Assessment of a sexual and reproductive health intervention for domestic workers in Nairobi, Kenya

STUDY TEAM

FHI 360 conducted this research in collaboration with

- National Organization of Peer Educators (NOPE)
- Kenya Union of Domestic, Hotels, Educational Institutions, Hospitals and Allied Workers (KUDHEIHA)

Objective

To assess an intervention to provide female and male domestic workers (DWs) in Nairobi with knowledge and practices to improve their sexual and reproductive health (SRH).

Background

For close to a decade, FHI 360 has conducted research and implemented programs that aimed to measure and build the life skills of female DWs, or house girls, in Nairobi to reduce their risk of unintended pregnancy and of STI/ HIV infection. A small scale assessment conducted in 2005 in collaboration with Kenyatta University and the Presbyterian Church of East Africa Bahati Martyrs Parish revealed that house girls are vulnerable to unintended pregnancy and STI/ HIV infection because of their poor socioeconomic background, isolation, low status of their work, and previous experiences with sexual coercion and violence (not necessarily at their work place). The assessment also showed that these house girls had some knowledge of modes of transmission and prevention of HIV; but, knowledge and use of contraception, including condoms, was low. A survey of 153 house girls in 2007 corroborated findings on knowledge of STIs, HIV and pregnancy prevention and led to the development of an intervention called the Health and Life Skills Project (HELP).

HELP was implemented from 2007 to 2010 at participating churches and was composed of seven modules: self-esteem and communications skills, SRH, STI/ HIV prevention, sexual violence, alcohol and drug abuse, personal savings and financial management, and, basic first aid. Data collection from surveys both before and after the intervention showed moderate changes in SRH knowledge; however, the changes were not as great as anticipated. Several recommendations emerged from this study: future interventions should focus on health outcomes, not just knowledge; interventions should be shorter in duration; more data are needed on barriers to prevention services; and an intervention should be developed that would reach a greater number of DWs (not just house girls) and consider a wider range of implementation partners beyond churches.

Building on these recommendations, FHI 360 worked with the Kenya Union of Domestic, Hotels, Educational Institutions, Hospitals and Allied Workers (KUDHEIHA), the union that represents DWs, and the National Organization of Peer Educations (NOPE) to develop a program of activities to reach a broader range of DWs--both males and females working as house boys and house girls, gardeners, guards and drivers. These activities were designed to empower DWs with SRH information and life skills to reduce their vulnerability to STIs including HIV, unintended pregnancy, and rape and other forms of sexual assault. The activities included conducting outreach in the houses where DWs are employed, training providers to offer DW- friendly SRH services, developing and packaging information on referrals for services, and conducting awareness sessions on health rights.

Intervention activities began in July 2013 and lasted for 11 months. The assessment was conducted in May, 2014, the last month of program activities. The objectives of the assessment were to (1) determine DWs' SRH knowledge and practices and their utilization of SRH services; (2) assess DWs' knowledge of reproductive health (RH) rights; (3) assess DWs' knowledge of and participation in NOPE activities; (4) compare profiles of DWs who participated in NOPE activities to those who did not; and (5) identify lessons learned from implementing the intervention.

Methods

This study was a formative assessment that used a combination of quantitative and qualitative methods. Data were collected through a survey with DWs in Nairobi. In addition, in-depth interviews (IDIs) were conducted with DWs and with stakeholders who included staff from NOPE and KUDHEIHA, community health workers (CHWs), service providers, supervisors and government officials. The study was approved by the Kenya Medical Research Institute (KEMRI) and FHI 360's Protection of Human Subjects Committee.

The survey was conducted in six intervention districts: Dagoretti, Embakasi, Kasarani, Lang'ata, Makadara, and Westlands. The target sample size was 400 DWs to be composed of half who participated in NOPE intervention activities and half who did not. Making use of a mapping exercise conducted by NOPE between July and August 2013 to develop a sampling frame of residential complexes or neighborhoods/ estates (catchment areas) where DWs are found, we selected DWs using a stratified two-stage sampling design. The sample was stratified by district and the sample size per district was proportional to the number of DWs identified in each district. Catchment areas within the districts were randomly selected for participation in the survey with the exception of Embakasi where all of the district's small number of catchment areas that were listed were selected. Within selected catchment areas, individual households were randomly selected for enumeration. Data collection teams approached households after receiving permission from the security staff at the gate. They enumerated the DWs in each household and then randomly selected a sample of the individual DWs according to NOPE participation status (whether they participated in intervention activities or not) then recruited them to complete the survey. Data collection was hindered by security concerns in Nairobi at the time of the survey in addition to some discrepancies between the mapping information and current situation. In total, 394 households were approached and interviews were conducted at 67% of them. The main reasons why an interview was not conducted at a household were that there was no DW at that household, the employer refused to allow the interview, or the DW was too busy.

A total of 264 DWs completed interviews including 83 who had participated in NOPE activities and 181 who had not. In addition, eight IDIs were conducted with DWs and 24 with stakeholders. Analysis for the survey was primarily descriptive with weights calculated to recalibrate the sample across districts to their population sizes. Although the study was not designed to attribute observed effects to NOPE activities, statistical tests were carried out on selected characteristics to compare those who participated in NOPE activities to those who did not participate. Chi-square tests accounting for the sampling design and weights were used for these comparisons.

Results

This brief presents key findings from the survey and the IDIs on the characteristics of DWs, their SRH knowledge and sources of that knowledge, their SRH practices, knowledge of their RH rights, their knowledge of and participation in NOPE activities, and lessons learned implementing the intervention.

DW CHARACTERISTICS

The characteristics of the two survey groups (participants and nonparticipants) reveal differences regarding marital status, education level, and rural or urban place of birth. In addition, there are some differences regarding their work situations.

- Both survey groups were predominantly female (85% vs. 90%) and the average age was in the late 20s (29.7 years vs. 28.0 years).
- A significantly higher percentage of participants were married (37%), had completed their secondary education (40%), and were born in an urban setting (28%) compared to nonparticipants (20% married, 18% completed secondary education and 7% born in an urban setting) ($p<.05$). Approximately 70% of both groups had children.
- Over half of the participants (51%) had worked as DWs for four or more years while nine percent have worked as DWs for less than a year. In contrast, 43% of nonparticipants had worked for four or more years while 20% had worked for a year or less.
- Participants were significantly more likely to live in their own home (41%) as opposed to their employer's or somebody else's home, compared to 25% of nonparticipants who lived in their own home ($p<.05$).
- Participants were significantly more likely than nonparticipants to have one day or more off per week. Only one percent of participants stated that they did not get any days off whereas 19% of nonparticipants stated that they did not.

SRH KNOWLEDGE

- All survey respondents except one could name at least one modern method of contraception. Among participants the average number named was 4.5 methods (with a range of 2-7). Nonparticipants on average knew of fewer methods, 3.4 (with a range of 1-7).
- Eighty-four percent of participants and 87% of nonparticipants agreed with the statement that it is better for the health of the mother and baby to wait at least two years between pregnancies. Forty-two percent of participants and 25% of nonparticipants correctly disagreed with the statement that a woman must be menstruating in order to begin using a family planning (FP) method.
- Virtually all the survey respondents could name at least one STI though knowledge of each individual STI was higher among participants compared to nonparticipants. Only 1% of participants and 8% of nonparticipants could not name any. Gonorrhea and syphilis were cited by over 90% of the participants, and 77% and 72% respectively by nonparticipants.
- Failure to use condoms and lack of information on STIs including HIV were cited by both groups as the two main factors contributing to STIs (including HIV) among DWs.
- Between 25% and 46% of both survey groups cited the following four barriers to condom use: lack of knowledge on condom use, partner refusal, rumors about condoms, and lack of access. Over 90% of respondents

in both groups agreed with the statement that it is all right for an unmarried woman to suggest using condoms to her partner. Fewer agreed that it was acceptable for a married woman to suggest condom use with her husband; 80% of participants and 63% of nonparticipants agreed with this statement.

- Lack of SRH knowledge, including signs and symptoms of an STI, FP methods, and HIV/STI prevention methods, was mentioned by nearly all IDI respondents as a contributor to STI infections (including HIV) and unintended pregnancies among DWs. Most IDI respondents cited this lack of knowledge. Many IDI respondents noted that because DWs often come from rural areas or have little formal education, they lack the information needed to make healthy decisions regarding their RH. Also, IDI respondents felt that DWs face stigma if they are infected with HIV or another STI, if they seek care for RH issues (for men), or even simply for being a DW. IDI respondents felt that this stigma affects DWs' willingness to seek help, thereby contributing to the spread of STIs/HIV and unintended pregnancies.

SOURCES OF SRH KNOWLEDGE

- All survey respondents had at least one source of SRH information. The most common sources for both participants and nonparticipants were the media, including print media, TV, and radio (83% vs. 68%) followed by health care providers (62% vs. 46%). Over one-fourth of participants also received information from peers and social support groups. While 22% of nonparticipants also said they receive information from peers, few received information from social support groups.

- The two main types of messages that both survey groups reported hearing are to use condoms correctly and consistently and to be faithful to one uninfected partner. When asked specifically about FP information, at least 80% of both groups said that they wanted more information on contraceptive methods.

- Nearly three-quarters of both survey groups suggested using the media to communicate SRH messages to DWs. In the participant group, peers (44%), social gatherings (28%) and social support groups (22%) were also mentioned while social gatherings (20%) and peers (19%) were mentioned by nonparticipants.

- Religious institutions and health facilities were also mentioned by just under half of both groups as venues for communicating SRH messages. In addition, 41% of participants and 31% of nonparticipants suggested local community centers.

- While at least half of the DW IDI respondents mentioned that television and radio were important sources of health information, most said that DWs get information from peers though as one stakeholder pointed out, *"They also talk to their peers, but you see the information that they get may not be correct.."* Half reported that they get health information from CHWs or outreach workers and from health facilities. Stakeholders and NOPE also reported these as the main sources of information.

- The majority of stakeholders, NOPE staff, and DW IDI respondents mentioned the inability to access health information as the primary barrier to receiving critical SRH messages. The reasons cited for the inaccessibility of health messages included the employer not allowing DWs to leave the estate or CHWs to enter, the employer not allowing the DWs to watch TV or listen to the radio, and the limited reach of outreach workers and CHWs.

SRH PRACTICES

Most of the survey respondents in both groups had ever had sexual intercourse (90%). Among those who had ever had sex:

- Many were not currently sexually active. About two-thirds of the participants and 37% of nonparticipants reported that they had had sexual intercourse in the month prior to the survey.

- In both groups, 9% reported having had more than one sexual partner in the past three months. Twelve percent of participants and 16% of nonparticipants believed that their partner had multiple partners.

- Forty-nine percent of participants and 56% of nonparticipants stated that they had used a condom the most recent time they had sex, though 36% of participants and half of nonparticipants felt that they are at risk of contracting an STI.

- Approximately 80% of both survey groups did not want another child for at least two years or did not want any more children. Despite this, 14% of participants and 35% of nonparticipants stated that they were not using any contraceptive method. For those using a method, injectables and male condoms were the two methods most commonly used.

- Most of the survey study sample did not want a pregnancy in the near future, and 74% of participants and 80% of nonparticipants felt that they would lose their job if they or their partner became pregnant.

REPRODUCTIVE HEALTH RIGHTS

- Over one-third of the participants and 12% of nonparticipants in the survey knew of at least one DW who had been sexually assaulted in the workplace.

- All but one of the participants knew of at least one place to go if assaulted or abused; however, 13% of nonparticipants did not know any place. Participants reported they would go to a health facility (76%), police station (71%), and KUDHEIHA (40%). Among nonparticipants 61% knew they could go to a health facility, 64% a police station and 19% a local administrator. Most of the respondents also knew where to go for more information on sexual assault or physical abuse. Most reported they would go to a health facility.

- About one-quarter of participants and 9% of nonparticipants reported that rape is one of the factors that contributes to unintended pregnancy.

- Sexual coercion, assault, and rape were discussed by the majority of IDI respondents. These topics were brought up in the context of (1) rape and sexual assault of a DW by a member of the household (usually male), (2) forced sexual coercion in exchange for money or bribes by a member of the household (also usually male), and

(3) being at an increased risk for rape or sexual assault in general.

- Most stakeholders, NOPE staff, and DWs mentioned living in poverty as a factor that can lead DWs to engage in sex work for additional income.

- About half of the stakeholders, most NOPE staff, and a few DWs felt that DWs feared losing their jobs if they were to disclose their positive HIV status, pregnancy, or sexual abuse by a member of the household, and/or ask for time to seek health services. The fear of losing their job over these issues was perceived to discourage DWs from seeking preventative services, education, or treatment.

SRH HEALTH SERVICES

- In the three months preceding the survey, about 36% of participants and 27% of nonparticipants needed to go to a health service either because they were sick or because they had a child who was sick. Of those who needed health services, the majority asked their employers for permission to seek health services. Of those who asked permission, 10 (combined from both groups) said that their employers did not let them go every time they asked.

- All of the participants and 88% of nonparticipants knew a source for FP services; the majority said they would go to a health facility and also felt that the service was either easily accessible, or accessible. However, 40% of participants and 29% of nonparticipants believed there were barriers to FP services.

- Most of the survey respondents knew of a source for STI/ HIV services, over 80% of both groups named health facilities/hospitals/health centers as a source. About 90% of both groups said that services were either easily accessible or accessible. The biggest barrier to accessing STI/ HIV services was lack of time or no permission to go which was cited by 36% of participants and 19% of nonparticipants. Approximately 95% of both groups said that if they suspected they had an STI, they would seek advice from a health facility. Most of the study respondents (99% of participants and 88% of nonparticipants) had received HIV tests, all of them received their test results.

- Accessibility (or lack thereof) was commonly mentioned in IDIs as a factor that influenced DWs' ability to protect themselves or seek health services for FP or treatment. DWs were limited by their jobs, their income, or the unavailability of health services when needed. Lack of time to access health facilities was the primary issue mentioned by the majority of IDI respondents as a barrier to getting health information and services. IDI respondents reported that DWs often work long hours and are given very little time off, limiting their ability to seek health care. Additionally, a few stakeholders and one DW said that when DWs do have time off, it tends to be on weekends when public facilities are closed. Most stakeholders and about half of the DWs in IDIs mentioned that DWs are often restricted by employers while working. Employers often prevent DWs from (1) having contact with anyone outside the house/estate (including CHWs who may come to provide information or services), (2) accessing the television or radio, or (3) having the freedom to leave when they please.

- The majority of IDI respondents agreed that public hospitals are where DWs most often seek health services because they provide free services, yet the long waiting times at these facilities create a barrier for DWs who have little free time. Because they need services quickly, DWs will seek treatment from local chemists who may not be capable of providing the necessary information or correct treatment to meet the RH needs of DWs. IDI respondents also mentioned that fees charged by chemists and private clinics are an additional barrier and as a result DWs may not seek the services they need until critically necessary. One stakeholder noted, *"You see for them to even get treated for any ailment, I think it is difficult because for her, when she has a minor ailment such as a headache, she sees no need to go to a health facility because she never has time anyway. So she'll just run over to the shop and get Panadol (painkiller) or something, and rush back to the house... the hospital or health facility is not the first place that she'll think to go. So by the time you see a domestic worker going to a health facility, then it is serious and she's really unwell."*

- Another barrier identified to seeking SRH services was social stigma. This stigma is two-fold; the stigma associated with being a DW and the stigma linked to having an STI or HIV which discourages people from waiting in line for STI/HIV services where they might be seen and judged by others. Stakeholders also felt that DWs were concerned about losing their jobs if they disclosed being sick or having a disease to their employers. In addition, many stakeholders also felt that many employers would quickly fire a DW if they found out the DW had HIV or another STI.

- Condoms were a specific point of discussion in most of the IDIs. Respondents believed DWs seek condoms primarily from chemists, with CHWs being the second most commonly identified source. However, stakeholders and DWs expressed concerns about how employers would perceive them if found with condoms. Stakeholders suspected that DWs were concerned about the employer thinking that the DWs were having sex in the house when they should be working, and hence DWs did not keep condoms with them. As a result, when DWs are given their short amount of time off duty, many do not have access to condoms and may have unprotected sex as a result. These concerns were confirmed by this DW who stated, *"Many of them fear that they will be known by their employers that they use condoms, and they will be asked what they are doing with the condoms in the employers' house. They will be asked 'What are you doing with these things in my house?' One big problem is being found with condoms in employer's house, and maybe you keep them elsewhere, far from the house."*

NOPE ACTIVITIES

- For those survey respondents that had heard of KUDHEIHA and NOPE activities, they first learned of the project through peer educators (46%) and program staff (38%). Among the nonparticipants, only 7% had heard of NOPE.

- DWs participated in an average of 3.1 NOPE activities (range of 1 to 9). The two that were cited most often as helpful were activities on STI/HIV prevention (47%) and FP (41%). Other activities that DW participants requested

were those that provided more information on STIs/HIV (27%), cancer screening (19%), drug and substance abuse (11%), and FP/ SRH (9%). The most important topics that DW participants reported learning about were STIs/HIV (89%) and contraceptive methods (71%).

- Participants also learned about their RH rights. Over 60% reported that they learned about their right to live free of violence, to access SRH information, and to decide for themselves the number and spacing of children they want to have. Just over 40% reported that they learned they have the right to marry and start a family, and that service providers should keep confidential any information DWs shared with them during consultations.

- All of the participants received health services through NOPE events; just over three-fourths received FP services, over half received STI/HIV information, over one-third received treatment for STIs/ HIV, and just under one-third received health education or counseling. The two locations where services were most often received were a social hall (42%) and a hotel (36%). Fourteen percent went to the nearest health facility. The majority of services were received from project staff (79%) and the remainder from service providers from public health facilities.

- Only 12 nonparticipants responded to the question about why they do not participate in any NOPE activities; nine stated that they did not have permission or time to participate.

LESSONS LEARNED

Both survey and IDI respondents had suggestions for improving DWs access to SRH information and services. Survey suggestions are summarized in the figure below. Specifically:

- There were a number of suggestions for KUDHEIHA. Most were voiced by participants since 72% of nonparticipants did not know KUDHEIHA. The suggestions noted the most often by participants were to sensitize DWs on better health-seeking behavior (70%), to sensitize employers on DWs' SRH needs (43%) and to hold health camps/health days (41%).

- About three-quarters of both survey groups felt that employers can support DWs' access to SRH services by giving them time off to seek services. Other suggestions were that employers should learn more about SRH and provide moral support. Less than one-fifth also said they should provide financial support.

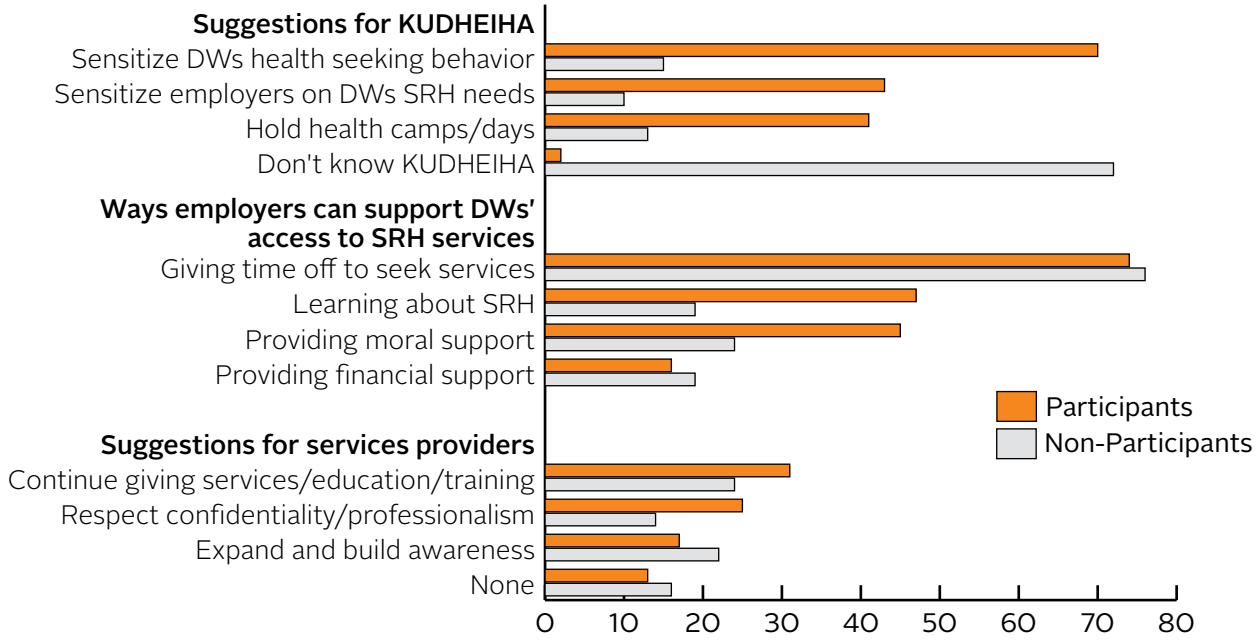
- Survey respondents also had suggestions for service providers. Nearly one-third of participants and one-quarter of nonparticipants wanted providers to continue giving services, education and training. Other suggestions were to show respect for DWs and to maintain confidentiality and professionalism. Finally they wanted providers to create and expand SRH awareness.

- From the IDIs, the feedback regarding the intervention was largely positive and many thought it was successful in building awareness and knowledge of HIV, STIs, and FP among DWs. Respondents overwhelmingly felt the project should continue and increase its reach and frequency. Of the eight DWs who participated in IDIs, half said it was a positive experience and six felt it created awareness of SRH issues affecting DWs.

- To improve the intervention, most DWs in the IDIs suggested that outreach should be more frequent and outreach efforts extended, and five felt that more peer educators should be trained. The majority of NOPE staff and other stakeholders also felt that these were necessary improvements. Some said outreach efforts among different NGOs and other organizations working with DWs should be better coordinated.

- Many IDI respondents also felt it was important to engage DW employers in future interventions. They felt in order to truly address DWs SRH needs, employers need to be aware of the issues DWs face and become more sensitized to both DWs' RH rights and general rights as workers.

DW Suggestions



Discussion and Conclusion

The results show differences in certain characteristics of the DWs who participated in NOPE activities and those who did not. More participants than nonparticipants were married, had secondary education, were born in an urban setting, lived in their own house (as opposed to the house of their employer), and had at least one day off from work a week. These differences may influence their desire and/or ability to participate in these activities. Participant SRH knowledge was also in some respects greater than that of nonparticipants. Finally, more participants were using a contraceptive method, though fewer used a condom at last sex; these behavioral differences may be related to marital status.

The DWs in this study would benefit from additional SRH information and increased access to services. While they have basic SRH knowledge some gaps were identified. Furthermore, there is evidence of risky SRH behaviors that could lead to STI/HIV infection or unintended pregnancy.

Several barriers were reported that hinder DWs' access to SRH information and services. Having limited or no time off appeared to be a major obstacle to seeking health care or even to listening to the radio or watching TV to receive SRH information. Social stigma also appears to be a multi-faceted barrier that needs to be addressed. Especially troubling are indications about the extent to which DWs face sexual coercion and rape. Efforts are needed to link DWs to post-assault services but even more importantly to reduce their risk of encountering harm in the first place.

The DW SRH intervention was well received and filled a needed role in providing DWs with SRH information and services. The results suggest that it would be worthwhile to continue this program. Finding ways to expand and provide services to a larger number of DWs, especially those who want to participate but cannot, is a needed but challenging next step. Many of the nonparticipants had never heard of NOPE or KUDHEIHA, so more outreach or publicity about these organizations is recommended. It should also be noted that DWs at households where the interviewers were refused entry or DWs who were too busy to complete the survey may have had even greater needs than this assessment demonstrates. Other means of providing information, such as the mobile phone, should be explored. Suggestions to actively involve employers in the intervention are also important and could prove beneficial to both employers and the people who work for them.

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