# MEDICAL SOCIOLOGY LEVEL V NOTES 2018

COMPILED BY
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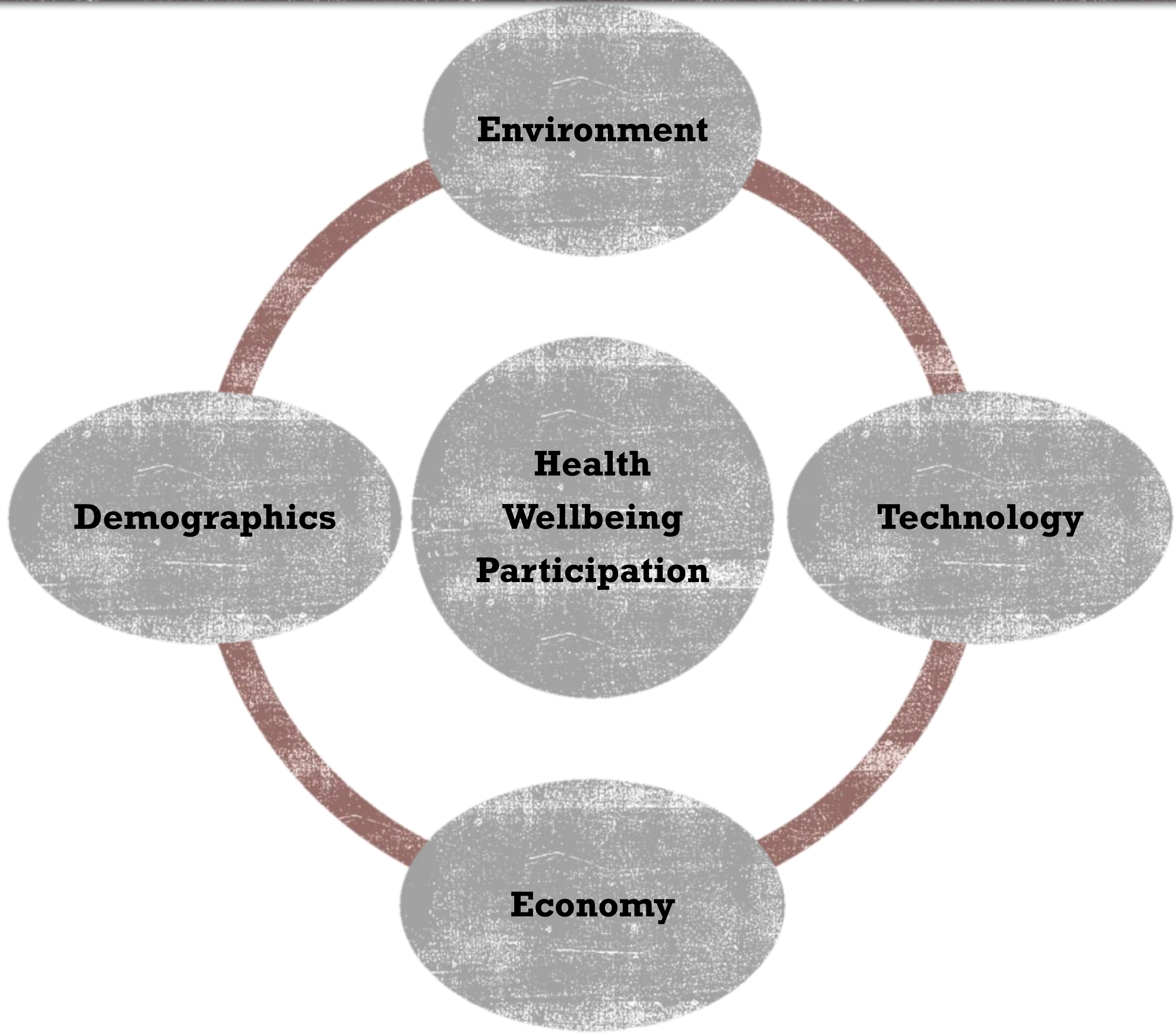
# 1. SOCIAL ISSUES IN HEALTH

BY: PROF. J. OLENJA

# WHAT IS A COMMUNITY?

- This is a fluid term.
- It is a social grouping
- A geographical, as well as, cultural grouping with shared values and practices.
  - This is the dominant community grouping in Kenya.
- 80% of the population lives in the rural areas and therefore efforts are geared at expanding the urban community.
- A community is defined by socio - economic as well as multi - ethnic groupings.

# SOCIAL DIMENSIONS OF HEALTH:
## Meeting global challenges through inter - disciplinarity



# SOCIAL DETERMINANTS OF HEALTH

- Social determinants of health are the conditions in which people are born, grow, live, work and age.
- These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. (WHO 2010).
- Country data consistently document significant disparities in utilization of health services and health outcomes defined by wealth, ethnicity, residence education, age, and other social factors.
- **Health inequity** is defined as "inequalities in health deemed to be unfair or to stem from some form of injustice."

# Cont.

- Since 2005, CSDH has provided information critical for understanding the role social status and context play in determining health.
- WHO Director - General DR. Margaret Chan (2013) reminded Member States that
  - "Factors that contribute to good health at low cost include a commitment to equity, effective governance systems, and context-specific programmes that address the wider social and environmental determinants of health"

# Community health problems in Kenya that are dependent on the environment:

- Communicable and non - communicable diseases are on the rise.
- Reproductive health needs and challenges.
- Food insecurity: malnutrition is a major problem
- Poverty and increased vulnerability

# Vulnerable/ special social groups in a community include:

- Youth/ adolescents
- Elderly
- Persons with disability
- People living in hard to reach areas – including urban slums
- People living with HIV/ AIDs
- Women of reproductive age
- NB: one can belong to more than one of these categories

# Adolescents/Youth

- More than 36% of the population (the "bulge")
- A challenge to development and service delivery
- Poor access to services due to social stigma
- Experience unmet need for services especially reproductive health services
- Experience poor service provider attitude
- Unplanned pregnancy  and early marriage

# Vulnerable women and girls

- Poor young mothers and often school dropouts with no prospects of employment
- Can be heads of households
- Though not designated as FSWs, are often engaged with multiple sexual partners to meet economic needs.
- Have no power to negotiate for condom use
- Highly vulnerable to HIV infection and victims of gender based violence

# The urban poor

- Also classified as **people in hard to reach areas**
- Poor access  to services for a cross - section of the population
- Poor environment and services
- Poverty/unemployment
- Insecurity
- Inadequate of food
- Predominantly use local/traditional  service providers

# Persons living with HIV/ AIDs

- Often poor
- In spite of the availability of ART - there is poor adherence to medication
- Stigma and fear of discrimination
- Fear of disclosure - keeps them away from services that are otherwise free
- Ironically access to health services becomes expensive as they incur transport to seek care elsewhere

# Persons living with disability

- Are not taken into acount when planning for services
- Communities do not generally seek care for persons with disability
- Advocacy for services for persons with disability is low
- We are just beginning to create awareness

# The Elderly

- Growing population - more people are living longer
- Suffer from chronic conditions
- Poor knowledge of these conditions
- Inadequate advocacy for services for the elderly
- High costs of services
- Depend on a social support system that may not cope with high costs of treatment and care.

# Gender Based Violence

- Immediate social factors
  - Economic inequality between men and women
  - Attitude towards gender roles and violence against women
  - Normalization of the culture of violence against women

KDHS 2014

- Physical violence
  - 38% of women (9% for men) reported experiencing physical violence
- Sexual violence
  - 14 % of women (4% men) reported experiencing sexual violence

# SOCIAL CHANGES (GLOBALIZATION) IN HEALTH

- Changes are happening in the following sectors:
  - Culture
  - Economic
  - Political etc.
- There are changes that are driven by exposure to education
- The influence of globalization has also played a role.

# What is globalization?

- The spread of knowledge, science & telecommunications resulting in:
  - Cultural and behavioral adaptations
  - Increased trade
  - Wider consumer choices
  - Access to health innovations

# Lifestyle & health issues

- Influence of globalization
- Sedentary lifestyles and lack of exercise
- Adoption of Habits  such as of Smoking and Alcoholism
- Urbanization and changes in living environments that limit movement(physical activity)
- Nutritional transitions and changes in life style
  - Changes in food variety and dietary practices
  - The role of the supermarket- highly processed foods
  - Global obesity epidemic- is fast growing in Africa)

# The rise in NCDs

- In both urban and rural settings
- Across the social classes - rich or poor
  - Obesity
  - Cardiovascular diseases
  - DM
  - Cancers

# NCDs in Kenya

- Non communicable diseases accounts for more than 50% of total hospital admissions and over 55% of hospital deaths in Kenya.
- The major NCDs are:
  - Cardiovascular conditions, cancers, DM & COPD, along with their sequelae and their shared risk factors.
- Equally contributing to the huge burden are violence and injuries, mental disorders, oral, eye and dental diseases

# Examples

- This rise in DM is associated with demographic and social changes such as:
  - Globalization, urbanization, aging population, adoption of unhealthy lifestyles such as consumption of unhealthy diets and physical inactivity.
- The prevalence of DM in adults is estimated to be 4.56% according to IDF, amounting to almost 750,000 persons and 20,000 annual deaths.
- There is a disparity in distribution with an estimate of approximately 10.7% among urban and 2.7% among rural dwellers (Diabetes Atlas 2014).

# The burden of NCDs

- Besides the burden of deaths and disability, non communicable diseases pose a greater social and economic burden to the economy.
- NCDs threaten progress in the post - 2015 development agenda as poverty is closely linked with NCDs.
- The rapid rise in NCDs is predicted to impede poverty reduction initiatives in low - income countries, particularly by increasing household costs associated with health care.
- Vulnerable and socially disadvantaged people get sicker and die sooner than people of higher social positions, because they are at greater risk of being exposed to harmful products, such as tobacco or unhealthy food, and they have limited access to health services.

# 2. COMMUNITY HEALTH PRACTICE

BY: PROF. J. OLENJA

# Available health services

- Multiple sources: medical pluralism
- Historical perspective:
  - Traditional medicine was discouraged by the colonial government and the new religions
  - It largely operates on the fringes of the health care system
  - It is not regulated
- There is therefore a dominance of the modern health system.

# Community health resources

- There is a whole array of community health resources located in both rural and urban centers.
- These include:
  - Traditional healers
  - Diviners
  - Traditional circumcisers
  - Traditional birth attendants (TBAs): conduct 50 – over 90% of deliveries even though the current policy does not permit the use od TBAs.

# Current community health practice

- It is varied and based on a combination of factors, i.e.,
  - Location & access to services
  - Entrenchment of the cultural belief system and perception of certain conditions
    - What service is required for what condition & when?
    - What is the cause of the disease/ condition
    - The role of explanatory models (biomedical vs. cultural)

# Health seeking

- Health seeking behavior: what people do when illness is recognized
- Involves a decision making process based on the magnitude of the problem as perceived
- Based on options available (Pluralism)

# BARRIERS TO CARE – SEEKING: Structural

- Socio-cultural factors (Perception of Health and disease)
- Role of stigma
- Awareness and recognition of signs and symptoms
- Awareness of availability of services
- Gender and the decision-making process

# BARRIERS TO CARE – SEEKING: Location & access

- Communities in hard to reach areas inevitably use more of the local resources for health care
- They have a more elaborate ethno medical system, out of necessity e.g. Pokot.
- Poor road network in both rural areas and urban slums

# What are the gender implications fo accessing health care

# GENDER & HEALTH

- Gender roles and relations can lead to differences in women's and men's:
  - ✓Social conditions of vulnerability to illness
  - ✓Ability to protect and maintain health
  - ✓Access to  care
  - ✓Quality of care received
  - ✓Burdens of ill - health
  - ✓Gender based violence

# Gender, health & decision making

- Poverty is strongly correlated with lower rate of contraceptive use.
- This relationship is mitigated by gender norms which prevent women of varying socioeconomic status from autonomous decision - making and control over and/or access to financial resources and services.
- Addressing gender as a social determinant of health appropriately can therefore make a difference to the health and well-being of both men and women.

# What is being done to improve access to care and hence care - seeking

- Health promotion: addressing myths and misconceptions about health & disease
- In sectors such as maternal health:
  - Preparedness: prepayments especially for delivery
  - Use of vouchers for poor women
- Political commitment
  - Maternal health services in facilities: currently free **(linda mama initiative)***
  - Maternal deaths: towards zero campaign by the 1st lady
  - Motivation of CHWs: token payment

# Community Engagement in Health

- Community participation as key concept in PHC
- Community Contribution to health facilities within their locality
- Engagement of community health resource persons
  - Redefining the role of Traditional Birth Attendants (TBAs)
- Support to community health initiatives

# Cont.

- Innovative disease e.g. shelters at health facilities

Innovative Ideas- Shelters at health facilities

The "Kirap" outside Ortum mission hospital

Innovative Ideas- Shelters at health facilities

Boarding facilities in the "Kirap" showing two prenant women and a nurse (in green)

# Enhancing community health

- Understanding the causes of inequity in health status and designing programmes to reduce it.
- It is essential to analyse social structures which inhibit access to and use of safe and effective health services.
- Public - health programmes that endeavour to provide equitable access to services by decreasing disparities in service utilization.
- Addressing GBV

# Cont.

- The entrenchment of the **community health strategy** to enhance:
  - Community mobilization & engagement
  - Drawing from available community resources
  - With the new constitutional dispensation: concerted effort to support & cushion the growing number of vulnerable groups

# WOMEN'S HEALTH IN THE CONTEXT OF SOCIAL DEVELOPMENT GOALS

BY: PROF. J. OLENJA

# REFER TO PROF'S SLIDES.

# 2. LEVEL 5 PRESENTATIONS FOR TERM II YEAR 2018

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# QUESTION 1

- What is the role of community participation in health care?

# DEFINITIONS

- COMMUNITY
  - Geographical as well as cultural grouping of people with shared values & practices.

# CONT.

- HEALTH CARE
  - The organized provision of medical care to individuals or a community.
  - Efforts made to maintain or restore physical, mental or emotional wellbeing especially by trained and licensed professionals (health care providers)

# CONT.

- COMMUNITY PARTICIPATION
  - A process by which the community mobilizes its resources, initiates and takes responsibilities for its own development activities and shares in decision making for and implementation of all other development programs for the overall improvement of its health status
  - The key to the successful organization of PHC is community participation.
  - Through this process, the people gain greater control over the social, political, economic & environmental factors determining their health.

# Types of participation

**Passive (manipulation):**

- Individuals and families are mere spectators

**Active (consultation):**

- The community may be carrying out some tasks in a program but it is not involved with the final decision making on what is to be done. The community does not, therefore, develop a sense of self - reliance

**Involvement (community control):**

- The community is involved in all aspects of a program. This type enables the community to participate willingly to improve its own health program for it to have lasting results i.e., thinking, planning, acting & evaluating.
- This empowers the community to make informed decisions in matters affecting their health and development.

# IMPORTANCE OF COMMUNITY PARTICIPATION IN HEALTH

- Create awareness of disease
- Reduces disease prevalence
- Promote health seeking practices
- Reduces morbidity and mortality
- Increased economic output
- The community provides secondary health care services.
- The community aids policy implementation
- Preventive measures are taken up to reduce incidence of disease.

# AIMS OF COMMUNITY PARTICIPATION

- The community develops self reliance
- The community develops critical awareness
- The community develops problem solving skills

# SOCIOECONOMIC SECTOR

- Positive:
  - There are collective fundraising drives towards facilitating health care provision amongst community members e.g. harambees, paybill numbers etc.
  - Support groups are being created to have a pool of finances from which members can access health care services.
  - People are getting involved in income generating activities hence they are able to seek health care.
- Negative:
  - Lack of confidence in the medical care provided within the society and an increase in the levels of outsourcing medical care e.g. going to India. These finances are directed away from the country resulting in a financial drain.

# CULTURAL SECTOR

- Positive:
  - Certain cultural practices have a beneficial effect on health e.g. male circumcision
  - Communities are receptive to suggested changes in their cultural practices that are promotive to health e.g. discouragement of FGM
  - Communities have volunteers who provide health care services at a grass - root level e.g. traditional birth attendants, CHEWs
- Negative:
  - Alternative health service providers skew the health – seeking behavior away from medical centers e.g. TBAs, herbalists
  - Certain cultural practices promote ill health e.g. wife – inheritance, myths in the community (HIV is a curse → stigmatization; TBAs have more experience in assisting a circumcised woman to deliver); husband breastfeeding the other breast

# AGRICULTURAL SECTOR

- Positive:
  - Good nutrition is encouraged by the society esp. in women to boost maternal and child health e.g. woman in West and South Africa as well as Western Kenya are encouraged to be well built
  - Farming and dairy production is a common economic activity in the African set up which promotes natural and healthy feeds which are cost – effective
- Negatives:
  - Increased spread of infections e.g. brucellosis in dairy producing areas
  - Increased use of pesticides has deleterious effects on health
  - Tendency to move from food crop to cash crop

# EDUCATION SECTOR

- Positive:
  - Particular health promotion activities are being encouraged in schools, churches etc. e.g. safe sexual practices, handwashing etc.
  - Embracing basic education in the community resulting in increased health literacy levels in the community
- Negative:
  - Spread of communicable diseases e.g. chicken pox etc.

# WORK ENVIRONMENT SECTOR

- Negative:
  - at the work environment, individual health is not prioritized above overall productivity.
- Positive:
  - Health insurance

# PHYSICAL ENVIRONMENT SECTOR

- People are encouraged to plant trees
- Negative:
  - Cutting down trees → deleterious effects on the environment.

# QUESTION 2

- Define the cultural model of health & apply to a disease or condition of your choice.

# DEFINITION

- Culture is what defines a community
- It is a belief system of any given community
- Shared knowledge based on socialization
- Identifiable practices that are unique to a particular community

# What is a cultural model

- This is what a culture defines health in its own terms.
- E.g. culturally, a para 6 + 0, should be able to deliver on her own as she must have experience. Medically, such a woman is a high risk patient and requires skilled obstetric care.

# Emic vs etic perspectives

**EMIC (*'insider perspective'*)**

- From within the social group
- This evaluates how local people think, how they perceive and categorize the world, their rules for behavior, what has meaning for them and how they imagine & explain things.
- This approach is subjective.
- Emphasizes differences between cultures
- Assumes behavior patterns are unique to a culture.
- Emic data is used to describe the perspective of a specific society, group or individual.

**ETIC (*'outsider perspective'*)**

- From the perspective of the observer
- This approach is scientist – oriented and is objective.
- It realizes that members of a culture are often too involved in what they are doing to interpret their cultures impartially.
- Emphasizes similarities between cultures
- Assumes behavior patterns are universal
- Etic data can be used to compare the traits, views and patterns of diverse societies, groups or individuals.

# Cultural model

- Illnesses and health are perceived as cultural phenomena
- Based on cultural ideas of disease causation
- Attribution of ill health to witchcraft, evil eyes, taboos and transgression e.g. malnutrition & HIV./ AIDs
- Influences health seeking behavior
- Supernatural forces lead to fatalism and resignation
- **EMIC perspectives**; reflects the views of an insider which seem irrational to an outsider.

# Examples of cultural practices

- FGM & circumcision
- Scarification among the Pokot
- Removal of teeth
- Foot biding among girls in ancient china
- Widow inheritance
- Anorexia nervosa
- Bulimia nervosa

# FGM

- Communities that practice it view it as a good cultural practice with the following relevance:
  - Transition period to adulthood and marriage
  - Hygiene
  - Beauty
- But there is a negative health impact such as:
  - Obstetric and gynecological problems e.g. complicated deliveries, dysmenorrhea, PPH & perinatal deaths
  - Physical and mental trauma

# question 3

- What is the role of gender in health? Illustrate with examples.

# What is gender?

- Gender is the state of being male or female with reference to social and cultural differences rather than biological ones i.e. the socially constructed roles, behaviors, activities and attributes that a given society considers appropriate for men and women.
- This differs greatly from “sex” which is the biological and physiological characteristics that define women and men.
- As for health, it is a state of complete ***physical***, ***mental*** and ***social wellbeing***, not just the absence of disease or infirmity.
- Health can influence an individual’s ability to reach his or her full potential in society.

# How do the 2 relate to each other?

- This connection stems from the idea that the different genders should be treated differently and separately from one another.
- These ideas themselves stem from society and cultural ideologies that plague both men and women based on roles assigned to each.
- In short, by being a woman or a man in the eyes of society, certain  treatment tailored to the gender role you have been assigned comes your way be it beneficial or detrimental. This not only affects the social aspect of health but it could also affect the other aspects of health as well such as physical, mental, emotional and even sexual.

# CONT.

- This eventually results in health inequity or disparities based on gender roles assigned to an individual, which obviously goes against the idea of fair opportunity to attain one's full health potential.
- Based on this, one could argue that the role of gender in health is to cause disharmony and bring about a lack of fairness and injustice in the process of obtaining health. Sad to say it is indeed the crux of the issue but through this injustice, a means to fight back can be devised.
- So in an actual sense, the role of gender in health is to aid in reviewing and addressing the social determinants of health appropriately so as to promote social justice and health equity for all.

# HOW IS GENDER USED IN MATTERS OF HEALTH?

- As mentioned earlier, by looking into the social injustice caused by gender roles, we health workers are able to pinpoint issues of concern and not only bring them to light but also manage them as best as we can. This is known as ***gender analysis.***
- To start with, it is indeed women that suffer greatly due to assigned gender roles and relations. By structuring society in such a way, we make women more vulnerable to abuse and mistreatment making them more prone to illness and early death. Examples;

# CONT.

- In some societies women are shunned from attaining tertiary education and forced to live uneducated lives which could result in poor health.
- Some women are mutilated as seen in FGM cases predisposing women to poor health in various aspects apart from physical.
- Societies functioning on a patriarchal framework predispose women and girls to physical, emotional and sexual abuse simply due to being viewed as property or seen as socially inferior to men.
- Healthcare systems though meant to provide and promote good health for all could be influenced by societal norms that in one way or another could be biased to women.

- It is important to note that men and boys could also suffer from health inequities due to assigning masculinity to aggressive and confrontational behavior

# EXAMPLES OF HEALTH DISPARITIES DUE TO MALE GENDER

- There is the issue of having more women based care in health systems compared to male based care centers. Due to the idea of men being hardy society does not see the need to invest in male health care.
- To add injury to insult most of these male healthcare clinics limit their services to urological conditions and infertility. In comparison to women healthcare clinics which receive multidisciplinary health services from gynecologic to obstetric to infertility, antenatal healthcare and breast care.
- There is also a noted predominance of screening and preventive procedures which are more women focused than men focused.

# CONT.

- The best way forward is through gender analysis which reveals how inequalities disadvantage men or women and the constraints they both face to attain health. This has been followed through by;
  - Gender mainstreaming.
  - Female empowerment.

# GENDER MAINSTREAMING

- This is the process of assessing the implications for women and men in any planned action such as in legislation, policy formation or programs. This means that any action taken is meant to consider how it will affect both men and women in the short term and in the long run. Be it in government or in the private sector.
- This goes a long way in ensuring gender equality.

# FEMALE EMPOWEREMENT

- Since women are most affected by this inequity, their empowerment is only necessary for a  move forward in the right direction.
- This is seen in;
  - Women gaining land rights.
  - Having monetary power.
  - Participation in various forums e.g. the political field, schools, households..
  - Giving microcredit to women.
  - Providing education for them.

# QUESTION 4

- In Kenya while over 90% of women attend ANC services just about half deliver in a health facility. Account for this discrepancy.

- Distance from the hospital and unavailability of transport and proper infrastructure.
- Lack of awareness, esp. amongst multiparous women who do not see the need of going to hospital to deliver.
- Lack of finances.
- 3 delays:
  - Decision to seek health
    - Culture
    - Low SES
    - Myths & misconceptions
    - Previous mistreatment in hospital → lack of confidence in hospital
    - Home is more comfortable
    - Lack of support from immediate family & spouse
  - Reaching the health facilit

# CONT.

- 2nd delay
  - Scarcity of health facilities in the immediate vicinity of the mothers
  - Poor infrastructure: roads etc.
- 3rd delay: in receiving adequate TREATMENT
  - Understaffing
  - Inadequately trained and poorly motivated staff

# HOW TO SOLVE THIS

- Create public awareness about the importance of delivering in a health facility (health education)
- Improving physical access of health facilities (appropriate and affordable transport)
- Maternal health care costs should be catered for
  - Linda mama initiative (find out)
- Train TBAs

# In brief, what is antenatal care?

'Care during pregnancy'

Ideally, should be eight ANC visits in an uncomplicated pregnancy as recommended by WHO.

(WHO) Should include measurement of blood pressure, diabetes, anemia, urine testing for proteinuria/bacteriuria, screening for STIs, malaria etc.

It also includes administering of supplements, vaccination, treatment of infections and controlling comorbidities.

The visits are also used to educate the women and families about danger signs and symptoms and about the risks of labor and delivery.

All this is done with the aim of improving maternal health and survival during the pregnancy and after birth.

# Factors that predict place of delivery.

- According to a study done in Kenya in 2013 by Kitui et al. , the following factors can strongly predict place of delivery:
  - Living in urban areas, being wealthy, more educated, using ANC services optimally, lower parity, insurance cover, region, ethnicity, type of facility used, marital status, maternal age

- Women most commonly cited distance and/or lack of transport as the reasons for not delivering in a health facility, but over 60% gave other reasons including 20.5% who considered health facility delivery unnecessary (especially the multipara), 18% who cited abrupt delivery as the reason and 11% who cited high cost.

# The discrepancies can be accounted for by these three points:

- Factors that lead to a delay in decision of the mother to seek care.
- Factors that lead to a delay in reaching care.
- Factors that lead to a delay in receiving adequate care.

# Factors that lead to delay in decision of the mother to seek care, include:

1. Low socio-economic status of the mother
2. Low level of education/lack of health education
3. Lack of confidence in hospitals – they perceive traditional birth attendants to be effective caregivers.
4. Comfort of home and avoiding hospital stay
5. Previous mistreatment in hospital
6. Culture/ beliefs
7. Lack of social support system

# Factors that lead to a delay in reaching care.

1. Distance to health facilities/hospitals
2. Availability and cost of transportation
3. Geography: e.g. mountainous, rivers

# Factors that lead to a delay in receiving adequate care.

1. Poor facilities and lack of medical supplies and equipment.
2. Inadequately trained and poorly motivated medical staff
3. Inadequate referral systems

# Ways to combat the discrepancy.

- Health education,
- Improving physical access by providing appropriate and affordable transport during labour.
- Improving the experiences and the outcome of mothers seeking health facility delivery.
- Lowering costs.

# Ways to combat the discrepancy.

- According to a study done in western Kenya in 2012 by Wangalwa et al. ; interventions at the community level have proven to be effective in increasing the number of women who have deliveries by skilled birth attendants
- These include:
  - Building the capacity of CHWS to provide community level services
  - Strengthening health facility- community linkages
  - Raising the community's awareness to their rights to health services

# Ways to combat the discrepancy.

- According to the same study, there was a statistically significant ($p < 0.05$) increase in essential maternal and neonatal care practices of four ANC visits, delivery by skilled birth attendants, uptake of sulfadoxine pyrimethamine for IPT for malaria, exclusive breastfeeding and knowledge of HIV status.

# Case scenario

- Khadija is a young lady from Kenya's coast. She's pregnant with her 1st child and is due any day now. She attended the ante-natal clinc severally and was assured the pregnancy is fine. However, her mother discouraged her from making any plans of delivering in a hospital. She said that people only went to hospital when there's a problem(which she seemingly does not have) also that at the hospital she would undergo

- Unnecessary procedures and operations that would make her less of a woman. Besides she hears the nurses are not very friendly. One is said to have slapped her neighbour when she was at labour because she did not push when she was told to.
- She had even hard from her chama group that men preffered women delivered by 'wakungas' (TBAs) more because they could resume sex much earlier, otherwise, they would have to take up 2nd 3rd

- Up 2nd/3rd wives. She would hate to compete with other women for her husband. Khadija also recalls that when her elder sister was in labour, she could not reach the hospital because it was very far and the roads were terrible, so even if she decided to go to hospital, she'd grapple with bad terrain. She is now very anxious, but is leaning towards delivering at home.

# Factors affecting healthcare seeking culture

- Education level and level of awareness of importance of seeking healthcare.
- Attitude towards healthcare providers and modern health facilities.
- Quality of healthcare services offered.
- Economic status of those seeking services
- Availability and accessibility of healthcare facilities
- Effects of culture and cultural beliefs: traditional cultures and religious beliefs.

# Possible reasons for low turn-out for hospital deliveries compared to high ANC turnout

## 1. Financial constraints or Poverty

While ANC services are free in government facilities some expenses are incurred in delivery.

Most of the population is not health insured thus unable to pay for these expenses thus women avoid hospital delivery altogether.

# 2.Few equiped facilities for delivery as compared to the Ante-natal Clinics.

ANC can be provided in more widespread centres like clinics dispensaries but healthcare facilities equipped with a labour ward are sparcely distributed.

Turn around time for ANC is less than for deliveries, which is a turn-off for most people thus preferring to come only for Ante-natal clinics only.

# 3.Poor transport and ambulance system

- Poor road networks in remote areas make it difficult for transportation to health facilities.
- Bodaboda is the most accessible means of transportation and is not ideal for transporting pregnant women to hospital.
- Ambulance system is still not widespread and also very expensive.

# 4.Attitude towards healthcare providers

- While most are comfortable going to health facilities for ANC due to technolgy(eg. U/S) and more medical knowledge of providers they prefer Traditional Birth Attendants (TBA) to mid-wives for deliveries due to them being more friendly. TBAs are also affordable and readily available.

# 5.Culture

- Some cultures have the belief that normal delivery (SVD) is a stronger safer and more natural way than cesarian sections of any other clinical deliveries.

# 6.Inadequate awareness on importance delivery in a well equiped facility.

- There's however more effort put in educating the public on importance of ANC visits as well as delivery within a healthcare facilit.

# QUESTION 5

- What are the health challenges that adolescents/youth face accessing RH health services in Kenya?

# INTRODUCTION

- A young population puts great demands on provision of health services, education, water and sanitation, housing and employment. At the same time, it provides opportunities for the country's development if the adolescents get opportunities to attain educational goals and receive an all round preparation for responsible adulthood. This segment of the population, therefore, requires close attention of all sectors of government, development partners and other stakeholders for the country to attain the Vision 2030 , African Youth Charter (2006) and Post-2015 Development Agenda through Sustainable Development Goals (SDGs).

# DEFINITIONS

**ADOLESCENTS**

- According to the World Health Organization (WHO), adolescents are defined as people aged between 10 and 19 years.
- According to Kenya Population Situation Analysis (2013) those aged below 20 years constitute about 24 percent of the country's total population (9.2 million).

**YOUTH**

- Article 55 of the Kenyan constitution defines youth as those aged between 18 and 35.

**NOTE :** The terms "Adolescents" "Youth" and "Young People" are interchangeably used for purposes of this presentation

# DEFINITIONS

**REPRODUCTIVE HEALTH**

- This is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system, its functions and processes.

**SEXUAL, REPRODUCTIVE HEALTH AND RIGHTS**

- The exercise of control over one's sexual and reproductive health linked to human rights and includes the right to:

- Reproductive health as a component of overall health, throughout life cycle, for both men and women;
- Reproductive health decision-making, including voluntary choice in marriage, family formation, determination of the number, timing and spacing of one's children, right to access information and means needed to exercise voluntary choice;
- Equality and equity for men and women, to enable individuals to make free and informed choices in all spheres of life, free from discrimination based on gender; and
- Sexual and reproductive health security, including freedom from sexual violence and coercion, and the right to privacy.

# DEFINITIONS

## SEXUAL HEALTH

- A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled

# SEXUAL AND REPRODUCTIVE HEALTH STATUS OF ADOLESCENTS IN KENYA

**SEXUAL DEBUT, CONTRACEPTION AND FERTILITY**

- 15% of women age 20-49 had first sexual intercourse by age 15, 50% percent by age 18, and 71% by age 20. 22% percent of men age 20-49 had first sexual intercourse by age 15, 56% by age 18, and 76% percent by age 20.
- 18% of adolescent women age 15-19 are already mothers or pregnant with their first child.
- The proportion of teenagers who have begun childbearing has not changed since the 2008-09 KDHS to the KDHS 2014
- Although many adolescents may choose to get pregnant, many pregnancies occur in the context of human rights violations including: child marriage, coerced sex and sexual abuse. Lack of education, low economic status and lack of contraceptive service access also contribute greatly to adolescent pregnancies.

# SEXUAL AND REPRODUCTIVE HEALTH STATUS OF ADOLESCENTS IN KENYA

- Adolescents have a disadvantage in maintaining healthy pregnancies due to lack of education, limited access to antenatal care due to cost and skilled delivery, physiological and biological and psychological immaturity. These among other factors such as smoking, substance abuse, anemia, malaria, HIV and AIDS and sexually transmitted infections contribute to adverse outcomes of pregnancy.
- Some of the adverse outcomes include: risk of maternal mortality and morbidities (obstetric fistulae), unsafe abortion and complications, prolonged labor, delivery and post-natal period.

# SEXUAL AND REPRODUCTIVE HEALTH STATUS OF ADOLESCENTS IN KENYA

- Evidence shows that among adolescent girls who had started childbearing by age 18 in Kenya, 98 percent were out of school, indicating that early pregnancy clearly means the end of education for almost all adolescent girls.

**HIV AND AIDS AND STIS**

- HIV prevalence has decreased significantly among young people aged 15 to 19 years, declining from about 3.0 percent in 2003 to 1.1 percent in 2012
- However, it is reported that HIV testing rates for Kenya are lowest among adolescents.

# SEXUAL AND REPRODUCTIVE HEALTH STATUS OF ADOLESCENTS IN KENYA

- Sexually transmitted infections (STIs), especially those that are ulcerative, are associated with an increased risk of HIV infection and have significant implications for reproductive health outcomes.28, 29 Among Kenyan adolescents aged 15-19, only one percent of girls and 0.3 percent of boys self-reported an STI.

**SEXUAL ABUSE AND VIOLENCE**

- Nearly half of both adolescent girls and boys reported experiencing physical violence in the 12 months preceding the KDHS 2014 survey. Adolescents who suffer sexual abuse are more likely to be exposed to unintended pregnancy, unsafe abortion and STIs including HIV.

# SEXUAL AND REPRODUCTIVE HEALTH STATUS OF ADOLESCENTS IN KENYA

**DRUG AND SUBSTANCE ABUSE**

- According to a 2012 rapid assessment of drugs and substance use in Kenya, about 18 percent of adolescents aged 15-17 reported ever using any drug or substance, including tobacco, Khat (Miraa), narcotics and inhalants. Specifically, about two percent of females and four percent of males aged 10-14 and about 11 percent of 15-17 year olds reported ever using alcohol.
- For adolescents, substance use and abuse is associated with increased risk for early sexual debut, multiple sexual partners and early childbearing.

# SEXUAL AND REPRODUCTIVE HEALTH STATUS OF ADOLESCENTS IN KENYA

**HARMFUL PRACTICES**

- Among those of most urgent concern to Policy are Female Genital Mutilation (FGM), sexual abuse and violence, drug and substance abuse as well as child marriage.
- Female Genital Mutilation is associated with immediate and long term social, physical, psychological and health consequence. Among young girls aged 15-19, FGM declined from 15 percent in 2008 to 11 percent in 2014. These levels are still quite high considering the numerous adverse consequences of FGM and that in some communities the practice is nearly universal,

# SEXUAL AND REPRODUCTIVE HEALTH STATUS OF ADOLESCENTS IN KENYA

- In addition, girls who have undergone FGM as a rite of passage are likely to drop out of school, experience child marriage and early child bearing

**MARGINALISED AND VULNERABLE ADOLESCENTS**

- These are groups of adolescents who find themselves in need of various facets of consideration including social, economic and health spheres of life and include:

1. Adolescents living in informal settlements
2. Adolescents in labor market
3. Adolescents with disabilities
4. Adolescents living with HIV
5. Married adolescents
6. Orphaned adolscents
7. Adolescents living in humanitarian/ emergency situations

# NATIONAL ADOLESCENT SEXUAL REPRODUCTIVE HEALTH POLICY 2015 KENYA

The Policy, therefore, identifies the following specific objectives:

1. Promote adolescent sexual reproductive health and rights;
2. Contribute to increased access to ASRH information and age appropriate comprehensive sexuality education (AACSE);
3. Contribute to reduction of STIs burden, including HPV and HIV as well as improvement of appropriate response for infected adolescents;
4. Reduce early and unintended pregnancies;
5. Reduction of harmful traditional practices;
6. Reduce drug and substance abuse;
7. Reduce Sexual and Gender-Based Violence (SGBV) incidences amongst adolescents to improve response; and
8. Address the special SRHR-related needs of marginalized and vulnerable adolescents.

# BARRIERS ADOLESCENTS FACE IN ACCESSING SRH SERVICES

**SOCIAL-CULTURAL BARRIERS**

- Adolescents are brought up in different social, cultural and economical environments which have a direct impact on their perspective on life and thus their reproductive health and future.
- Social-cultural barriers take restrictive forms as follows

1. **Embarrassment and fear of stigma:** These prevent many young people from seeking information about SRH and from accessing services if they fear they might be seen or their information shared with family members.
2. **Social pressure** and **cultural norms** around early child-bearing and contraceptive use imposed by **partners, family, religious communities**, and the **larger society** often limit a young person's desire and ability to access and utilize SRH services

# BARRIERS ADOLESCENTS FACE IN ACCESSING SRH SERVICES

**ACCESSIBILITY BARRIER**

- These take two major forms:

1. **Cost:** They may be unable to afford them and may not feel comfortable asking friends or family to provide funds for such expenses.
2. **Location:** SRH providers far from where youth live, works, or attends school, and limited access to transportation can prevent young people from accessing SRH service providers.

# BARRIERS ADOLESCENTS FACE IN ACCESSING SRH SERVICES

**INFORMATION BARRIERS**

- Lack of comprehensive and correct information about service locations.
- Unfamiliarity with the healthcare system may pose barriers to access for young people who might otherwise make use of SRH services.
- Lack of knowledge of their own need for SRH services
- Uncertain about the safety and reliability of SRH services and contraceptive methods, and consequently, unwilling to use them.

# BARRIERS ADOLESCENTS FACE IN ACCESSING SRH SERVICES

**PROVIDER AND SERVICE DELIVERY BARRIER**

- Fear of being served by a familiar person they know.
- Fear of sharing health facility with adults.
- Lack of skilled providers to provide high quality, comprehensive and confidential care.
- Stigma and disapproval from health care provider.
- Stock out of commodities in sexual reproductive health service facility.
- Crowding of waiting areas.
- Limited hours for walk in to facilities providing SRH services

# REFERENCES


- National Adolescent Sexual Reproductive Health Policy 2015 by Ministry of Health Republic of Kenya
- National guidelines for provision of Adolescent youth-friendly Services (YFS) in Kenya by Ministry of Health
- ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH CARE SERVICES BY ADOLESCENT GIRLS AGED 15-19 YEARS AMONG PASTORAL COMMUNITIES IN NAROK COUNTY, KENYA. By Njoki Mbugua Leah
- Constitution of Kenya 2010
- Kenya Population Situation Analysis 2013
- http://www.who.int/topics/adolescent_health/en/

# QUESTION 6

- To what extent is nutrition a bio – cultural issue?

# Introduction:

- Biological and Cultural issues affecting Nutrition.
- Nutrition is the process of providing or obtaining food necessary for health and growth.

# Biological aspects affecting Nutrition:

- Medical conditions: allergies, disease conditions such as PUD.
- Age
- Gender
- Physiological States e.g. Pregnancy

# Cultural Aspects affecting Nutrition:

What is Culture?

Identifiable practices unique to a Community.

- Religion: Muslims don’t consume pork, Hindus and Cows.
- Ethnicity: Kikuyu community- certain animal parts are exclusively set aside for men e.g. liver and gizzard.
- Economic activities: Fishing communities, Pastoral Communities e.g. Maasai.
- Westernization: Pizza, Burgers, Fries
- Stereotypic Thinking: Sukuma and Ugali associated with limited resources i.e. poverty

# Conclusion:

- Pattern of nutrition is influenced by both cultural and biological factors and the extent varies from individual and society.
- Certain Biological and Cultural aspects on nutrition have both positive and negative impacts on an individual.
- Poor nutrition can lead to reduced immunity, reduced mental performance and reduced productivity.
- Therefore we should embrace the positive biocultural aspects on nutrition.

# DEFINITIONS

- What is nutrition?
- What is Bioculture?
- This question requires one to look at both nutrition & biocultural issues in totality & not individually.

# QUESTION 7

- To what extent does health provider - client interaction affect health seeking behaviour?

# Swala Kuu!!!!!

- To what extent does health care provider- client interaction affect health seeking behavior?

# DEFINITIONS

- Health care provider- an individual providing professional medical services in a health care facility
- Client- an individual seeking medical attention in a health care facility
- HCP_client relationship- interaction between the HCP and the client at the point of receiving care.

# Current situation in Kenya

- There's a great disparity between this relationship in the private sector and in the public sector with the public sector being doctor centered and the private being patient centered.
- This has resulted in better outcomes in the private sector than the public sector with good client health seeking behaviors there than in the public sector

# BUT WHY???

- The public sector has many patients making it hard to offer patients personalized care
- Close monitoring of HCP is lacking hence they don't do their best.
- Consequences from patients complaints is lacking in the public sector hence no fear among HCP
- Poor staff motivation in the public sector( pay, rewards/incentives)
- Lack of working equipments
- Lack of proper explanation of diseases and treatment making them opt for other treatment.
- Poor working culture

# What's in the private sector, you ask?

- Fewer patients make it possible to personalise care.
- Close monitoring of HCP
- Patients complaints are listened to very well and actions taken.
- Presence of facilities
- Better motivated workers
- Good working conditions
- Good working culture.

# The patients contribution to this relationship

- Galaorous patients create a negative impression among HCP and hence affect the quality of that relationship
- Patients not knowing their rights reinforces the bad relationship
- Culture promoting alternative healthcare to HCP e.g TBAs in case of FGM patients.
- Ignorance of patients / patients being less educated.

# Patient promoting factors.

- Education to know their rights
- Patients in the private sector have financial empowerment and hence will want value for their money by asking as many questions as possible regarding their illness and treatment too

# conclusion

- To conclude, patient satisfaction is measured by the curing of their disease and quality of concern/ care accorded to them.
- Where a patient experiences good rlation with the HCP it creates a chanell for that patient to feel confident in that person and hence will not hesitate to seek medical attention should they get ill again (the contrary is also true)
- This relationship is very fundamental in the health seeking behavior in the client and thus more empasis and more importance need to be put to the betterment of this relationship.

# Thank you Royals

- **Any questions????**

# QUESTION 8

- HIV starts with and ends with behaviour. Everything else is in between (Dazon 2011). Elaborate on this statement.

# Question 8

HIV starts and ends with behaviour. Everything else is in between. (Dazon 2011)

Elaborate on this statement.

# Individual Level

- Risky Sexual behaviour
- Substance use
- Partner instability
- Intimate partner violence
- HIV/STI awareness

# Risky Behaviour

- Lack of condom use
- Multiple sexual partners
- Unknown partner status/history
- Relationship duration
- Substance use

# Substance Abuse

- Impaired judgment with respect to sexual partners
- Needle sharing
- Impaired decision making

# Partner Instability

Low marriage rates, norms in relationships, marriage, premarital sex, unemployment, economic stability, high drug use and abuse.

# Intimate Partner Violence

- Secrecy

    Seeking care, prevention, treatment or support.

# Risk awareness

- HIV/ STI awareness

# Community Level

- Poverty
- Social Concurrency
- Stigma and Discrimination

# Poverty

- Sex Exchange
- Homelessness/ poor housing
- Financial stability
- Unemployement
- Inadequate access to healthcare

# Social Concurrency

- Sexual Relationships that overlap in time.
- Low male: female

# Stigma and Discrimination

Social networks influence social support and social influence, engagement and attachment as well as access to resources and material goods.

# Prevention

- Individual factors
- Activism and Advocacy
- Community Education
- Organizational support

# Prevention

- Healthy Love Party

Core competencies of HIV prevention focus on educating, awareness, risk perception, risk awareness, skill building and use of preventative measures.

Sex positivity and centered on women's sexual expression, sexual rights, HIV awareness, sexual communication and identity as a sexually active human being.

Diffusion of effective Evidence Based Interventions

# Conclusion

HIV Starts and Ends With Behavior!!!!

AIDs Is Real

Get Tested Today!

# QUESTION 9

- To what extent would you describe FGM as gender based violence.

# QUESTION 10

- Discuss obstetric fistula in the context of social determinants of health.

# QUESTION 11

- Using two examples of your choice demonstrate the role of lifestyle in disease.

# EXAMPLES

1. Diabetes
2. Hypertension

# INTRODUCTION

- NCDs are diseases that are not spread through an infectious vector or its pathogenic products.
- They are caused by:
  - Lifestyle
  - Social determinants e.g. where you were born
  - Environmental exposure
  - Genetics/ birth defects
- They may be chronic and as a result may have a negative impact on a person's quality of life & the general health of a population.

# DM

- A group of diseases characterized by defects in insulin production, insulin action or both.
- Type 2 DM  is a result of insulin resistance by tissues of the body.
- About 1% of deaths in Kenya were directly attributable to diabetes in 2012 (WHO)
- Prevalence of diabetes in Kenya in 2010 was at 3.3%, and is predicted to rise to 4.5% by 2025 (WHO)

# HTN

- A chronic condition characterized by persistent elevated blood pressure in the arteries (>140/90mmHg) that can lead to complications such as coronary artery disease, heart failure & stroke.
- The leading cardiovascular disorder in Africa with over 20 million people affected.
- In a study conducted by members of the School of Public Health in 2014, the prevalence of hypertension was 22.8% among test subjects, with 20% of people were aware of their hypertensive status.

# THE ROLE OF LIFESTLY

- The following play a role in the causation of both DM & HTN:
  - Diet
  - Sedentary lifestyle
  - Social behaviors
  - Health seeking behavior

# diet

- As a result of growing populations and globalization, there is an increased amount of processed foods.
- Increased popularity and availability of fast food, sweetened drinks, snacks and high cholesterol meals.
- Change in cooking habits, with an increased tendency for deep frying, cooking oils and salt.
- All these factors lead to an increase risk of developing obesity, diabetes and hypertension

# SEDENTARY LIFESTYLE

- With urbanization, there is a gradual shift from an agricultural society to a more commercial/technological one.
- Manual labour/physical activity have been substituted for long office hours and traffic.
- People have to take time out of their day to exercise which is inconvenient.
- Lack of exercise which is a defined risk factor in the development of obesity, diabetes and hypertension among others.

# SOCIAL BEHAVIORS

- Smoking and alcohol intake are critical risk factors in the development of non-communicable diseases
- Labelling of cigarette packets and alcoholic drinks with regulations on use and marketing are methods used to attempt to reduce use and abuse

# HEALTH SEEKING BEHAVIOR

- Health seeking behaviour plays a major role in the development of chronic non - communicable diseases.
- People are likely to wait until the manifestations of the disease affect their daily life, as opposed to having regular check ups.
- Access to health care and socioeconomic/financial status also limits people from seeking help.
- Poor quality of health services and transport also play a role

# QUESTION 12

- Persons with disability and in particular women experience poor access to RH service. Discuss the reasons for this