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Cognizance of sexually transmitted infections among low-income men in western Kenya

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ABSTRACT

Sexually transmitted infections (STIs) pose a worldwide health problem. To improve the efforts of prevention of STIs it is important to gain insight into the awareness of STIs among people in the society.
Objective: To describe the cognizance of STIs among low-income men in western Kenya.
Method: Data was collected from eight focus groups consisted of 64 men between15 and 54 years of age. The interviews were audio taped and content analysis was used for the analysis.
Findings: Three categories were derived: Consciousness of STIs, Risk of and prevention of STIs, and Marital relationship and STIs. The results indicate that men had some limited consciousness of STIs but that there were misunderstandings. The treatments the men mentioned were hospital treatment help, from traditional herbalists and self-administration. Condoms were regarded as an effective prevention method, but there were obstacles to using them as well as to talking about STIs within marriage.
Conclusion: The study stresses the need to promote cognizance of STIs, including gender aspects, and to reduce the gap between knowing and practising.

Introduction

Sexually transmitted infections (STIs) present a public health problem worldwide and cause complications and sequelae in women, men and newborns. Poverty and gender inequities entailing a lack of power for women are significant barriers in the prevention of STIs [1,2].

In Kenya, the prevalence of HIV in 2003 among adults aged 15–49 years was estimated at 6.7% [3]. Regarding other STIs, the prevalence in the general population is unknown. Available information comes from studies of specific groups of populations. For instance, among men aged 18–24 in Kisumu in western Kenya, 9% tested positive for HIV and 7.6% for STIs such as Gonorrhoea, Chlamydia and Trichomonas [4]. Rates of STIs in patients at antenatal and family planning clinics have been found to be around 47–56% for Trichomoniasis or Candidiasis, 5–9% for Gonorrhoea and Chlamydia, and 4% for Syphilis [5–7]. Some STIs increase the risk of the acquisition and transmission of HIV, and are therefore a co-factor in the spread of HIV in Kenya [5,8].

Many people living in poverty have no opportunity to find employment close to home, and migration carries a risk of STI transmission [2]. Generally, people in Kenya migrate to major towns in search of economic opportunities. According to the discussion in Moses et al. [7], this mobility within towns as well as back and forth to rural areas plays a role in the transmission of STIs due to the practice among men of having several sex partners and visiting sex workers. In studies of sexual workers in Kenya, it has been found that the use of condoms is more common with occasional partners, about 66% [9] and 75% [10], whereas unsafe sex was often practised with regular partners <55.8% [9] and 40% [10]. The application of a chemical substance and actions taken to tighten the vagina before sexual intercourse, so-called dry sex, have also been associated with inconsistent condom use and previous STIs [9,11].

A study of truck drivers and their assistants showed that more than half of their sexual acts occurred with sex workers. Among those who reported STIs the number of partners, as well as the prevalence of self-reported STIs, was higher than that of the general population [12]. Truck drivers travel long distances, and at stop-over facilities the purchase of sex from commercial sex workers is common and there is often inconsistent condom use [7,9]. These truck drivers also exhibit health-seeking behaviour, seeking medical attention at different points [12].

This study was carried out in Bungoma District in western Kenya, whose economic activities consist of farming and business supported by the Kenya–Uganda railway in terms of transport. Commercial sex is rampant along the Trans-Africa Highway, which passes through the district to Uganda, Rwanda and the Democratic

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Republic of Congo. Bungoma Township is the last stop-over for trucks travelling from the Port of Mombasa to neighbouring countries. The district's current population is 1.3 million and it faces three major health issues, i.e. Malaria, AIDS and a lack of access to affordable and quality health care [13]. The prevalence of HIV/AIDS in this district is about 10%, which is slightly higher than the national average [14].

To improve health promotion and health care services, it is essential to gain insight into the awareness of STIs among people in the society. Hence, the aim of this study was to describe the cognizance of STIs delimited to low-income men in Bungoma District in western Kenya.

Methods

The study has a descriptive and exploratory design. Focus group interviews were chosen for the collection of data. This specific interview is a process involving people with similar backgrounds and interests, and the method has been found to be useful in the collection of data regarding attitudes and experiences. The sample size of the focus group can vary, but it has been suggested that 6–8 may be an ideal size [15].

Participants

Study participants of low economic status, earning less than 80 Kenyan shillings a day (equivalent to one US dollar), were recruited from Bumula Division (rural) and Bungoma Township (urban), both divisions within Bungoma District. Men of different ages and from both rural and township areas were recruited to achieve variety. The income earned in Bungoma District is unevenly distributed as the income levels and distribution are largely determined by the type of production activity. Many economic activities are conducted in Bungoma Township, but Bumula Division has relatively low incomes. Those from Bumula were engaged in subsistence farming or worked as casuals, while those from Bungoma Township were engaged in small income-generating errands which brought them very little income [16]. The focus group interviews were conducted among men who had volunteered to participate. The participants were men with various backgrounds according to age range and urban vs. rural residence. Four groups were formed in Bumula and four in Bungoma Township, making a total of eight focus groups consisting of eight participants in each group, making a total of sixty-four (64) participants. The participants were divided into four groups in each area based on their ages: 15–24, 25–34, 35–44 and 45–54 years of age.

Procedure

A semi-structured interview guide was used, developed by the research group (the three authors) and consisting of open-ended questions about STIs. Prior to the study a test focus group session was held and was then discussed within the research group, resulting in minor revisions to the interview guide. This particular group was omitted in the analysis.

Normally in Kenya, local chiefs organize community meetings known as "chief's baraza" to deliberate on issues affecting the community. It was during such a meeting that the first author explained the intentions of the study and men were invited to participate. They were informed that their participation was not compulsory and that they were free to withdraw at any time. The researcher and the men who wanted to participate and had given verbal consent agreed on venue, date and time.

The focus group sessions were conducted by two people: The first author (TW) led the discussion using the interview guide and the research assistant operated the tape recorder and took notes. The focus group interview aims at obtaining perceptions concerning a defined area of interest in a permissive non-threatening environment. In every focus group, the participants were encouraged to feel comfortable with everyone in the group to allow for easy communication and contribution. Some groups needed more encouragement to talk freely and to interact with each other. As the focus group interview continued, the interaction between the participants developed in a positive direction. All interviews were conducted in the national local language, Kiswahili, which all the men spoke fluently.

The interviews were then translated into English by an assistant researcher conversant in Kiswahili and English. The interviews were audio-taped and lasted one and a half to 2 h.

The study was approved by the Moi University Institutional Research and Ethics Committee as well as the Bungoma District Commissioner.

Data analysis

Content analysis was applied in the data analysis [17]. First, the interviews were read several times to get a sense of the whole. Secondly, the text was broken into smaller fractions (meaning units), which were then condensed and labelled with codes. The codes were compared and divided into sub-categories and finally into categories. The analysis was performed by two of the authors and was then discussed with the third author until consensus was reached (Table 1).

Findings

Three major categories were derived from the content of the focus group discussions: Consciousness of STIs; Risk of and prevention of STIs; and Marital relationship and STIs. Verbatim quotations are used to illustrate the findings and show a connection to the original data.

Category 1: Consciousness of STIs

The participants had some consciousness of STIs in that they were able to name several of them. Names such as Syphilis, Gonorrhoea, genital herpes and HIV/AIDS were familiar to many of the participants and were mentioned as being common in society. The participants were aware of some medically defined symptoms of STIs such as pain when urinating and the urethral discharge of pus, as well as conditions that are not defined as STIs and that could be general symptoms, such as the passing of red urine. Conditions such as swelling of the testes and wounds/boils on the penis were referred to by their ethnic name "eduwas" and, citing hearsay, occasional stomach problems were mentioned as a symptom of STIs. There was an opinion that the occurrence of symptoms was expected on the third day: Some men mentioned that this was the first time they had heard about these symptoms, whereas others said they had only heard about some specific signs and that these could be expected to occur on the third day. One man said: "*It is just now Ím hearing about these diseases*" and was not contradicted, but another man said "*I have heard about the one that make the testes swell*" (Bungoma, 15–24 years of age).

When it came to treatment the participants were aware that, once infected, one would have to seek treatment regardless of the source of the STI. The way different options were used varied. Hospital treatments were sought alone or with one's wife. Hospitals normally require both partners to be treated to avoid re-infection, and participants were of the opinion that this demand by the hospitals could cause problems, as tracing a casual partner would be