent of the slum population. Purposive sampling was also used to include youth groups whose members were exclusively within the study's age bracket (18 – 25). The youth groups that met this criterion were five namely, St. John's Sports Society (230), Mwamko wa Vijana (120), Yes we Can (112), Napenda Kuishi (250) and Jungle Africa (110) which makes a total of 822 youths. According to Gay and Diehl (1992), generally the number of respondents acceptable for a study depends upon the type of research involved. For descriptive research, the sample should be 10% of the population. But if the population is small then 20% may be required. In view of that, twenty percent of the respondents from the five youth groups were sampled using stratified random sampling. The members of the selected youth groups were divided into two strata: female (320) and male (502). This ensured desired proportionate inclusion of each stratum in the sample. Systematic random sampling of the second member per every ten members from each group in every stratum was done. This gave rise to a total of 164 youths that is, (64 females and 100 males).

There were six health facilities in the Korogocho slum namely MAKWK, Bidii, Vision, Provide, Tumaini Nursing Home and Comboni Mission. Purposive sampling was used to select the facilities which offer reproductive health services information to be included in the research; five health facilities met this criterion. An officer in-charge from each of the five sampled facilities was the key informant who provided the researcher with information to verify the responses from the target population. Three FGDs were conducted with randomly selected officials from each of the youth groups. A total of 8 officials participated in each of the FGDs.

3.5 Research Instruments

The research instruments were questionnaires, key informants interview schedules and focus group discussion guide (Jejeebhoy, 2004). The questionnaires contained closed and open-ended items that sought information on the dependent variable (access to RHS information) and on the independent variables (selected socio-cultural factors, availability of youth reproductive health service information, information the Korogocho youth have on RHS and dissemination of RHS information). They were administered to the respondents (youths) to determine the reproductive health service information access and to examine the influence of the selected socio-cultural factors on access of the same. Key informant interview schedule was used to obtain data on dissemination of reproductive health service information by health providers. It was administered to the persons in charge of the health facilities. Focus group discussions guide helped the researcher to obtain in-depth data related to reproductive health service information from the youth

3.6 Pre-testing

Pre-testing was done to ensure reliability and validity of research instrument to capture pertinent data to answer research questions and enable the study to achieve its objectives. Pre-testing enhanced the efficacy of research instruments to collect fairly reliable data upon which the findings, conclusions and recommendations of the study were based.

The validity of a test is a measure of how well a test measures what it is supposed to measure. It can also be defined as the degree to which the empirical measure or several measures of the concept, accurately measure the concept. It is the extent to which an instrument measures what it is supposed to measure. All data collections tools were constructed in close consultation with the university supervisors to ensure validity. Further, validity was established through rigorous pilot study of the tools to ascertain that they yielded consistent findings when used by various study respondents sampled in the pilot study. The findings of the pilot study were further used to fine-tune and ensure the efficacy of validity of each tool prior to the actual field study.

Reliability concerns the degree to which a particular measuring procedure gives similar results over a number of repeated trials. It is a measure of degree to which a research instrument yields constant results after trials (Mugenda & Mugenda, 2003). The researcher used tested reliability methods which involved administering the same instruments to many respondents during pilot study to ensure reliability of the data collection instruments. The findings of the pilot study were further used to fine-tune

and ensure the efficacy of each tool to capture reliable data prior to the actual study to validate the findings of the study to enable their generalization.

A sample of ten (10) youths from one youth group who were not included in the main study sample was interviewed. It was done to ensure that the instruments measure what they were intended to (relevant) and that they consistently and correctly measure the variables in the study (valid). A reliability coefficient of 0.8 was obtained implying a high degree of reliability. While reliability is concerned with the degree to which a research instrument yields consistent results or data after repeated trials, validity is concerned with accuracy and meaningfulness of inference based on the research results, (Mugenda & Mugenda, 2003). Pre-testing therefore aided in reviewing, reconstructing and adjusting unclear items.

3.7 Data Collection Techniques

The researcher was assisted by two research assistants (RAs) in data collection. They were trained rigorously on data collection before beginning the research work. The researcher ensured that the RAs familiarized themselves with the study objectives and variables and understood the items in the research instruments. For quality control purposes, the research assistants were closely supervised and guided by the researcher throughout the study. Note taking was used to record the data collected.

3.8 Data Analysis

The data obtained was analyzed at 95% confidence level. Both quantitative and qualitative techniques were used to complement each other in the analysis and to enrich the discussion of study findings. The Statistical Package for Social Sciences

(SPSS) was used for quantitative data analysis. For qualitative data, coding and assigning labels to various categories was done, conclusions drawn and themes relevant to the research objectives discussed (Gall and Borg, 1998).

Both descriptive and inferential data analysis techniques were used (Gay and Diehl, 1992). Descriptive analysis utilized numerical and graphical methods to look for patterns in a data set, summarize the information revealed in a data set and to present that information in a convenient way (McClave and Sincich, 2000). For this study, descriptive data on availability and accessibility of reproductive health services information to the youth was analyzed using frequencies and percentages.

Inferential statistics was used to draw conclusions and make generalizations based on the information obtained from the sample (Mugenda and Mugenda, 2003). This study used Chi-square (χ^2) to analyze categorical data. A Chi-square statistic was used to investigate whether distributions of categorical variables differ from one another. It compares the tallies or counts of categorical responses between two or more independent groups against a predetermined level of significance, (Corder and Foreman, 2009). The Chi-square test was used in this study to show relationships between variables namely: socio-cultural factors and information dissemination to ascertain if they significantly influence accessibility to RHS information. Regression analysis was used to get the statistical significance of independent variables. The level of significance is predetermined at 0.05. Contingency tables are used in Chi-square analysis to compare two sets of empirical data expressed as frequencies (Mutai, 2000). Contingency tables were employed to establish relationships between independent variables in the study. When two categories of two independent

variables, for example hearing about RHS/visiting health facility are compared using a contingency table, the following formula is applied;

$$\chi^2 = \frac{(ad - bc)^2 (a + b + c + d)}{(a + d)(c + d)(b + d)(a + c)}$$

= first category for the first variable
= second category for the first variable
= first category for the second variable
d = second category for the second variable.

Qualitative analysis of data refers to non-empirical analysis (Mugenda and Mugenda, 2003). It was used in this study to analyze the respondents' views and opinions in a meaningful way. This enabled the researcher to fill the information gaps not catered for by the quantitative analysis. Coding and assigning labels to various qualitative data collected was done. Related themes were obtained and discussed to reveal trends and patterns, to enable the researcher to come to some useful conclusions and recommendations.

3.9 Variables

(i) Dependent Variable

The dependent variable was youth's access to reproductive health service information was measured by asking respondents questions on their accessibility to RHS information.

(ii) Independent Variables

Independent variables were the availability of youth RHSI, Knowledge of RHS, influence of socio-cultural factors on accessibility to RHSI and Dissemination of RHSI

3.10 Logical and Ethical Consideration

The researcher sought permission from relevant authorities including a permit from the National Council for Science and Technology (NCCST) to conduct the study. Ethical issues like confidentiality were observed and consent of the respondents was respected by concealing their identity. The researcher also solicited the assistance of the chief, informal elders and administration police officers, for security reasons.

CHAPTER FOUR: RESULTS AND DISCUSSION

4.0 Introduction

This chapter presents the research findings, data analysis and interpretation. The findings are presented under the following subtitles: background information of the respondents, reproductive health services information available to the youth, the RHS information the youths have, the socio-cultural factors influencing accessibility to RHS information and the RHS information disseminated to the youth by the health providers in Korogocho slum. Of the targeted 164 respondents, 150 correctly filled in and returned the questionnaires. Consequently, a response rate of 91.5% was realized.

4.1 Background Information of the Respondents

In this study just over half of the youths 78 (52%), were aged between 22-25 years and less than half 72 (48%) were aged between 18-21 years. On the other hand, over three quarters (76.7%) of the respondents were single, while 22.7% were married and 0.7% was separated or divorced. The findings indicate that about a third (36.7%) of the respondents had attained secondary education, 30.7% who had attained primary, 26% had attained tertiary college education, 5.3% had attained university education and 1.3% had no schooling.

The study established that more than a third (38%) of the respondents were living on their own, 35.3% with their parents, 8.7% with their relatives while 2.7% lived with their friends. Findings on religion indicate that 88% of the respondents were Christians and 12% were Muslims.

4.2 Availability of Reproductive Health Service Information to the Youth

The respondents were asked if they had heard of RHS and the finding is summarized in Figure 4.1

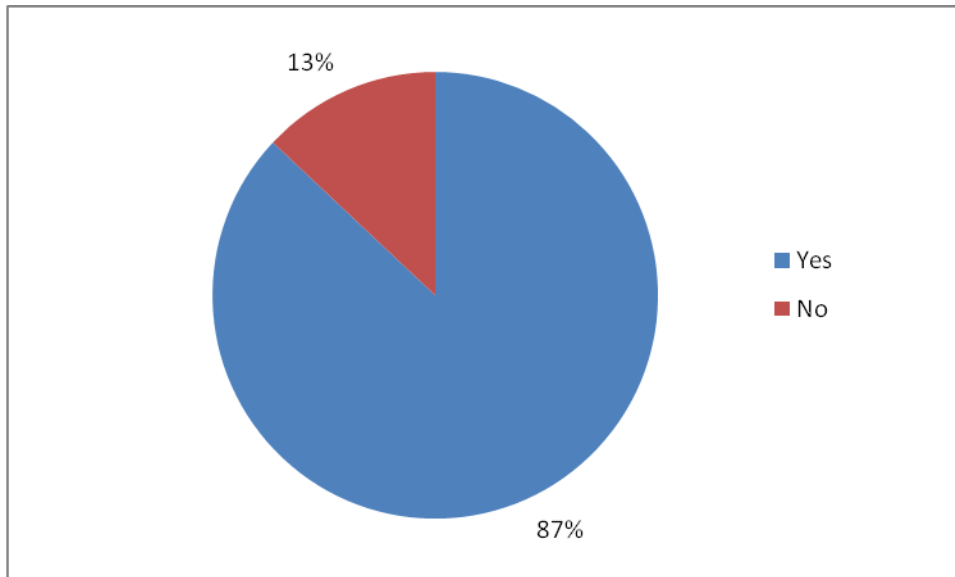


Figure 4.1: Heard of RHS Information

It was established that the majority 131 (87%) had this information compared to 19 (13%) youths who had not heard of the RHS information. Lack of RHS information is partly attributed to opposition of introduction of Family Life Education (FLE) into schools by some policy makers and religious organizations. For example, an attempt by the National Council for Population and Development (NCPD) to formulate an explicit policy on FLE and reproductive health services for youth in 1996 was rejected by parliament.

4.2.1 Sources of Reproductive Health Service Information

The main sources of RHS information reported in the study were peer counselors (38.9%), health facilities (32.8%), community leaders and media (20.6%) parents (3.8%) and relatives (3.8%) as summarized in Table 4.1 below.

Table 4.1: Sources of Reproductive Health Service Information

| Source of RHS | Frequency | Percent |
|--|------------------|----------------|
| Parents | 5 | 3.8 |
| Relatives | 5 | 3.8 |
| Peers | 51 | 38.9 |
| Health Facility | 43 | 32.8 |
| Others (Religion leaders, media, elders) | 27 | 20.6 |
| Total | 131 | 100 |

This implies that the peers were the most consistent source of RHS information which may be of a greater risks due to lack of adequate information on RHSI since according to (PATH, 2002), there is lack of systematic education programs for in and out of school youths, controversy and opposition to provision of services to youths, and a pervasive concern that provision of sexuality education and contraceptive services will lead to promiscuity.

From the FGDs, it was noted that majority of the respondents sought for RHS information from their peers as they feared their parents and most of the parents were not ready to discuss, others were of the opinion that some parents who discussed lacked all the relevant information.

“..... Some information parents may not have in full and thus in most moments we source it from our friends and from the print and electronic media. In addition, our parents shy off from giving us RH information and if we inquire, they mistake us for seeking the wrong kind of information by referring to it as dirty information.....”

(FGD, 05/05/2011, Korogocho, Nairobi)

Another important source of RHS information was the health facilities. A total of 43 (32.8%) identified this source. Though a third of the youth observed that health facilities were a good source of RHS information, accessibility to the facilities was greatly hampered by financial constraints, the youth noted that the available health facilities are majorly private owned, which charge higher prices for the reproductive health service information. Mass media was therefore reported as an alternative source of RHS information. As pointed out during focus group discussion.

“Because we are unable to afford services at the private health facilities, one has to go to Kariobangi where free services are offered by the government facility. Here we depend on mass media especially Koch FM and Ghetto Radio and television (for those who have), for teaching on reproductive health service information. (FGD, 05/05/2011, Korogocho, Nairobi)”

This observation is supported by (Anon, 2006) whose study documented that mass media interventions have been successful in changing and nurturing both youth health activities and social and cultural norms.

4.2.2 Visit to Health Facility

Having established the availability of the RHS information in the facilities, the study sought to find out how many youths had ever visited the health facilities in their area of residence to seek for RHS information. The study findings are summarized as shown in Figure 4.2.

The study findings established that slightly over a half (55%) of the youths who identified health facilities as a source of RHSI had visited them, but since almost a

half (45%) of the them had never visited the health facilities in order to access the reproductive health service information.

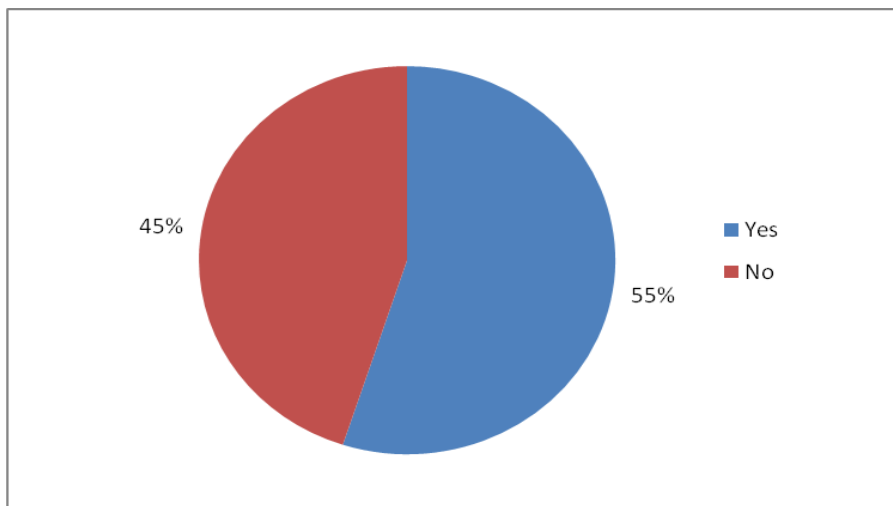


Figure 4.2: Youth who had visited to Health Facility to seek RHSI

It can be implied that good number of the youths may be reluctant to seek RHS information from the health facilities. The reluctance is explained by Senderowitz (1999) who views the health facilities as unaccommodating to the youths. The youths avoid them due to moralistic lectures from nurses, the risk of encountering neighbours or relatives within the facilities and the news of their visits reaching their parents.

4.2.3 Relationship between Hearing RHSI and Visit to a Health Facility

The researcher further sought to establish whether there was any relationship between hearing of RHSI and a visit to a health facility.

Table 4.2: Relationship between hearing RHSI and Visit to Health Facility

| | Visit to health facility | |
|--------------|--------------------------|----|
| | Yes | No |
| Heard of RHS | Yes | 44 |
| | No | 23 |
| Total | 83 | 67 |

Chi-Square = 21.872 df = 1 p value = 0.04

Table 4.2 indicates that there was statistical significant relationship between a visit to health facility and hearing of RHS information in Korogocho, as supported by a Chi-square distribution of a P value = 0.04 which is less than .05 significance level indicating there was a significant relationship between a visit to a facility and hearing of RHS information, with a p value of 0.04 which is close to 0.05 the significance level it showed that the relationship was however weak.

The findings were in agreement with those of (Williams, 2007) whose study indicated significant relationship on the youth's RHS information sourcing and visiting a health facility. However, the study also indicated that of all those who have not visited the health facilities, 85.2 % of them have never heard of RHSI.

4.2.4 Persons Lived with as Sources of RHS Information

Parents and relatives lived with were reported to be insignificant sources of RHS information to the youth. They both recorded 3.8%. The study went further to establish the relationship between persons lived with, and that included parents, friends, relatives, those living alone and others, with hearing RHS information. The results are summarized in the table 4.3

Table 4.3: Relationships between Hearing RHSI and Persons Lived With

| Who do you live with? | | | | | | | | |
|-----------------------|-----|---|---------|---------|-----------|-------|-------|-------|
| Heard of RHSI | | | Parents | Friends | Relatives | Alone | Other | Total |
| | Yes | F | | 42 | 2 | 10 | 52 | 17 |
| | % | | 34.1 | 1.6 | 8.1 | 42.3 | 13.8 | 100 |
| No | F | | 11 | 2 | 3 | 5 | 6 | 27 |
| | % | | 40.7 | 7.4 | 11.1 | 18.5 | 22.2 | 100 |
| Total | F | | 53 | 4 | 13 | 57 | 23 | 150 |
| | % | | 35.3 | 2.7 | 8.7 | 38.0 | 15.3 | 100 |

$$\chi^2 = 17.582 \text{ d.f}= 4 \text{ P}= 0.00$$

The study found out that there was a significant relationship between having heard RHS information and the people the youths lived with, as 57.7% of the youth got the RHSI from those they lived with. This was supported by a chi-square distribution P-value of $0.00 < 0.05$, the significance level. The total number of the respondents who have heard of the RHSI was 123 out of 150 respondents (82 %). Fifty two of the respondents (42.3%) who had heard about youth reproductive health services were living alone and forty two (34.1%) lived with their parents. In contrast, eleven out of 23 (40.7 %) who did not hear about RHSI lived with their parents. This implies that some of the parents were shying off from giving the RHS information. The findings were in tandem with (Jaccard & Dittus, 2001) whose results claimed that parents who are considered important stakeholders of the youths' reproductive health expressed some criticism and opposition about the programs tailored for the youths concerning HIV and AIDs prevention or reproductive health.

4.3 The RHS Information possessed by the Youths

Access to RHSI that focus on the special needs of youths has been a subject of great concern (PATH, 2000). Inadequate knowledge about youth sexual behavior, cultural influences, and the limited capacity of implementers hinder the provision of reproductive health education and services to young people (PATH, 2000). It is therefore essential to have data on the information the youths have on RHSI in order to have a clear understanding of the situation. To this end and in line with the second study objective, items on the questionnaires required the respondents to indicate which reproductive health services information they sought and the one they already had. The findings are presented in the sections that follow.

4.3.1 The RHS Information Sought

The most commonly reported RHS information services sought by the respondents were HIV and AIDS prevention and ways of avoiding early or unwanted pregnancy. As one of the respondent puts it: *...we do not get enough information on HIV/AIDS prevention and unwanted pregnancies. Telling us to abstain is not workable. It is like encouraging ignorance. They should avail more information on safe sex, use of contraceptives and VCT and information on the difference between HIV/AIDS, STI's infection and treatment so that we can protect ourselves. Unfortunately in this region there is no trust, everybody is feared due to lack of co-operation from the village elders and numerous cases of mistaken identity for criminal offenders, and furthermore since crimes are committed during broad daylight, the locals live in fear of being attacked by the offenders thus nobody is willing to come forward with information concerning the offenders. As news spreads around the outside world of the plight of fear that the locals live with, those not living here are also afraid of bringing in information into the slums.* (FGD, 05/05/2011, Korogocho, Nairobi)"

4.3.2 HIV and AIDS Prevention Services information Sought

The study isolated the three most commonly sought services in HIV and AIDS prevention. The respondents were asked which reproductive health services information they sought from the health facilities and the results obtained are shown in Table 4.4.

Table 4.4: Common HIV and AIDS Prevention information Sought

| Common HIV and AIDS prevention sought | Frequency out of 150 | % |
|---------------------------------------|----------------------|------|
| Information on Abstain | 126 | 86.3 |
| Getting tested | 116 | 79.5 |
| Counseling | 101 | 69.2 |

It is worth noting that 86.3% reported abstinence from sex as the most common HIV and AIDS prevention method sought, while 79.5% sought information on HIV and AIDS testing and 69.2% sought information on counseling services; these findings were synonymous with (Senderowitz, 1999) who endorsed the three services as necessary for youths.

From the FGD, there was need for provision of more information on HIV and AIDS, specifically Anti-retrovirals (ARVs) as well as taboos and myths on the same. It is important to note that the youth in the study location were familiar only with the male condom. In fact, one respondent observed; *“..... we need to be trained and familiarized on how to use both the male and female condoms especially the female condom since it is not common in this slum. Telling them to abstain is encouraging ignorance people should also be made to understand that raping young girls will not cleanse off HIV and AIDS for it is just a myth”*(FGD, 04/05/2011, Korogocho, Nairobi)

4.3.3: Information on Ways of Preventing Early Pregnancy

Many female youths are at high risk of unwanted pregnancy. In view of this, the study sought to find out the services they sought to avoid early pregnancies. The study findings are summarized in Figure 4.3.

The results indicated that 47% of the youths sought services on abstinence, while 29% sought services on condoms and/or the use of emergency pills. These can be attributed to the availability of condoms and emergency pills over the counters in the available local pharmacy.

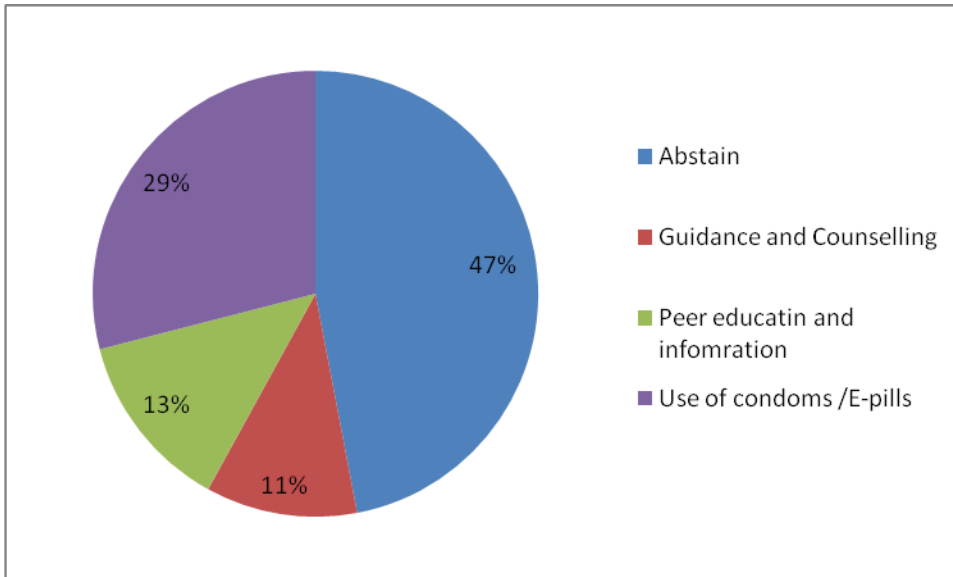


Figure 4.3: Information on Services Sought to Avoid Early Pregnancy

4.3.4 Information on Contraceptives

Young people in general are not experienced in using contraceptives, and those youths who do initiate a family planning method often do not plan in advance or lack the skills or motivation to use it correctly and consistently (PATH, 2000). Thus the study sought to find out the contraceptives the youths know about. The results are shown in Table 4.6.

Table 4.5: Information on Contraceptives awareness by the Youths

| Contraceptives known by the youths | Frequency | % out of 150 |
|------------------------------------|-----------|--------------|
| Condom | 120 | 80.0 |
| Emergency pills | 107 | 71.3 |
| Depo provera | 99 | 66.0 |
| Diaphragm | 94 | 62.7 |
| Copper-T | 86 | 57.3 |
| Coil | 80 | 53.3 |
| Tube ligation / vasectomy | 66 | 44.0 |

The most commonly known contraceptive was the condom (80%), followed by emergency pills (71.3%). This may be attributed to their availability in shops and over the counters in the local chemists. This finding could be attributed to the Ministry of Health's demand creation, advocacy and promotion on the condom; the Government stimulated demand for condoms through a variety of ways that combined public education, communication and marketing techniques. The process of demand creation was conducted in a professional manner using the services of external expertise and technical support as necessary (MoH, 2001).

During the FGD, it was observed that though the condoms were very common amongst the youths, they needed more information about them especially on how to differentiate genuine from counterfeits. Further, they requested for more information on the emergency pills to avoid abusing them. Here is an extract from the FGD; “... *Ukinywa dawa za kupanga uzazi utazaa watoto walemavu wanakaa wanyama na pia wavulana huogopa kwamba msichana akitumia zinamaliza nguvu za kiume ...*” (When a lady takes contraceptives she gives birth to deformed babies and it sometimes reduces libidos among the males) (FGD, male respondent, 05/05/2011, Korogocho, Nairobi).

4.4 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).

Therefore, the study sought to examine the influence of selected socio-cultural factors on accessibility to RHS information. The socio-cultural factors of peer influence, religion, family values and education were put on Likert scales to measure their influence. The respondents chose from a scale of 1-4 and the findings were summarized using frequencies and percentages.

4.4.1 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 4.6

Table 1.6: 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. Further, 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 4.7

Table 4.7: T- table on peer 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 to Reproductive Health Service Information. Peer group had an influence on the reproductive health service information among the target group in Korogocho slums.

4.4.2 Religion and access to RHS Information

Against the background of the respondents' religion, 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 4.8

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.

Key: SA- Strongly Agree A – Agree D-Disagree SD-Strongly Disagree

Table 4.8: 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 |

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 study also found out 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.

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.

4.4.3 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.

4.4.4 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 4.5

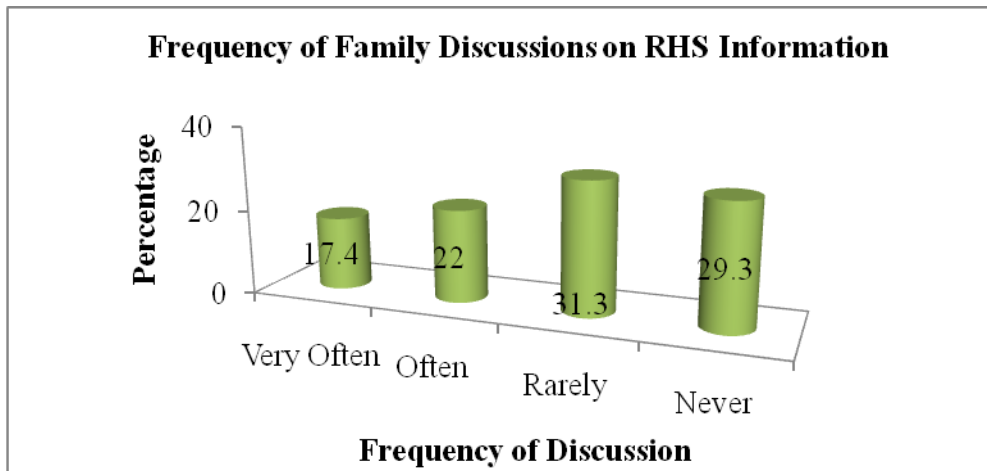


Figure 4.5: Family Members and Reproductive Health

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 & Nafliissatou, 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.

4.4.5 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 4.10.

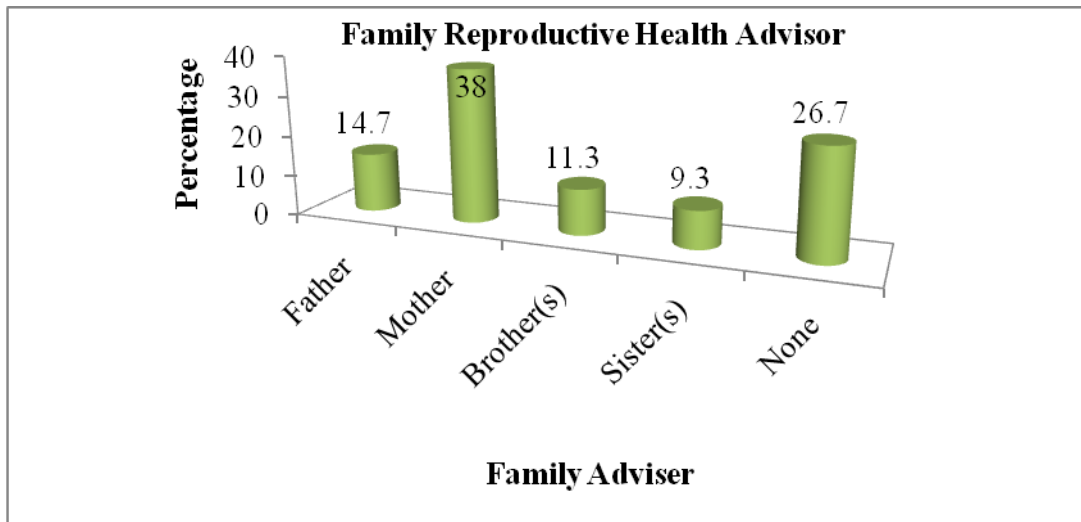


Figure 4.5: Source of RHS Information in the Family

The finding in figure 4.10 depict that 38% of the respondents (both male and female) said that their mothers were bestowed with the responsibility of guiding them on RHS information. 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).

4.4.6 Type of RHS information Discussed in the Family

To establish whether families shared RHS information with the youths, the researcher sought to find out what RHS information is discussed in the family. Respondents were required to indicate their opinion on a four-point Likert scale. The findings are summarized using frequencies and percentages and the results shown in Table 4.9

Key: SA- Strongly Agree A – Agree D-Disagree SD-Strongly Disagree

Table 4.9: 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 |

The study findings indicated that 45 (30%) of the respondents disagreed that families gave information on contraception while 36 (24%) strongly disagreed; this implies that some family members (54%) did not give any information on contraceptives. Regarding safe/unsafe sex 44 (29%) of the respondents strongly agreed that families provided information as 39 (26%) agreed. This could be induced by the need to

provide information on HIV and AIDS and unwanted pregnancy whose victims the family members would strive not to become. This conclusion is reflected by the high numbers of the families reportedly giving information on HIV and AIDS and pregnancy at 115 (77%) and 112 (75%) respectively. Moreover, the findings indicated that 20 (13%) of the respondents disagreed that family gave information on abortion with 61 (41%) strongly disagreeing; this implies that the families could be avoiding the topic of abortion with their children. This was also the case with STIs for which 55 (37%) of respondents disagreed that their families gave information and 37 (25%) of the respondents strongly disagreed. As pointed out by PPFA (1997), failure to have adequate knowledge on these reproductive health issues may hinder the family members from freely discussing them with the youth. The findings were supported by past studies such as (Bearinger, Sieving, Ferguson and Sharma, 2007) which acknowledged that globally, the negative effects of sexuality like early/unwanted pregnancy, unsafe abortion and sexually transmitted infections (STIs) including HIV and AIDS threaten the health and social life of youths (18-30 years of age) more than any other age group. These negative reproductive health outcomes are prevalent among the present generation of youths in sub-Saharan Africa who was born into the era of HIV/AIDS, widespread poverty, social conflicts and rapid societal changes (Bohmer, and Kirumira, (1997); Blum & Nelson, 2004) and (Zabin & Kiragu, 1998).

To sum up, a regression analysis on the selected socio-cultural factors that affect access to reproductive health service information is as shown in table 4.10.

Table 4.10: Selected socio-cultural factors and Access to RHSI

| | Un-standardized Coefficients | | Standardized Coefficients | T | Sig. | 95% Confidence Interval for B | |
|--------------------|------------------------------|------------|---------------------------|--------|-------|-------------------------------|-------------|
| | B | Std. Error | Beta | | | Lower Bound | Upper Bound |
| (Constant) | 1.728 | 0.604 | | 2.86 | 0.006 | 0.516 | 2.939 |
| level of education | -0.118 | 0.097 | -0.171 | -1.224 | 0.227 | -0.312 | 0.076 |
| family values | -0.005 | 0.019 | -0.037 | -0.279 | 0.781 | -0.043 | 0.032 |
| Religion | 0.055 | 0.025 | 0.304 | 2.246 | 0.029 | 0.006 | 0.105 |
| Peer influence | -0.004 | 0.022 | -0.025 | -0.182 | 0.037 | -0.027 | 0.019 |

All the independent variables were of statistical significance in explaining access to RHSI given by the fact that they all have t- values that are greater than their respective upper and lower bounds. Interestingly from table 4.10, peer influence was found to be the most significant factor influencing access to RHS; this is because it has the lowest significance value closer to zero from the statistical analysis, followed by religion, level of education, and family values respectively.

4.5 The RHS Information Disseminated by Health Providers

The fourth research objective aimed at investigating information access on 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.

4.5.1 Services Offered by Health Facilities

Services offered by the health facilities under the study locality were investigated and the findings are tabulated in Table 4.11.

Table 4.11: 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.

4.5.2 Youth Reproductive Health Services Information

Reproductive health services for the youth can be offered alongside other primary health-care services in existing health facilities. They can also be offered in stand-alone or youth-only facilities, as well as in mobile or community settings, thus the

researcher sought to find out the kinds of RH services specifically offered to the youths. The findings are summarized in Table 4.12.

Table 4.12: Youth Reproductive Health Services Information

| Youth reproductive health services. | Health facilities offering RHSI | % |
|--|--|----------|
| Youth family planning | 1 | 20 |
| Youth health talk | 4 | 80 |
| Youth counseling | 2 | 40 |

Four of the five health facilities offered reproductive health talks to the youths, two offered counseling while only one health facility offered family planning for the youth. The findings were in tandem with a pilot study in Jinja, Uganda, to evaluate the impact of reproductive health services for the youth. Which found that more youths utilized routine reproductive health services (antenatal care, family planning, maternity care, management of sexually transmitted infections [STIs], and laboratory services) in the pilot facilities (meant for the youths) than in the control (general health) facilities (Mbonye, 2003). Therefore, there was need to have more youth friendly health facilities with services tailored to meet the needs of the young people.

4.5.3 Content and Form of RHS Information in Health Facilities

There is need to have guidelines and modes which can be used to ensure maximum delivery of the required RHS information to the youths. The researcher sought information on the content and forms of the RHS information the health facilities had for the youth. The content of this information is given in Table 4.13.

Table 4.13: Forms and Contents of the RHS Information

| Forms and Content Information for Youths | Health facilities offering RHSI | % |
|--|---------------------------------|----|
| Abstain from sex | 4 | 80 |
| VCT | 3 | 60 |
| Use of condom | 4 | 80 |
| No to unsafe sex | 4 | 80 |

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).

4.5.4 Effective Strategies of Motivating Youths to Access RHS Information

There are various strategies which can be employed to disseminate information among the youth. The study sought information on the most effective strategies employed by the health facilities. The findings are summarized in Tables 4.14.

Table 4.14: Effective Dissemination Strategies

| Strategy | Frequency out of 5 | % |
|------------------------|---------------------------|----------|
| Working with clubs | 3 | 60 |
| Youth friendly centers | 2 | 40 |
| Free medical camps | 2 | 40 |

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 4.15.

Table 4.15: 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 |

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 4.16 below.

Table 4.16: 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.

4.5.5 Challenges Faced by Health Providers

The researcher sought to find whether the health providers were experiencing any challenges as there were trying to reach youths with RHS information. The findings are summarized in Figure 4.6.

(The health providers were drawn one from each of the five health facilities.). 80% of the health providers were faced with challenges, which included lack of resources, lack of capital, insecurity, lack of qualified personnel among others.

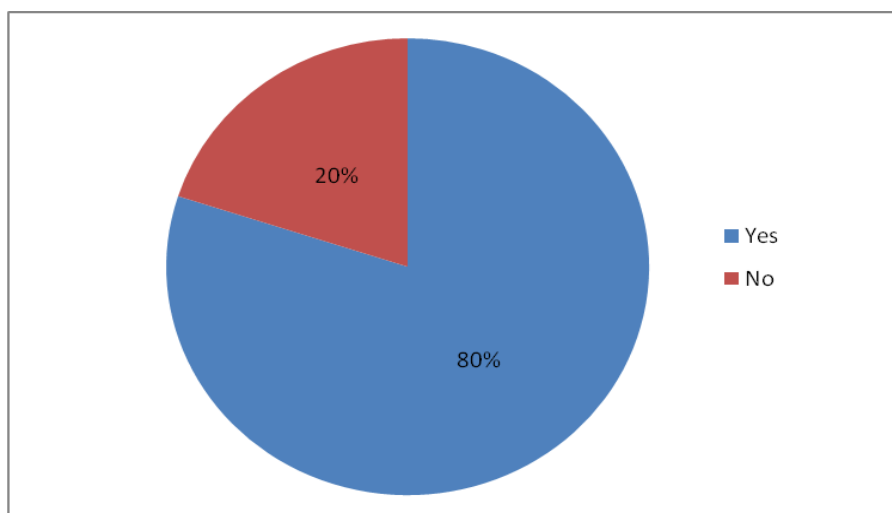


Figure 4.6: Challenges faced by health providers

They suggested that the government and donors can assist them with more resources in order to ensure there were enough resources.

4.5.6 Factors Influencing Access to RHS Information

Finally, the study sought to find out, from the health officers in charge, factors that influence the youth's accessibility to the available RHS information. The study results are presented in table 4.17

Table 4.17: Factors influencing access to RHS information

| Factors | Health facilities involved | % |
|-----------------------------------|-----------------------------------|----------|
| The youth social economic status. | 4 | 80 |
| Family values | 3 | 60 |
| Education | 4 | 80 |
| Peer influence | 3 | 60 |
| Religion | 2 | 40 |
| Home environment | 2 | 40 |
| The source of information | 3 | 60 |
| The mode of dissemination. | 3 | 60 |

The study findings indicated that majority of the health officers four out of the five health facilities in the area, considered the youth socio economic status and education as the main factors affecting accessibility to RHS information

4.6 Relationship between RHS Information Access and Independent Variables (socio-cultural factors)

Chi-square tests were used to cross tabulate the dependent variable (access to RHS information) with selected independent variables such as religion; persons lived with, education and visit to health facilities.

4.6.1 Relationship between RHS Information Access and Religion

According to the study findings in Table 4.18, 27.8 percent of the Muslim respondents had accessed the RHS information while 62.9% of the Christians had accessed RHS information. On the basis of this, religion influences the youth RHS information access.

Table 4.18: Cross Tabulation between RHS Information Access and Religion

| Access to RHS Information | | | | |
|----------------------------------|---|------------|-----------|--------------|
| Religion | | Yes | No | Total |
| Muslim | F | 5.0 | 13.0 | 18 |
| | % | 27.8 | 72.2 | 100 |
| Christian | F | 83.0 | 49.0 | 132 |
| | % | 62.9 | 37.1 | 100 |
| Total | F | 88.0 | 62.0 | 150 |
| | % | 58.7 | 41.3 | 100 |

$$\chi^2 = 29.253 \text{ d.f} = 1 \text{ P} = .000$$

The data analyzed, at 0.05 level of significance showed a probability value of 0.00 in a chi-square distribution with 1 DF ($0.00 < 0.05$) indicating that the religion of the respondent had a statistical significance in explaining the access to the RHSI. With $p=0.00$, religion had a very strong influence on access to RHSI. This is supported by figure 4.28 whose the t-value of 0.66 is greater than the upper and lower bonds in absolute terms (-0.038 and 0.76) that indicates statistical significance in explaining the access to RHSI.

4.6.2 Relationship between RHS Information Access and Person You Live with

Analysis in Table 4.20 depicts that 56.6% of the youths who live with their parents have had access to RHS information. Further, 68.4% who live alone have had access to RHS information.

Table 4.19: Cross Tabulation between RHS Information Access and Persons Lived with

| Access to RHS Information | | | | |
|---------------------------|---|------|------|-------|
| Person live with | | Yes | No | Total |
| Parents | f | 30.0 | 23.0 | 53 |
| | % | 56.6 | 43.4 | 100 |
| Friends | f | 1.0 | 3.0 | 4 |
| | % | 25.0 | 75.0 | 100 |
| Relatives | f | 5.0 | 8.0 | 13 |
| | % | 38.5 | 61.5 | 100 |
| Alone | f | 39.0 | 18.0 | 57 |
| | % | 68.4 | 31.6 | 100 |
| Other | f | 14.0 | 9.0 | 23 |
| | % | 60.9 | 39.1 | 100 |
| Total | f | 89.0 | 61.0 | 150 |
| | % | 59.3 | 40.7 | 100 |

$X^2=75.733$ $p=0.00$ $df =4$

The study findings revealed that there is a significant statistical relationship between access to RHS information and the person lived with. This is indicated by a Chi square statistics at 0.05 significance level with 4 degrees of freedom, having a P value of $0.000 < 0.05$ (the significance level). The person lived with had a bearing on the RHSI access in the target population, this is shown by the statistical significance.

4.6.3 Relationship between RHS Information Access and Education

According to Table 4.20, 69.1% of the youths who had attained the secondary education had accessed RHS information. In addition, 69.2% of those who had attained college/tertiary education had accessed RHS information.

Table 4.20: Cross Tabulation between RHS Information Access and Education

| Education | Access to RHS Information | | | |
|------------------|---------------------------|------|-------|-------|
| | | Yes | No | Total |
| No schooling | f | 0.0 | 2.0 | 2 |
| | % | 0.0 | 100.0 | 100 |
| Primary | f | 15.0 | 19.0 | 34 |
| | % | 50.7 | 41.3 | 100 |
| Secondary | f | 38.0 | 17.0 | 55 |
| | % | 69.1 | 30.9 | 100 |
| Tertiary/college | f | 27.0 | 12.0 | 39 |
| | % | 69.2 | 30.8 | 100 |
| University | f | 17.0 | 3.0 | 20 |
| | % | 70.5 | 37.8 | 100 |
| Total | f | 97.0 | 53.0 | 150 |
| | % | 64.7 | 35.3 | 100 |

$$\chi^2 = 74.333 \text{ df.} = 4 \text{ p} = 0.00$$

The study findings revealed that there is a significant statistical relationship between access to RHS information and the level of education. This is indicated by a chi

square statistics with 4 degrees of freedom, and P value =.000 at 0.05 significance level. Therefore, ($P = 0.00 < 0.05$). This shows that the level of education was of a statistical significance in explaining the access to the RHSI. The p value = 0.00 showed a very strong influence on the level of education and access to RHSI.

4.6.4 Relationship between RHS Information Access and Visit to Health Facility

The study findings indicates 83.1% of the respondents who had visited a health facility had access to RHS information as compared to 82.1% of whom had not visited the health centre had not accessed RHS information.

Table 4.21: Cross Tabulation between RHS Information Access and Visit to Health Facility

| | | Access to RHS Information | | | |
|--------------------------|-----|---------------------------|------|-------|-----|
| | | Yes | No | Total | |
| Visit to Health Facility | Yes | f | 69.0 | 14.0 | 83 |
| | | % | 83.1 | 16.9 | 100 |
| No | | f | 12.0 | 55.0 | 67 |
| | | % | 17.9 | 82.1 | 100 |
| Total | | f | 81.0 | 69.0 | 150 |
| | | % | 54.0 | 46.0 | 100 |

$$\chi^2 = 1.707 \quad df = 1 \quad P = 0.191$$

The study findings revealed that there is no significant statistical relationship between access to RHS information and a visit to the health facility. This is indicated by a chi square statistics with 1 degree of freedom, at 0.05 significance level, the P value is $0.191 > 0.05$ (level of significance). On aggregate of all the factors that affected the access to RHSI, the analysis of the data on a t- table showed the following result.

4.7 Regression Analysis

Table 4.22: Regression Analysis between access to RHSI and the Independent

| | Un-standardized Coefficients | | Standardized Coefficients | t | Sig. | 95.0% Confidence Interval | |
|----------------------------------|------------------------------|------------|---------------------------|--------|-------|---------------------------|-------------|
| | B | Std. Error | Beta | | | Lower Bound | Upper Bound |
| (Constant) | 2.664 | 0.338 | | 7.882 | 0.000 | 1.995 | 3.332 |
| Availability of RHS | -0.401 | 0.200 | -0.217 | -2.003 | 0.047 | -0.796 | -0.005 |
| RHSI the youth have | -0.050 | 0.070 | -0.062 | -0.706 | 0.482 | -0.189 | 0.090 |
| Selected socio-cultural factors. | 0.022 | 0.058 | 0.004 | 0.387 | 0.700 | -0.092 | 0.109 |
| RHSI dissemination | 0.206 | 0.078 | 0.287 | 2.645 | 0.009 | 0.052 | 0.360 |

From table 4.23, the regression analysis between access to RHSI and the independent Variables are discussed below:

Availability of youth reproductive health services information

With a t-value of t_j (-2.003) which was greater than the upper and lower bound in their absolute terms (-0.796 and -0.005) respectively showed that the variable was of statistical significance in explaining the dependent variable, we therefore reject the null hypothesis that there is no reproductive health service information available to youth in Korogocho and accept the alternative hypothesis that there is reproductive health service information available to youth in Korogocho.

Information the Korogocho youth have on RHSI

Regression analysis of how the information the Korogocho youth have influenced access to RHSI had a t- value of this variable (-0.706) which is greater than the upper and lower bonds (-0.189 and 0.090) respectively in absolute terms showing a statistical significance in explaining access to RHSI we therefore reject the null

hypothesis that the youth in Korogocho do not have information about reproductive health services and accept the alternative hypothesis that the youth in Korogocho slum have information on RHSI.

The selected socio-cultural factors

The selected socio cultural factors were of statistical significance to the access to the RHSI having a t-value of $0.387 < (-0.092 \text{ and } 1.09)$ the upper and lower bounds respectively. Since majority of the respondents had socio-cultural factors that positively impact on the RHSI. In the target population, the sample taken showed those socio-cultural factors such as religion, peer influence and education as having direct positive relationship with access to RHSI. We therefore reject the null hypothesis that selected socio-cultural factors do not influence reproductive health service Information access among the youth in Korogocho and accept the alternative hypothesis that the selected socio cultural factor that influence on RHSI access in Korogocho slum.

Dissemination of information

Dissemination of information was of statistical significance as 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. We therefore, reject the null hypothesis that reproductive health service information is not being disseminated by health providers in Korogocho and accept the alternative hypothesis that Reproductive health service information is being disseminated by health providers in Korogocho. The respondents argued that the source passing the information on RHSI had influence on the access to these services.

CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This chapter contains the conclusions drawn from the study and the recommendations for policy and practice as well as recommendations for further research.

5.1 Summary of Findings

5.1.1 Availability of RHS Information

The main sources of RHS information available in the study location were peers, health facilities and the media. Though majority of the youth (82%) had generally heard of RHS information, empirical evidence showed that they had a problem accessing the information from the perceived sources. Majority of the health facility officers (80%) admitted that they had challenges reaching the youth with information. From the FGD, it emerged that access to RHS information from the health facilities was greatly hampered by financial constraints. The most consistent sources of RHS information were the peers and the media. The mass media particularly radio stations like Koch Fm and Ghetto Radio is the most reliable source of RHS information for the youth in the slum.

5.1.2 RHS Information the Youths have

The study relied on the reproductive health services the youth would seek to establish the information they already had on RHS. 69.2% of the respondents reported counseling, testing (79.55) and abstinence (86.3%) as ways of HIV and AIDS prevention. They also listed several contraceptives with the best known being the condom (80%) and emergency pills (71.3%) while the least known was tube ligation

and vasectomy (44%). Among ways of preventing early pregnancies, abstinence was the highest (47%) followed by use of condoms and e-pills (29%). The least sought way of avoiding early pregnancy was guidance and counseling at 11%.

5.1.3 Socio-cultural Factors and RHS Information

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 peer was a source, 72% youth reported to have received RHS information from their peers) of RHSI and as well influenced the access to RHSI by the respondents. The peers influenced learning about sex, contraception, how to deal with pregnancy and HIV and AIDS. From primary to university level, education was found to be an important influence to access to information. It was noted that the higher the level of education, the greater the access to RHS information. 50.7% of those with primary school education level accessed RHSI while 70.2% of those with university level education accessed RHSI.

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.). The respondents reported that most family members rarely (31.3%) or never (29.3%) discussed RHS information with the youth especially on contraception (54%) and abortion (54%). The mother played the most important role (38%) compared to the father (14.7%). Religion influenced access by providing the respondents with adequate information on VCT and abstinence. Religion was reported to negatively view contraception, abortion and safe sex.

5.1.4 RHS Information Dissemination

The study findings revealed that the RHS information available for the youth in the health facilities were family planning, counseling and health talks. From the frequency tables, the only one of the health facilities provided family planning information and two provided counseling to the youth. The information available to the youth in the facilities covered abstinence, VCT and condom use. Three 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.

5.2 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. From the regression analysis done in chapter four, the study rejected the null hypothesis, that there was no reproductive health service information available to youth in Korogocho, and accepts the alternative hypothesis that there is reproductive health service information available to youth in Korogocho. The study therefore concludes that there is RHSI available to the youth in Korogocho.

The study also found out that the youth in Korogocho slum have information on RHSI, they 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 ligation 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. The study therefore concludes that the youth in Korogocho have information about reproductive health services information.

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 $0.387 < (-0.092 \text{ and } 1.09)$. the study therefore, rejects the null hypothesis that show that socio-cultural factors do not influence reproductive health service information access among the youth in Korogocho and accepts the

alternative hypothesis that the selected socio cultural factor influence on RHSI access in Korogocho slum, the study therefore concludes that the 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.

5.3 Recommendations for Policy and Practice

Based on the study results and conclusions on selected socio-cultural factors influencing access to reproductive health service information among the youths in Korogocho slums, the study recommends the following on policy and practice.

5.3.1 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 starting 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 as APHYA II Kenya and the Ministry of Sports and Youth Affairs.

5.3.2 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.

5.4 Suggestion for Further Research

- i. A similar study should be carried out in all the slums in the country so as to confirm the findings of the study with more attention being given to various age groups such as from 14 to 35.

- ii. Further, future studies should be considered, including other socio-cultural factors such as circumcision and gender roles, socio-economical factors such as poverty influencing the RHS information access.
- iii. A comparative study should be carried out on the various religious practices and their influence on the RHS information.
- iv. A study on the youth access to reproductive health services is strongly recommended

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APPENDICES**APPENDIX I: LETTER OF INTRODUCTION**

Dear Respondent,

I am a Post-graduate student at Kenyatta University pursuing a Master of science degree in Community Resource Management and Extension. I am carrying out a research on Selected Socio-Cultural Factors Influencing Reproductive Health Service Information among the Youth in Korogocho Slum of Nairobi North District, Kasarani Division.

I hereby request you to respond to the questionnaire. All information given will be treated with strict confidentiality, as the purpose of this study is purely academic. Your cooperation will be highly appreciated.

Thanking you in advance.

Yours Sincerely,

Lucy K. Omweno

APPENDIX II: QUESTIONNAIRE FOR THE YOUTH

This questionnaire seeks to obtain data on the background information of the youth, their knowledge, reproductive health services and information available for the youth and their perception on the influence of socio-cultural factors on accessibility to reproductive health services information. The information you give will be treated with confidentiality.

Section A: Background Information

1. What is your sex?

(1) Male (2) Female

2. How old are you? years

3. What is your marital status?

(1) Single (2) Married (3) Separated or Divorced

(4) Widowed (5) Other (specify).....

4. What is your highest level of education achieved?

(1) No schooling (2) Primary level (3) Secondary level

(4) Tertiary/College level (5) University level

5. Who do you live with?

(1) Parents (2) Friends (3) Relatives

(4) Alone (5) Other (specify).....

6. What is your religion?

(1) Christian (2) Muslim (3) Hindu

(4) Other (specify).....

Section B: Access to Reproductive Health Services Information

7. Have you ever visited a health facility in your locality for reproductive health service(s)?

(1)Yes [] (2) No []

8. In your own opinion what is reproductive health services?

9. Have you ever heard of youth reproductive health services?

(1) Yes [] (2) No []

10. If Yes, from whom did you hear about it?

(1) Parents [] (2) Relatives [] (3) Peers []

(4) Health facility [] (5) Others (specify)

Section C: Availability of RHS information

11. Please rate the following in relation to RHS information.

| Statement | Strongly Agree | Agree | Disagree | Strongly Disagree |
|---|----------------|-------|----------|-------------------|
| Health facilities available provide RHS information | | | | |
| RHS information is adequate | | | | |
| Qualified personnel gives RHS information | | | | |
| Age mates don't have sufficient RHS information. | | | | |
| Health Clinic/Hospital reaches out to youth with RHS information. | | | | |

12. What services would you seek to avoid

1) Contracting HIV/AIDS?.....

2) Early pregnancy?

13. List some of the contraceptives you know of

Section D: Influence of Socio-cultural factors

i) Peer influence

14. Please rate the following in relation to RHS information.

| Statement | Strongly Agree | Agree | Disagree | Strongly Disagree |
|--|----------------|-------|----------|-------------------|
| Youth's learn about reproductive health from peers. | | | | |
| Peers are first to give information on sex | | | | |
| I learned about contraceptive from friends | | | | |
| I would first seek help from friends if realize I'm pregnant | | | | |
| I Would go for a HIV test if friends decided the same | | | | |

ii) Religion

15. What do you think about the information your religion gives on the above issues?

| Statement | Strongly Agree | Agree | Disagree | Strongly Disagree |
|---|----------------|-------|----------|-------------------|
| My religion approves youth seeking RHS | | | | |
| Contraceptive use is against God's teaching | | | | |
| Contraception is killing | | | | |
| Contraception encourages promiscuity | | | | |
| Youth can access contraception | | | | |
| Youth can access safe abortion | | | | |
| Single youth can have safe sex | | | | |
| Single youth must practice abstinence. | | | | |
| Youth should go for VCT | | | | |

iii) Family values

16. My family members discuss reproductive health issues;

(1) Very Often [] (2) Often [] (3) Rarely [] (4) Never []

17. Who in your family advises you on reproductive health issues?

1) Father [] 2. Mother []

3. Brother(s) [] 4. Sister(s) [] 5. None []

18. My family readily gives information on the following reproductive health services

| | 1. Strongly Agree | 2. Agree | 3. Disagree | 4. Strongly disagree |
|-------------------|----------------------|-------------|----------------|-------------------------|
| 1.Contraception | | | | |
| 2.Safe/unsafe sex | | | | |
| 3.Abortion | | | | |
| 4.HIV/AIDS | | | | |
| 5.STIs | | | | |
| 6.Pregnancy | | | | |

iv). Customs and Taboos

19. What do you think about the customs and taboos gives in relation to RHS information?

| Statement | Strongly agree | Agree | Disagree | Strongly Disagree |
|--|----------------|-------|----------|-------------------|
| Community norms and taboos determine individual reproductive behaviour | | | | |
| Family planning does not accord to the norms. | | | | |
| Cultural taboos are obstacles to informed RHS information. | | | | |
| Premarital sex is forbidden. | | | | |
| Discussions on RHS information is a taboo. | | | | |

20. In your opinion, which of the following factors mostly influences your access to RHS information. Tick one.

- 1) Family values []
- 2) Education []
- 3) Peer influence []
- 4) Religion []

*****END*** Thank you for participation**

APPENDIX III: KEY INFORMANT INTERVIEW QUESTIONNAIRE

Facility Name Respondent's Name

1. What types of services do you offer in this facility?

2. Which reproductive health services do you provide?

3. Which of these services do you avail to young people in this community?

.....

4. Which forms and content of information on RHS do you have for the youth?.....

6. From your knowledge and experience in this community, what are some of the;

a). Most effective strategies of reaching, involving, and motivating the youth to access

RHS information?

b). Least effective strategies?

7. Do you experience any challenges in your efforts to reach the youth with information on reproductive health services in Korogocho? 1.Yes [] 2.No []

If Yes, Explain.

8. What suggestions do you have in terms of how we might meet these challenges?

.....

9. Which of the following do you think are the best strategies for reaching the youth in Korogocho with messages on RHS? Why do you think so?

1) Fashion Show [].....

2) Rap Contest [].....

- 3) Music festival [].....
- 4) Drama festival [].....
- 5) Dance Contest [].....
- 6) Sports days [].....
- 7) Tee-Shirt and cap messages [].....
- 8) Wall, street posters and banners [].....

12. In your opinion, do the following factors influence the youths' accessibility to available RHS information? How?

- 5) The youth's socio-economic status.....
- 6) Family values.....
- 7) Education.....
- 8) Peer influence.....
- 9) Religion.....
- 10) Home environment.....
- 11) The source of information.....
- 12) The mode of dissemination.....

13. Which bodies or government departments do you partner with in making information on reproductive health services accessible to the youth?

Thank you

APPENDIX IV: FOCUS GROUP DISCUSSIONS GUIDE

Group..... Site of FGD.....

Date Start Time..... End Time

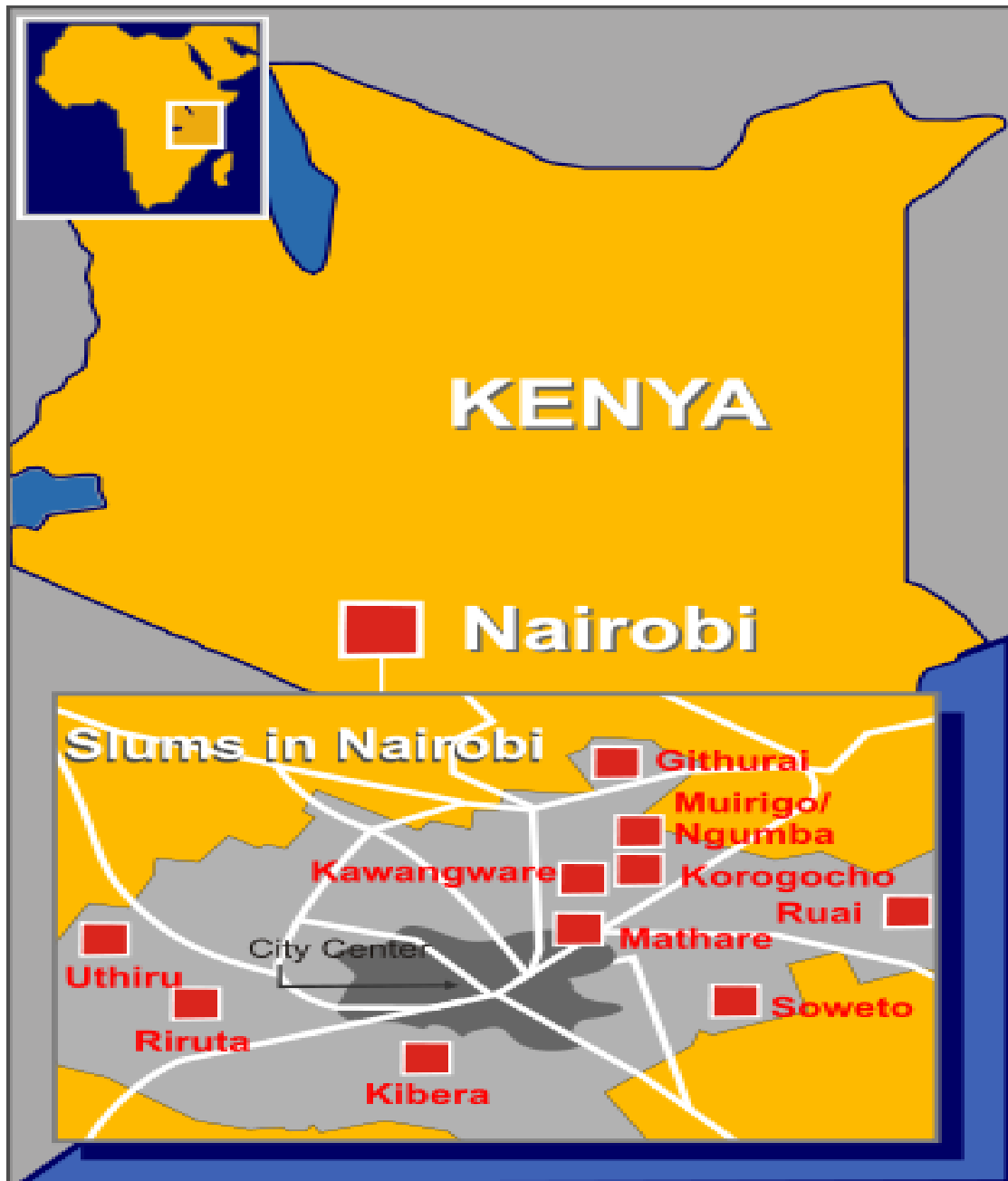
No. of Participants Facilitator

Males

Females

1. What reproductive health services do health facilities in your villages provide?
2. As youths in Korogocho, which reproductive health services information do you need?
3. Which services do you get sufficient and insufficient information about?
4. What are the advantages of getting adequate and accurate information on these services?
1. What risks may you face if you don't receive correct information on these services?
6. What are the sources of information about RHS?
7. In what form do you receive information on RHS?
8. What factors in your community enhance your accessibility to RHS information?
9. What obstacles may hinder their accessibility to this information?

APPENDIX V: A MAP OF THE LOCATION OF STUDY



Source : Nairobi Slum Area-Kenya Map, <http://www.mapsof.net/map/nairobi-slums>

APPENDIX VI: AUTHORIZATION LETTER

REPUBLIC OF KENYA



NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY

Telegrams: "SCIENCE TECH", Nairobi
 Telephone: 254-020-241349, 2213102
 254-020-310571, 2213123
 Fax: 254-020-2213215, 318245, 318249
 When replying please quote

P.O. Box 30623-00100
 NAIROBI-KENYA
 Website: www.ncst.go.ke

Our Ref:

NCST/RR/12/1/SS-011/661/5

Date:

24th May, 2011

Lucy Kwamboka Omweno
 Kenyatta University
 P. O. Box 43844
 NAIROBI

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on **"Selected socio-cultural factors influencing access to reproductive health services information among the youth on Korogocho slums of Nairobi, Kenya"** I am pleased to inform you that you have been authorized to undertake research in **Nairobi Province** for a period ending **31st August, 2011**.

You are advised to report to the **Provincial Commissioner, Nairobi Province, the District Commissioner & the District Education Officer, Nairobi North District, the Provincial Director of Medical Services, Nairobi Province** before embarking on the research project.

On completion of the research, you are expected to submit **one hard copy and one soft copy** of the research report/thesis to our office.

P. N. NYAKUNDI
FOR: SECRETARY/CEO

Copy to:
 The Provincial Commissioner
 Nairobi Province

The Provincial Director of Medical Services
 Nairobi Province

APPENDIX VII: RESEARCH AUTHORIZATION PERMIT FROM NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY

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THIS IS TO CERTIFY THAT:

Prof./Dr./Mr./Mrs./Miss LUCY KWAMBOKA
OMWENO

of (Address) KENYATTA UNIVERSITY
BOX 43844 NAIROBI

has been permitted to conduct research in

.....Location,
NAIROBI District,

.....Province,
NAIROBI

on the topic. SELECTED SOCIO-CULTURAL
FACTORS INFLUENCING ACCESS TO
REPRODUCTIVE HEALTH SERVICES

INFORMATION AMONG THE YOUTH ON
KOROGOCHO SLUMS OF NAIROBI, KENYA.

for a period ending...31ST AUGUST...20.11....

PAGE 3

NCST/RRI/12/1/SS-011/671

Research Permit No.....

Date of issue...24/5/2011.....

Fee received...KSHS .1000.....



Applicant's
Signature

[Handwritten Signature]
Secretary
National Council for
Science and Technology