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Socio-Economic Factors Affecting Access to Reproductive Health Information among Teenage Girls in Kaptembwo, Nakuru, Kenya

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Abstract: This study aims at investigating the socio-economic factors affecting access to reproductive health information among teenage girls in Kaptembwo, Nakuru, Kenya. Data was collected from a sample of 127 teenage girls aged between 13-19 of Nakuru West Secondary school, Kaptembwo Primary school and Youth for Christ Group Nakuru having a total population of 681. Quantitative data obtained through the use of questionnaires was analyzed using Statistical Package for Social Sciences (SPSS) version 21 software. Qualitative data was analyzed using narrative statements based on relevant thematic areas. Purposive sampling, simple random sampling and proportionate sampling techniques were used. The results obtained from Kaptembwo showed that, teenagers with a higher level of education, teenagers with parents with formal employment and teenagers with financial support from their parents had a better chance of accessing reproductive health information and vice versa. The teenagers with a higher level of poverty accessed reproductive health information at a lower rate. The study concludes that, socio-economic factors have been found to be interacting with access and use of reproductive health information among teenage girls. Based on the findings, the study recommended that, Kenyan government should provide reproductive health sources and facilities and also should initiate programs on creating awareness on reproductive health.

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I. 1 INTRODUCTION

Reproductive health (RH) is a state of complete physical, mental and social well-being (not merely the absence of reproductive disease and infirmity) in all matters relating to reproductive system, its functions and processes (WHO, 2011). Such matters relating to reproductive health include promotion of responsible and healthy reproductive behaviour, management and prevention of sexually transmitted infections (STI) including HIV/AIDS, having safe sexual experiences, which are free from discrimination and management of complications that may arise due to abortion. According to World Health Organisation (2004), sexual and reproductive health is made of family planning, antenatal, safe delivery and post natal care, prevention and treatment of infertility, prevention of abortion and management of consequences of abortion, treatment of reproductive tract infection, prevention, care and treatment of STIs including HIV/AIDs and information, education and counseling. Good reproductive health should include freedom from risk of sexually transmitted diseases, the right to regulate one's own fertility with full knowledge of contraceptive choices and the ability to control sexuality without discrimination because of age, marital status, income or similar considerations (Meena*et al.*, 2015).

Globally, existing barriers to access and use of reproductive health information include poor access, availability and acceptability of the services, lack of clear directions and services, lack of privacy, appointment times that do not accommodate teenage girls' little or no accommodation for walk-in patients, limited services and contraceptive supplies and options calling for referral (WHO, 2004). Adolescents are free in seeking medical care when they have injury accident but they are not free in seeking treatment on sexually transmitted infections. Adolescents globally access health services frequently than expected and are more likely to seek information and services after sexual exposure (Hocklong*et al.*, 2003). Teenagers feel embarrassed when seeking for information on reproductive health. They rely on information that, reproductive health information is tailored to meet the needs of adult generation that is married men and women.

The 1994 International Conference on Population and Development (ICPD) set the stage for putting teenagers' sexual and reproductive health (SRH) on the international agenda. During the conference, it was realised that existing health, education and other social programmes had largely ignored reproductive health

needs of young people (MOH, 2005). The conference adopted plan of action which had formed the basis for programmes addressing the SRH needs of adolescents globally. The five year progress review of this plan (ICPD +5) made a further call for countries to ensure that adolescents have access to user friendly services that effectively address their sexuality, education and counseling and health promotion activities while encouraging their active participation (WHO, 2004). Information on reproductive health need to be made available to teenagers to help them understand their sexuality and protect them from unwanted pregnancies and sexually transmitted infections. Teenagers should have a right to access all the services without any discrimination in the society. The ICPD further highlighted the vulnerabilities of adolescents and call for greater recognition of teenagers as a special category with special needs. It emphasised the need to provide adolescents with reproductive health information. Additionally, the ICPD raised the need to remove social barriers that hinder adolescents in accessing reproductive health services (Germain, 2000). ICPD suggested that teenage sexual and reproductive health issues are addressed through the elevation of accountable and healthy reproductive and sexual behaviour, including voluntary abstinence and the establishment of suitable services and counseling precisely suitable for that age group (WHO, 2004).

According to the study done in Sub-Saharan Africa on Adolescent reproductive health concern, it shows that teenagers have specific reproductive health vulnerabilities such as high adolescent birth rate, kidnapping, destructive traditional practices (such as female genital mutilation), unwanted pregnancies, abortions and Sexually Transmitted Infections (STIs). These young people need access to sexual and reproductive health information and services so that they can prevent unintended pregnancy and decide if and when to have children (Lukale, 2015). Most teenage girls engaged in sexual activities because they lack support from their parents. Some teenagers may be forced to drop out of school because of unplanned pregnancies. Teenage girls are at high risk because they might also expose their children to malnutrition which may lead to dead.

Ministry of Health in Kenya formally approved the country's first National Reproductive Health Policy (NRHP, 2003) to help in providing framework for equitable, efficient and effective delivery of quality reproductive health services to the population especially those considered vulnerable such as teenagers. In pursuit of reproductive health agenda which was deliberated in ICPD 1994 held in Cairo, the government of Kenya adopted the National Reproductive Health strategy (NRHS, 1997-2010). The aim of the policy was to identify reproductive health priority areas as; family planning, safe motherhood, child survival initiatives, promotion of adolescent and youth reproductive health, management of STIs including HIV/AIDs, management of infertility, harmful practices like early and forced marriages, female genital mutilation (FGM), drug and substance abuse (MOH, 2005). Teenagers need to be engaged in all matters relating to sexual and reproductive health to help them gain information that will help them make informed decisions. Ministry of health has tried to help in providing framework for equitable, efficient and effective delivery of quality reproductive health services to all teenagers.

The youths in Nakuru County like any other county in Kenya have range of issues and challenges related to reproductive health; mainly teenage pregnancies, abortions, school dropout, drug and substance abuse and sexual violence (KSPA, 2010). In Nakuru County, other than the government of Kenya, Non-Governmental Organisations (NGO) has also put a lot of effort to increase access and use of reproductive health services among young people through various initiatives. For example Family Health Options of Kenya (FHOK) has started various Youth Friendly Reproductive Health Services (YFRHS).

Kaptembwo is one of the largest informal settlement area located to the west of Nakuru, Kenya. It is a cosmopolitan estate hosting various races and tribes in Kenya. The causes of poverty in Kaptembwo includes un-employment, landlessness, lack of water, insecurity, lack of basic services like health and education facilities and poor social services (Municipal Council of Nakuru Strategic Plan, 2007). Teenagers living in informal settlements like Kaptembwo face challenges as they transition to adulthood in a hostile environment. In relation to Kaptembwo, teenagers need to have access to proven- effective sexual and reproductive health (SRH) interventions such as comprehensive sexual health education and counseling, access to condoms, contraceptives and HIV tests. The persistence of reproductive health challenges among teenage girls globally, internationally and Kenya that has been revealed from the literature also apply to Nakuru, Kenya.

II. Material and Methods

The study employed descriptive survey design that involves interviewing or administering questionnaires to a sample of teenage girls from Kaptembwo primary school, Nakuru West secondary school and Youth for Christ NakuruThe target population in the study comprised all teenage girls who were aged between 13-19 years in and out of school in Kaptembwo, Nakuru Kenya. The accessible population comprised of selected teenage girls from the ages 13-19 years from Nakuru West Secondary School (408 teenage girls), Kaptembwo Primary School (183 teenage girls) according to the school register, (2016) and Youth for Christ group Nakuru (90 teenage girls) making a total of 681 teenage girls.

Study Design: The study employed descriptive survey design
Study Location: The study was conducted in Kaptembwo, Nakuru Kenya
Study Duration: March 2017 to March 2018.
Sample size: 127 teenage girls
Sample size calculation: From a study population of 681, a sample size was drawn using Nassiuma's (2000) formulae:

$$n = \frac{NC^2}{C^2 + (N-1)e^2}$$

$$n = \frac{681 \times 0.25^2}{0.25^2 + (681-1)0.02^2}$$

$$n = \frac{42.5625}{0.3345} \qquad n = 127.1300$$

Thus, the sample size is 127samples
Where: n = Sample size,
N = Population,
C = Coefficient of variation,
e = Standard error.
C=25% is acceptable according to Nassiuma (2000), e = 0.02 and N= 681

Subjects & selection method: From the selected schools, the researcher used simple random sampling technique to select 76 teenage girls in Nakuru West secondary school, 34 teenage girls in Kaptembwo primary school (upper primary class 6-8). To select teenage girls who were out of school, the researcher purposively selected Youth for Christ group Nakuru which is a youth group formed to represent teenage girls who were out of school. The researcher used simple random sampling to select 17 teenage girls in the group.
Inclusion criteria:
1. Teenage girls
2. Ages 13 to 19 years

Exclusion criteria:
1. Teenage boys
2. Teenage girls less than 13 yearsand teenage girls above 19 years

Procedure methodology: The researcher sought an introductory letter from Egerton University Graduate School to assist in obtaining a research permit from the National Commission for Science, Technology and Innovation before starting the research process. The researcher visited the County Commissioner's Office and the County Director of Education to inform them of the intention to collect data. The researcher proceeded to the two schools and the youth group to obtain consent from the heads and the area chief. Questionnaires were then taken to the teenage girls in their classes. The questionnaires were also taken to the youth group at their meeting place and it was researcher administered. The researcher herself distributed the questionnaires to the teenage girls who were purposively selected and waited for the respondents to complete and go back with the complete questionnaires. This helped the researcher to avoid loss of questionnaires and the researcher was able to clarify some questions to the respondents. The researcher assisted in reading the questions because some teenage girls in the group were illiterate. After concluding quantitative data collected through the questionnaire, the researcher embarked on interviewing the key informants (heads from each school who were one female teacher and one male teacher as well as head of the youth group and health care worker in Rhonda Health Centre). The purpose of the interview was to get more in depth information that was used to explain in a detailed manner, the results found from quantitative phase. The researcher met the respondents (3 heads and the health care worker) and clearly explained the purpose of carrying out the research. The researcher interacted well with the respondents and records all the responses while ensuring that the most important points were noted. After the entire interview questions were answered, complete interview schedule was then organised in readiness for analysis and interpretation.
Statistical analysis: Both qualitative and quantitative techniques were used in the analysis and to enrich the discussions of the study findings. Quantitative data obtained through the questionnaires were analysed using Statistical Package for Social Sciences (SPSS) version 21 software. The data was then presented using descriptive statistics of mean scores, frequency tables and percentages. The influence was tested using Regression Coefficient. For qualitative data, data was analyzed using narrative statements based on relevant thematic.

III. Results

The teenagers were required to assess the level of access using a 5-point score ranging from Very low, Low, Medium, High and Very High. From each of the different approaches used in information provision, the scores were then added to form a combined index called level of access to reproductive health information. The descriptive statistics and the frequency distribution of the index are given in Table 1.

Table 1: Frequency Distribution of the Index of Level of Access of Reproductive Health Information by the Teenagers

Index categories	Frequency	Percentage
20-30 (Low)	36	28.3
31-40 (Medium)	69	54.4
41-50 (High)	22	17.3
Total	127	100

Mean 34.7, median 35, mode 35, standard deviation 6.31, minimum 21, maximum 47

The majority of the teenagers (54.4 %) in the study area had a medium level of access to reproductive health information. The index was used to determine the relationships between the socioeconomic conditions of the teenagers and their level of access to reproductive health information. These findings imply that most teenage girls are not free in seeking reproductive health information because they don't want to be seen by other women. Nurses are responsible in guiding teenage girls on the best family planning methods which will help them to make their informed decisions relating to their sexual and reproductive health. Outreach services helped teenage girls to be aware of services offered.

4.4.2 Effect of the Level of Education of the Teenagers on Access to Reproductive Health Information

The linear regression analysis was used to determine the effect of teenager's level of education on the access to reproductive health information. The index of access to reproductive health by the teenagers formed the dependent variable, while the level of formal education attained formed the independent variable. The results of the regression model are presented in Table 2.

Table 1: Regression model summary for level of formal education attained by teenagers

Model	R	R square	Adjusted R square	Standard error of the estimate
1	.303[a]	.092	.085	6.037

[a] predictors: (constant), level of formal education attained by the teenagers

The model indicates an adjusted R^2 value of .085; this means that the independent variable level of formal education attained by the teenagers explained approximately 8.5 % of the variation in dependent variable which is access to reproductive health information. The regression coefficients of the model showing the beta, t statistics and the tolerance levels are given in Table 3.

Table 2Regression Coefficients for Level of Formal Education Attained by the Teenagers

	Unstandardized coefficients		Standardized coefficients			
	B	Std. error	Beta	t	P	VIF
(Constant)	27.405	2.118		12.937	.000	
Age	2.932	.824	.303	3.560	.001	1.000

a. Dependent Variable: index of access to reproductive health information

The regression analysis indicates that the level of formal education attained by the teenagers had a positive and significant influence with β= .303 and p=.000 on the access to reproductive health information. These results indicate that the level of formal education attained by the teenagers significantly influences the access to reproductive health information. The teenagers with a higher level of education accessed reproductive health information more than the teenagers with a lower education level. This finding may be as a result of educated teenagers being aware of their vulnerability to reproductive ill health than their less educated counter parts. When there is usually lack of understanding of sexual and reproductive health issues, it makes it difficult for behavioural change to occur among targeted audience regardless of their awareness.

4.4.3 Effect of Poverty Levels on the Access of Reproductive Health Information to the Teenagers

The linear regression analysis was used to determine the effect of teenager's poverty level on the access to reproductive health information. The index of access to reproductive health by the teenagers formed the dependent variable, while the level of poverty formed the independent variable. The results of the regression model are presented in Table 4.

Table 3: Regression model summary for level of poverty

Model	R	R square	Adjusted R square	Standard error of the estimate
1	.350[a]	.122	.155	5.883

[a] predictors: (constant), level of poverty of the teenagers

The model indicates an adjusted R^2 value of .122. This means that the independent variable level of poverty of the teenagers explained approximately 12.2 % of the variation in dependent variable access to reproductive health information. The regression coefficients of the model showing the beta, t statistics and the tolerance levels are given in Table 5.

Table 4: Regression Coefficients for poverty levels

	Unstandardized coefficients		Standardized coefficients			
	B	Std. error	Beta	t	P	VIF
(Constant)	39.733	1.339		29.667	.000	
Poverty levels	-2.511	.604	-.350	-4.156	.000	1.000

a. Dependent Variable: index of access to reproductive health information

The regression analysis indicates that the poverty levels had a negative and significant influence with β= -.350 and p=.000 on the access to reproductive health information. These results indicate that, the level of poverty significantly influences the access to reproductive health information. The teenagers with a higher level of poverty accessed reproductive health information at a lower rate.

4.4.4 Effect of Parent's Income on the Access of Reproductive Health Information to the Teenagers

Effects of formal employment of the parents on the access to reproductive health information among teenage girls were examined. Financial support from the parents was also examined.

Effect of Formal Employment of the Parents on the Access to Reproductive Health Information among the Teenagers

The linear regression analysis was used to determine the effect of the parent's formal employment on the teenager's access to reproductive health information. The index of access to reproductive health by the teenagers formed the dependent variable, while the formal employment of the parents formed the independent variable. The results of the regression model are presented in Table 6.

Table 5: Regression Model Summary for Formal Employment of the Parent

Model	R	R square	Adjusted R square	Standard error of the estimate
1	.392[a]	.153	.147	5.830

[a] predictors: (constant), level of formal employment of the parents

The model indicates an adjusted R^2 value of .153; this means that the independent variable formal employment of the parents explained approximately 15.3 % of the variation in dependent variable access to reproductive health information. The regression coefficients of the model showing the beta, t statistics and the tolerance levels are given in Table 7.

Table 6Regression Coefficients for Formal Employment of the Parents

	Unstandardized coefficients		Standardized coefficients			
	B	Std. error	Beta	t	P	VIF
(Constant)	37.030	.712		51.986	.000	
Formal employment	4.930	1.036	.392	4.757	.000	1.000

a. Dependent Variable: index of access to reproductive health information.

The regression analysis indicates that formal employment of the parents had a positive and significant influence with β= .392and p=.000 on the access to reproductive health information. These results indicate that the formal employment of the parents significantly influences the access to reproductive health information. The teenagers with parents with formal employment also had a higher access to reproductive health information and vice versa.

Effect of Financial Support to Teenagers by Parents on their Access to Reproductive Health Information

The linear regression analysis was used to determine the effect of the parent's provision of money to their teenagers and their access to reproductive health information. The index of access to reproductive health by the teenagers formed the dependent variable, while the provision of money by the parents formed the independent variable. The results of the regression model are presented in Table 8.

Table 7: Regression Model Summary for Financial Support by Parents

Model	**R**	**R square**	**Adjusted R square**	**Standard error of the estimate**
1	.309[a]	.096	.088	6.025

[a] predictors: (constant), financial support by the parents

The model indicates an adjusted R^2 value of .088; this means that the independent variable parental financial support explained approximately 8.8 % of the variation in dependent variable access to reproductive health information. The regression coefficients of the model showing the beta, t statistics and the tolerance levels are given in Table 9.

Table 8Regression Coefficients for the Financial Support by the Parent

	Unstandardized coefficients		Standardized coefficients			
	B	Std. error	Beta	t	P	VIF
(Constant)	37.419	.919		40.722	.000	
Formal employment	4.109	1.130	.309	3.637	.000	1.000

a. Dependent Variable: index of access to reproductive health information

The regression analysis indicates that financial support by the parents had a positive and significant influence with β= .309 and p=.000 on the access to reproductive health information. These results indicate that the financial support by the parent significantly influences the access to reproductive health information. The teenagers with financial support from their parents also had a higher access to reproductive health information.

Effect of two parent's family on the access of reproductive health information

The number of parents (also referred to as two-parent families) was investigated. The linear regression analysis was used to determine the effect of number of parents on the teenager's access to reproductive health information. The index of access to reproductive health by the teenagers formed the dependent variable, while the number of parents formed the independent variable. The results of the regression model are presented in Table 10.

Table 10 Regression model summary for two parent's family

Model	R	R square	Adjusted R square	Standard error of the estimate
1	.181[a]	.033	.025	6.231

[a] predictors: (constant), number of parents

The model indicates an adjusted R^2 value of .033; this means that the independent variable number of parents explained approximately 3.3 % of the variation in dependent variable access to reproductive health information. The regression coefficients of the model showing the beta, t statistics and the tolerance levels are given in Table 11.

Table 9Regression Coefficients for two parent's family

	Unstandardized coefficients		Standardized coefficients			
	B	Std. error	Beta	t	P	VIF
(Constant)	35.729	.745		47.971	.000	
Number of parents	2.290	1.112	.181	2.060	.041	1.000

a. Dependent Variable: index of access to reproductive health information

The regression analysis indicates that number of parents (or two parent families) had a positive and significant influence with β= .181 and p=.000 on the access to reproductive health information. These results indicate that the number of parents significantly influences the access to reproductive health information. The teenagers with both parents also had a higher access to reproductive health information because they get financial support from the two parents.

IV. DISCUSSION

The findings of the study done by Mbeba (2012) in Tanzania showed that, none of the 38 facilities in Mtwara district had designated areas for provision of youth friendly services since services provided were mostly adult centred. Sexual and reproductive health services offered include condom provision, contraceptives and postnatal care. The findings further showed that, most teenage girls ages between 10-18 years in Mtwara rural district did not have a place within their communities where they could visit and talk about relationships, sex, contraception, sexually transmitted infection and HIV/AIDS. The community members and service providers in the district thought it was inappropriate for girls of age 10-18 years to access sexual and reproductive health services especially family planning.

Another study done by Similo (2015) in Zimbabwe found that the adolescent girls did not have adequate access to sexual and reproductive health information. The community library in Filabusi, strategically set to provide information on health and sexual matters. Respondents in the study revealed that they did not seek sexual and reproductive health information with the elderly people in the community. Instead, they discussed such issues with their friends.

These results are in line with the findings by Engen (2013) in Cameroon, pointing out that, access to sexual and reproductive health information is an important element in promoting and improving adolescents' reproductive health. Offering them with sexual and reproductive health education, either in a school setting or in a health facility empowers them with the skills and knowledge needed to make informed responsible decisions regarding their sexuality. This in turn may lead to reduction in the challenges relating to sexual and reproductive health like pregnancies and mitigation of other reproductive health concerns.

These results are in line with World Health Organization (2003) which states that, poor people have higher than average child and maternal mortality, higher levels of diseases and more limited access to health care and social protection. When people become ill or injured, the entire household can become trapped in a downward spiral of lost income and high health care costs. Investment in health is increasingly recognized as an importance means of economic development and a prerequisite for developing countries.

V. CONCLUSION

The study concludes that, socio-economic factors have been found to be interacting with access and use of reproductive health information among teenage girls.

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