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Perceptions of family planning and sexually transmitted infections among low-income men in Western Kenya

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To my family

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ABSTRACT

Family planning has long been practiced in Kenya. Despite this, however, the country has had a high yearly increase rate of inhabitants. Family planning and sexually transmitted infections (STIs) are stressed in the Millennium Development Goals by WHO, and are challenging issues worldwide. Many interventions and studies concerning reproductive and sexual health have traditionally focused on women. Therefore, there is an increasing request for a focus on men in studies of these issues. Men in Kenya have rarely been involved in either receiving or providing information on sexuality, reproductive health, birth spacing or prevention of STIs.

The aims in these studies were to describe perceptions/cognizance of family planning and STIs among low-income men in western Kenya. It is important to gain more understanding of men's perceptions in these issues, as they are often the decision-makers in countries where poverty and gender inequities are barriers to promoting sexual health. A qualitative method was used, and was carried out by means of focus groups interviews. Sixty four men (15-54 years of age, 8 in each group) were interviewed. The data were analyzed by means of manifest content analysis. The findings were presented according to major themes and categories regarding family planning and STIs, respectively. The themes regarding family planning were: Family planning views and reasons; Methods of contraception; Children out of wedlock; Views on family planning programmes; and Policy on male contraception. The categories regarding STIs were: Consciousness of STIs; Risk of and prevention of STIs; and Marital relationship and STIs.

The studies demonstrated that men in western Kenya had poor, and sometimes misguided, knowledge of family planning and STIs. Attitudes and cultural beliefs were strongly connected to practice. The findings stress that preventive sexual and reproductive health care should provide services that meet men's need for information and participation, aiming to increase awareness of sexual health and reduce the gap between knowing and practicing.



LIST OF PAPERS

This thesis is based upon the following papers, which will be referred to in the text by their Roman numerals (I and II):

- I. Wambui Theresah, Ek Anna-Christina, Alehagen Siw. Perceptions of family planning among low-income men in Western Kenya. *International Nursing Review* 2009, 56, 340-345.

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- II. Wambui Theresah, Ek Anna-Christina, Alehagen Siw. Cognizance of sexually transmitted infections among low-income men in Western Kenya. *Sexual & Reproductive Healthcare* 2011, 2, 169-178.

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INTRODUCTION

High fertility combined with declining mortality gave Kenya one of the world's fastest population growth rates in the 1970s and 1980s (Yin & Kent, 2008), but declined to fewer than five births per woman in the early or mid-1990s before coming to a standstill at 4.7, and currently 4.6, births per woman. There are substantial differences in fertility levels throughout Kenya. Total fertility is considerably higher in rural areas (5.2 children per woman) than in urban areas (2.9 children per woman) (Kenya National Bureau of Statistics, 2010). Infant mortality has been on the rise, probably due to the HIV/AIDS epidemic, increasing poverty and poor health services (Kenya Bureau of Statistics, 2008). The high population growth has added to the pressure on land and resources in Kenya, yet the community highly values large families. Although Kenya was one of the first Sub-Sahara African countries to encourage family planning, the idea of limiting the birth rate has been slow in being accepted. The Kenyan government has a policy that supports family planning, and the Ministry of Health (MOH) has set goals to increase the family planning uptake (Kenya Demographic and Health Survey, 2003). Despite the family planning policy, however, the population has grown rapidly because so many young people are reaching reproductive age. This has raised concern that the country's economic growth cannot keep pace (Mulama, 2009).

Kenya, a predominantly patriarchy society, has given men decision-making powers in all matters, including family size. In the African tradition, a man's status is higher than a woman's in both family and social activities. Men dominate decision-making within the household through a range of formal and informal ways. Men have control over economic resources, which is a source of power. Their power is exercised in both public and private institutions within society (Mburugu & Adams, 2004).

Unequal power relations between men and women often limit women's control over their sexual activity and ability to protect themselves from unwanted pregnancy and sexually transmitted infections (STIs), including HIV/AIDS. In Africa, HIV-positive women outnumber infected men by two million. With limited choice in sexual decisions, and an inability to abstain from sexual intercourse, women are forced to endure domination by their husbands in marital relationships. Thus, a link has been found between gender inequality and the sexual health conditions in a society (Aina, et al., 2006).

Family Planning Programmes in Kenya that became available in the 1950s to 1960s through private medical practitioners targeted women as their clientele. Since the time of its establishment, the Kenya National Family Planning Programme has not been popularly supported and has lacked public confidence. Men have a strong desire for large families and a prevalence of many sons, who are regarded as their heirs (Nganga, 2009). From men's point of view, large family size gives an assurance of economic rewards, respect and security for old age (Mburugu & Adams, 2004).

Although the 1994 International Conference on Population and Development advocated for male involvement in family planning, the men's low acceptance and near rejection of family planning has been due to a lack of information, education and communication on male involvement in family planning. This makes the men feel belittled, as they are regarded as decision-makers. They may also not readily accept family planning because of the widely spread myths and misconceptions about family planning concerning men and women. Men's own belief is that family planning, for instance, makes women frigid in bed (UNFP, 2009).

Family planning services are offered mostly at Maternal and Child health clinics, which are viewed as "women's places", and men do not want to mix with women for fear of being seen as being henpecked or considered effeminate. Men are usually hostile to women who provide family education and distribute contraceptives (Musalia, 2008).

The Millennium Development Goals (MDGs) advocates for universal primary education, the promotion of gender equality and the combating of HIV/AIDS. This can only be achieved through developing and implementing family planning for men and women (Dodd & Cassels, 2006). The MDGs are inter-dependent; all of them influence health, and health influences all the MDGs. Therefore, the World Health Organization (WHO) helps countries reach the millennium development goals by: advising on increasing access to safe, effective, quality medicines and diagnostics for HIV/AIDS, tuberculosis, malaria and reproductive health; addressing gender inequalities that limit women's and girls' ability to protect their health; and increasing access to sexual and reproductive health services including family planning, infertility services, and the prevention and treatment of STIs (WHO, 2011).

Worldwide, STIs present a public health problem because they cause complications and sequelae in women, men and newborns. Also, the risk of HIV is increased by the presence of some STIs (WHO, 2007). In Kenya, the prevalence of STIs in the general population is not

known because the focus regarding the prevalence has been on specific populations. In 2003 the prevalence of HIV among adults aged 15-49 in Kenya was estimated at 6.7% (WHO, 2006a). The National AIDS Control Council estimated that about 1.5 million Kenyans have already died from the disease. The Ministry of Health (2010) states that HIV prevalence in women aged 15-49 is 8.7%, while for men in the same age bracket it is 4.6%; the prevalence is highest among women aged 20-24, and among men aged 30-39. It is higher among the urban population; for example, the prevalence among women living in urban areas is 12% compared to 8% among rural women. According to Moses et al. (2002), as men move within towns in search of economic opportunities, then back and forth to rural areas, they have a habit of having several sex partners and visiting sex workers. This habit contributes greatly to the transmission of STIs.

Heterosexual men have been neglected in national STI screening policy and planning because there are significant differences in health-seeking behaviours and access to services meant for heterosexual men and women. Usually, women access health care services when they experience genital symptoms, for contraception and for pap smears to be taken for cytology. On the other hand, men have no immediate reasons to seek preventive services. They always portray avoidance attitudes and behaviours, and when they have symptoms they do not regard them as important. Therefore, they assume things will get better and continue to have sex (Darroch, et al., 2003).

In a study carried out in Bangladesh, Hawkes (1998) reported that in low resource countries, where there is no basic epidemiological information on the prevalence of STIs, the decision on where and how to target STI services would be based on the knowledge of who is most likely to be at risk and the capability of existing clinical services to provide effective management for these target groups.

According to Finer, et al. (2003), the provision of male services is not universal and not all health facilities and agencies serve men. Men who may come in for services are the partners of female clients who have agreed to accompany them. The numbers of male clients are very few, and there are still several barriers to serving men, such as funding constraints, men's unawareness of services, and perceptions that clinics are dominated by women.

The high prevalence of STIs and their role in HIV transmission have necessitated the integration of STI prevention and management into existing family planning and antenatal

care programmes in most resource-poor countries, including Kenya. The integration is particularly preferred because there is a high level of overlap between the population at risk for unplanned pregnancy and those at risk for STIs and HIV. In addition, family planning programmes create an opportunity for counselling sexually active groups about sexual risks, including unintended pregnancy and exposure to HIV, and the same providers can be oriented with minimal input to serve both types of clients. Through integration the hard-to-reach clients, including men and youth, can be contacted (Ministry of Health, 2010). Men would benefit more if reproductive health information and care were fully integrated into their general care, which may include medical services as well as social and community services (Finer, et al., 2003).

BACKGROUND

Kenya is a low-income country, with an average per capita annual income of about US \$360. The 2006 Kenya Integrated Household and budget survey found that 46% of the population is poor, i.e. below poverty line, whereas 49% of rural population is absolutely poor (Kenya National Bureau of statistics, 2007). Despite decades of work by African governments, internal Non-Governmental Organizations (NGOs) and foreign aid programmes, the incidence of poverty never seems to go down. This is a result of many factors, all interacting with one another, making this problem of poverty very difficult to solve (Szczepanski, 2010).

Family planning

In Kenya, a quarter of currently married women has an unmet need for family planning; this figure has been constant since 1998. Three-fifths of unmet need is comprised of women who want to wait two or more years before having their next child and are referred to as spacers, while two-fifths is comprised of women who want no more children, referred to as limiters (Kenya Demographic and Health Survey, 2003).

The Kenyan family planning became available in the 1950s, or even earlier, through private medical practitioners and through the use of condoms obtained from pharmacies. The services were geared more towards the limited numbers of members of the European and Asian communities. Only a few Africans would have been able to utilise the services of the private doctors or afford to buy commodities from pharmacies. In the 1950s, the family planning associations were established in Nairobi and Mombasa and the focus was on the provision of family planning services to Africans. The leadership of these associations included Africans, Asians and Europeans, with external financial support from the Pathfinder Fund in 1958. The Family Planning Association of Kenya was legally registered in 1962 and shortly became affiliated with the International Planned Parenthood Federation (Heisel, 2007). This was later replicated by the Ministry of Health and developed into Maternal and Child Health Services.

Family planning programmes have a role to play in helping people get the information and services they need to make informed choices. Reducing unmet need is a complicated task, because of the wide range of circumstances and beliefs that forbid women from acting on their intentions (Casterline, et al., 2003).

In 1971, WHO defined family planning as “a way of thinking and living that is adopted voluntarily, upon the basis of knowledge, attitudes and responsible decisions, by individuals and couples, in order to promote the welfare of the family group and thus contribute effectively to the social development of a country” (WHO, 1971, p. 5).

Family planning is not a substitute term for contraception, birth control or fertility regulation in this matter. The word family describes the basic unit of human existence or genealogy. Planning is said to be a manifesto that signifies an awareness of the future, and that by wilful decision something can be done to guide or alter that future (Edmands, 1984). Therefore, family planning as a concept advocates that families through their own design can plan when, how often, and at what intervals they wish to have children.

Inherent in the concept of family planning is the freedom to choose, which stems from basic sexual rights and implies that couples are free to make their own decisions regarding the number of children they want and at what intervals. The 14th World Congress of Sexology in 1999 approved the amendment to the Declaration on Sexual Rights in establishing that “sexual rights are universal human rights, based on inherent freedom, dignity and equality of all human beings”. Since health is a fundamental human right, so is the result of an environment which recognizes, promotes and defends sexual rights. Sexual health therefore, “is the enabling environment wherein the sexual rights of an individual are protected”. WHO (2005) gave a working definition of sexual rights which stated that sexual rights embrace human rights. These are rights which are already recognized in national laws and international human rights documents. This means that for family planning to succeed and truly benefit people, the freedom to choose must be maintained without pressure or coercion from outside sources.

The concept of family planning is not new, as man’s desire to determine his own reproductive destiny appears to be as old as humanity. The Ebers Papyrus, from circa 1550 BC, describes many birth control methods, and Aristotle, the Greek philosopher who lived during the fourth century BC, described methods of contraception and recommended laws to limit the number

of children a family could have in order to keep the population of city states stable. In Nigeria the practice of birth control among the Yoruba has existed from time immemorial, and Europeans only added or complemented the existing means of controlling births (Orimoogunje, 2009).

In view of these concepts, family planning then enables couples and individuals to freely and responsibly determine the number and spacing of their children, and to have the information and means to do so. It also means that people have the ongoing availability of a full range of safe and effective contraceptive methods that enable them to take action according to these decisions (Rice, 2002).

Each year, in less developed regions, more than 50 million of the 190 million women who become pregnant have unsafe abortions, which contribute to high rates of maternal death and injury. Unwanted births, on the other hand, contribute to children's health problems and rapid population growth in these resource-strapped countries (Ashford, 2003).

Half a million women die each year due to pregnancy-related complications, and 95% of them come from the developing world. The lifetime risk of a woman dying of pregnancy-related causes in developing countries is 1:40, compared to 1:3600 in the developed world (Begum, et al., 2003). Maternal mortality – the death of a woman while pregnant or within 42 days of the termination of pregnancy from any cause related to or aggravated by the pregnancy or its management – can be reduced by increasing the use of contraception. Maternal morbidity is any illness or injury caused or aggravated by, or associated with, pregnancy or childbirth (Prual et al., 2000).

Many women around the world die each year from lack of pregnancy-related services. A considerable number of women – between 100 and 200 million in less developed countries, or about 17% of all married women – want to space their pregnancies or cease childbearing but are not using any form of effective family planning method because they lack access to information and services or support from their husbands or communities. These women are said to have an unmet need for contraception that could lead to unintended pregnancy (Ross & Winfrey, 2002).

Kenya's maternal mortality rate continues to be quite high. An approximate 14,700 women and girls die each year due to pregnancy-related complications in Kenya. Another 294,000 to 441,000 women and girls suffer disabilities caused by complications during pregnancy and

childbirth. Women are at a greater risk of death and injury during childbirth, and are generally willing to use family planning. In Kenya, 15% of maternal deaths could be prevented if women aged 15-49 years who want no more children had access to reliable contraception (Kenya Demographic and Health Survey, 2003).

Male involvement in family planning

Family planning programmes in Africa have traditionally concentrated on reaching women through the Maternal and Child Health Services, and have largely ignored men. The most striking indicator of the lack of male involvement in family planning in Africa is the very low use of male methods of contraception, e.g. the condom, vasectomy, withdrawal and periodic abstinence. Equally important in the involvement of men is planning and caring for their children. A common assumption regarding traditional and modernizing societies is that men have little good to say about family planning. This assumption is perhaps the one most strongly held about men in Africa, where patriarchy has a long history and families have traditionally been very large (Mburugu & Adams, 2004).

Men in most communities are socialized in exercising overall authority and decision-making on all family matters, including reproductive health. Traditionally, they exercise preponderant power in nearly every sphere of life, ranging from personal decisions regarding the size of the family to the policy and programme decisions taken at all levels of government. Yet current population and reproductive health programmes make little provision for male involvement. One of the reasons for this is the limitation in the number of male methods of fertility regulation, and the fact that most reproductive health services have been provided in settings which are predominantly woman-oriented, such as Maternal and Child health clinics. Thus, men who are interested in making decisions on the number of children to have and the timing of the births are unable to do so constructively in a way that meets their partner's needs, because they have no knowledge and no services that cater to their needs (Kenya Demographic and Health Survey, 2003).

Historically, the predominant methods of preventing births in most parts of the world were methods used by or requiring the co-operation of men. The oldest of these, coitus interruptus or withdrawal, was known to at least three ancient religious traditions, and historical

demography reveals that it was the principle method responsible for the demographic transition in Europe in the last century. In the 1990s it was still used by an estimated 35 million couples worldwide, and is the method most widely used in Turkey, a country with substantial access to modern methods (Ringheim, 1996).

According to Bauni and Jarabi (2003), the condom dates back to Roman times when animal bladders were used to prevent the spread of sexually transmitted diseases. In family planning the condom, the major non-permanent male method, was promoted and used as a barrier method. Currently, the condom is the most effective barrier method because it can be used for disease prevention in conjunction with other methods or alone, for the dual purpose of protection from pregnancy and from disease transmission.

The condom as a contraceptive usually has a higher failure rate than the pill, and would be more likely to be discontinued for the following reasons: a desire to switch to a more effective method; the husband's objections; and inconvenience. In countries with generalized HIV pandemics, there is a need to enormously increase condom use. Condom use within marriage is rare, and those who try the method abandon it within a period of 12 months (Ali, et al., 2004).

In Sub-Saharan Africa, the prevalence of HIV is high and the number of young people infected with HIV is increasing. Therefore, promoting condom use for sexually active young people remains a key part of the effort to curtail the spread of HIV. The correct and consistent use of condoms can serve the purpose of preventing both HIV as well as unintended pregnancy, for which sexually active young people are at risk (Bankole et al., 2008).

Despite great improvements in its clinical technique, vasectomy – a simple, safe and cost-effective method of fertility regulation for men – has lagged far behind the prevalence rates of female sterilization in the world (Bunce et al., 2007).

Over the past five years, the Demographic and Health Survey (DHS) studies conducted in 21 countries confirmed that one of the family planning methods that is the least known, understood and used, and often ignored, is vasectomy. For example, in Sub-Saharan Africa, except for Ghana, Kenya, Malawi and Uganda, the majority of men had not heard of vasectomy (Jacobstein & Pile, 2007).

The use of vasectomy in the world varies significantly by region and country. According to Jacobstein and Pile (2007), almost three-fourths of the 37 million couples who use vasectomy live in Asia, with China and India alone accounting for more than two-thirds of this total. Four and a half million men in the developing world outside these two countries use vasectomy. Vasectomy use in Latin America has increased four-fold in the past ten years. While prevalence remains less than 1% in the most of the region, vasectomy rates in almost all of Africa are 0.1% or less, despite the fact that vasectomy services have already been introduced in some of Sub-Saharan African countries such as Ghana, Kenya, Malawi and Tanzania (Jacobstein & Pile, 2007).

Sexually transmitted infections

Unprotected sexual activity leads to the risk of either a pregnancy that may not have been planned or an STI. The available estimate by WHO indicates that 340 million new cases of syphilis, gonorrhoea, chlamydia and trichomoniasis occur in men and women aged 15-49 years annually; overall, STI prevalence rates continue to rise in most countries, including developed countries (WHO, 2001). Many STIs could have severe long-term consequences. According to WHO, in early untreated syphilis in pregnant women, 25% of pregnancies result in stillbirth and neonatal death – an overall perinatal mortality of about 40% (WHO, 2007).

STIs remain major causes of reproductive morbidity and mortality in developing countries, and their high prevalence facilitates HIV transmission (Sri Devi & Swarnalatha, 2007). STIs are usually contracted in core groups, such as female sex workers, characterized by a high number of partners and poor health care-seeking behaviour in developing countries (Thomas & Tucker, 1996). With the exclusion of HIV, STIs and other reproductive tract infections account for a substantial proportion of outpatient health care visits among adults of reproductive age, and in most nations are ranked among the top five leading reasons individuals seek health care (Dallabetta et al., 2006).

Shame and stigmatization, or both, lead many affected individuals to seek treatment outside established health care systems, whether with traditional healers, through self-treatment using alternative drugs bought over-the-counter or through other avenues, or to not seek treatment at all. Although in many nations a variety of challenges apply to both the private and public

sector in STI management, more STIs are treated in the private than the public sector. In Kenya, both married and unmarried men migrate to Nairobi and other large towns within the country from rural areas for economic opportunity (leaving their families behind) and commonly purchase sex from female sex workers, as stated by Moses et al. (2002).

Married men in Kenyan towns often have extramarital sex partners, married women much less commonly. The extramarital or other concurrent partners may be commercial or non-commercial. The most important predictor of STI risk for both men and women is the number of reported sex partners. The significant predictors of STI risk among men are said to be: purchase of sex and being unmarried, or being married but living apart from their wives (Moses et al., 2002).

In Kenya, the prevalence of HIV among adults aged 15-49 years was estimated at 6.7% during the Demographic and Health Survey in 2003 (Kenya Demographic and Health Survey, 2003). HIV prevalence in the general population is not known, because the available information comes from specific population groups. The prevalence of the four STIs was found among unselected antenatal attendees in Nairobi to be as follows: syphilis 3.1%; gonorrhoea 2.4%; chlamydia infection 8.8%; and trichomoniasis 19.9%. In another study, of a trucking company male employees working as long-distance truck drivers in the Kenyan port of Mombasa, the prevalence of the same four STIs was: syphilis 5.3%; gonorrhoea 3.4%; chlamydia infection 3.6%; and trichomoniasis 6.0%. The generally higher rates among the Mombasa men may reflect their higher risk for STIs than the general population of men (Moses et al., 2002).

The study of the truck drivers and their assistants showed that more than half of their sexual acts occurred with sex workers. Among those who reported any STI, the mean number of partners was significantly high and the self-reported prevalence of STIs among the truckers was significantly higher than that of the self-reported prevalence of urethral discharge and genital sores among men in the general population in Kenya (Morris & Ferguson, 2007).

In Kenya, the STI programme has made remarkable achievements in the scaling up of the syndromic approach treatment in the country through effective and feasible interventions. Over 3,500 health facilities offer STI treatment, and could save the lives of 450,000 people per year (NAS COP, 2008). It has also been estimated that 10,000 new cases of HIV infection

could be prevented if data on prevention and treatment intervention involving 500 sex workers were to be used (WHO, 2006).

In the management of STIs, the programme outputs are: syndromic management of STIs; syphilis screening and treatment offered at all antenatal clinics; mobilization and capacity-building at private practitioners and alternative health care providers; and the establishment and etiological surveillance of STIs. STI drugs are available at most health facilities, and STI clinics are in place at all health facilities. However, the Ministry of Health remains committed to providing STI services as a way of supporting HIV prevention in addition to diagnosis. At least 90% of patients diagnosed with STI are offered HIV testing, and 90% are offered appropriate symptomatic treatment (NASCOP, 2008).

It is widely known that STIs are significant in the transmission of HIV and that their prompt and efficient management goes a long way in reducing the prevalence and incidence of HIV as well as STI/HIV/AIDS transmission; this is why there has been a widespread and uniform adoption of a syndromic approach in the management of STIs. The prompt and efficient treatment of STI still remains the pillar of prevention of HIV transmission. The syndromic approach has a major advantage, in that it reduces treatment delay with its consequent trickle-down benefits (NASCOP, 2008).

Men and HIV/STI prevention

There have been comparatively few HIV/STI prevention interventions targeting adult heterosexual men as a distinct client group. HIV/STI prevention initiatives target men at their places of work for interventions. Worksites that have targeted men include trucking companies (Jackson et al., 1997; Laukamm-Josten et al., 2000).

Wilson (2004) reported on a prevention programme aimed at Kenyan fishermen, but the report contains little information about the impact of the programme. Laukamm-Josten et al. (2000) evaluated a peer education programme that targeted Tanzanian truck drivers. Trends shown by surveys done during an 18-month intensive phase of peer education about condom use followed by a 24-month maintenance phase showed that reported condom use increased from 56 to 76% amongst men (Laukamm-Josten et al., 2000). Leonard et al. (2000) reported on a peer education programme of HIV prevention and condom promotion among Senegalese

transport workers, and found significant increases in men's HIV-related knowledge and use of condoms.

The study by Jackson et al. (1997) on trucking workers in Kenya found increases in condom use and a decrease in the percentage of men who had had extramarital sex, as well as a decline in numbers of men who had had sex with sex workers following their cognitive behavioural intervention.



AIMS

In reproductive and sexual health care there is a need to understand men's perceptions of family planning and STIs.

The aims of the current studies were:

to describe the perceptions of family planning among low-income men in western Kenya (Study I) and

to describe the cognizance of STIs among low-income men in western Kenya (Study II).



METHODS

A descriptive qualitative study design was used and focus group interviews were conducted among the men who consented to participate in the study. A focus group is a round table discussion process involving the use of purposive interviews that focus on people with similar backgrounds and common interests, and is designed to obtain information on a specific topic. The ideal size of a focus group ranges between six and ten individuals. The method is useful in the collection of data regarding attitudes and experiences. The participants of a focus group are expected to stimulate each other in the discussion, communicate freely and express opinions on the subject (Krueger & Casey, 2000; Rabiee 2004).

Participants

To guarantee diversity, participants were drawn from both rural and urban areas; namely Bumula Division (rural) and Bungoma Township (urban). The participants were of low-income background, meaning earning less than one US dollar per day (equivalent to 80 Kenyan Shillings). Usually, their earnings are either from running small-scale errands or working low-paying jobs like the manual harvesting of sugar cane. Bungoma District is one of the six districts in Western Province. It had a projected 2008 population of 1.2 million, a fertility rate of 5.8 and 12% contraceptive use (Bungoma District, 2002; Kenya National Bureau of Statistics 2008).

A convenience sample of participants was selected from people of varying ages and backgrounds, whose residence was either urban or rural, and who were willing to talk freely. A total of 64 men in the age ranges of 15-24, 25-34, 35-44 and 45-54 years were recruited, forming eight groups of four from each area: Bumula Division and Bungoma Township.

Procedure

A semi-structured questionnaire with open-ended questions was designed by the research team. One focus group session was conducted prior to the study to evaluate the questions, and

thereafter minor changes were made; this group was not included in the analysis. The following are two examples of the questions: What do you know about family planning? What can you say about sexually transmitted infections?

During a community meeting, one member of the research team gave a briefing on the intended research and the attendants were invited to participate after this. Both the researcher and the selected participants agreed on the venue, date and time, and the participants were informed of their freedom to participate or withdraw.

The principal researcher, who is familiar with both family planning and STI policies, led all the focus group interviews. These interviews were conducted according to the men's age range, thus enhancing the authenticity of the shared information. The members of each focus group were encouraged to feel free with each other as well as with the research team, and to actively participate in the interviews. A majority of the participants were comfortable in self-disclosure, while others required trust and some effort was required. All the interviews were conducted in Kiswahili and were then translated into English. The research assistant was present to observe and take notes. The focus groups were audio-taped and lasted between 1½ and 2 hours.

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

Study area

Bungoma is one of the six districts in Western Province. The district borders the Republic of Uganda and Mt. Elgon District to the northwest, Trans-Nzoia to the north, Kakamega District to the east, and Busia and Teso Districts to the west and southwest. The population growth rate is 3.7% (Bungoma District, 2002).

The district is divided into seven administrative divisions, but only two of the seven were used: Kanduyi and Bumula Divisions. Bungoma Township (municipality) is one of the locations in Kanduyi Division. Kanduyi Division, which houses the District Headquarters (namely Bungoma Township, with a population of 148,027 and total of 20,960 households) was used for comparison purposes.

Bungoma municipality has an urban population of 39,829 with a total of 4,978 households. The urban population growth rate is 3.5% per annum and the intercensal growth rate is 1.9%. Polygamy is common in Bungoma District, and it is a general preference to have male children (Bungoma District, 2002).

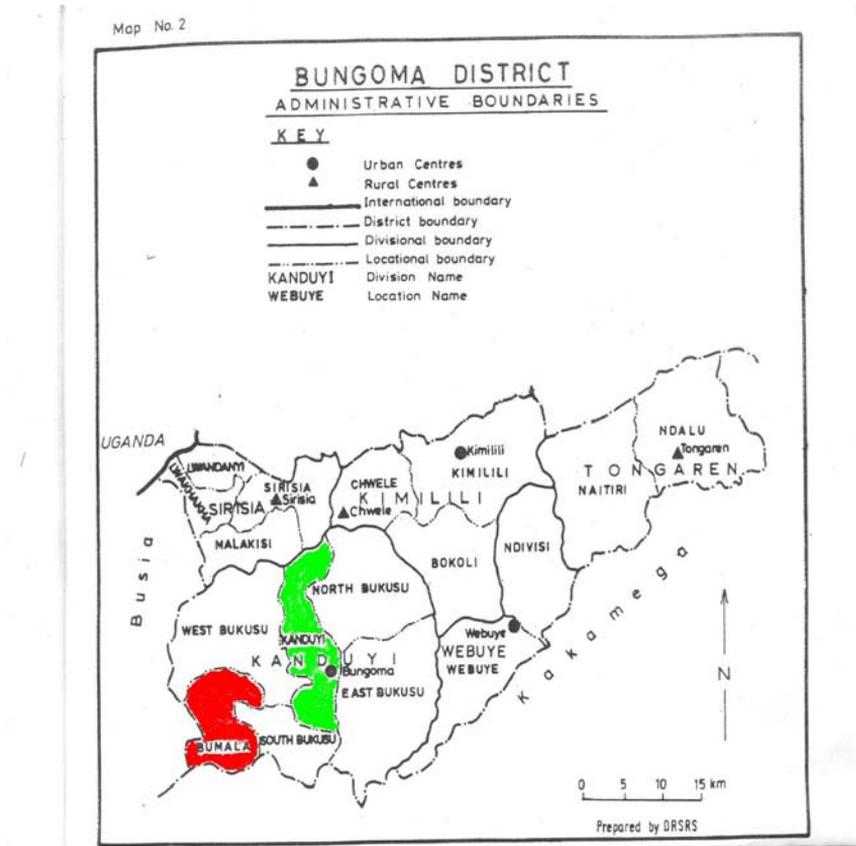


Fig 1: The districts with their administrative boundaries.

(Adapted from: Bungoma District, 2002)

Note: The shaded areas are the two divisions, Kanduyi (Bungoma Township) and Bumula, used for the research study.

The total population for Bungoma District during the 1999 census was 60,650, with an intercensal growth rate of 1.9%. In 2001 its population was estimated to rise to 720,650 in 1997, 763,789 in 1999 and then 809,293 in 2001 (Central Bureau of Statistics, 2001). The rapid growth of the population will exert pressure on existing infrastructure like education, health and other facilities, leading to the delivery of unsatisfactory services, and therefore calls for more investment in social infrastructure, which would be at the expense of other productive investments.

As the district has a large number of children and adolescents in its population, young people greatly outnumber adults. When this generation of young people reaches adulthood, the number of potential parents will inevitably be much larger than at present. This will make the total population increase at a higher rate.

The high population density coupled with limited resources is the major cause of poverty in the district. Available land is increasingly being fragmented into sub-economic units. The high population is also threatening the environment through the destruction of vegetation for wood fuel (Bungoma District, 2002).

The use of modern family planning methods in the district was low, at 12% according to the figures from 1991-2001 (Bungoma District, 2002). One major reason for the low use of modern family planning methods in the district is that most clinics have a shortage of family planning supplies, which tends to discourage their use. The other reason is that communities in the district have a polygamous lifestyle and also prefer male offspring, thus ending up having more children in the effort to have boys. The family planning goal here is to make available high-quality and sustainable family planning services to all who need them in order to reduce the unmet needs for family planning (Bungoma District, 2002).

The prevalence of HIV/AIDS in the district is about 10%, which is slightly higher than the national average of 6.7% (Broesch, 2008). Commercial sex is rampant along the Trans-Africa Highway, which passes through the district to Uganda, Rwanda and the Democratic Republic of Congo. The economic activities consist of handling farm produce and small-scale businesses supported by the Kenya-Uganda railway in terms of transport. The heavy cargo is transported from the Port of Mombasa on trucks which make stop-overs along the route, and Bungoma is the last stop-over for the trucks going to the neighbouring countries. This facilitates a thriving commercial sex trade (Bungoma District, 2002).

Data analysis

Qualitative data analysis is a process of bringing meaning to a situation rather than a search for truth (Rabiee, 2004). The tape-recorded focus group interviews were transcribed and translated from Kiswahili into English by the researcher, who is well conversant in Kiswahili. Manifest content analysis was done according to Granheim & Lundman (2004), whereby the text is broken into small meaning units which are then condensed. These units were then labelled with codes. From the transcripts, themes and categories emerging from the data were identified and verified by the three members of the research team while two members tested the coding of the themes and categories that emerged.

De Vos (1998) says that four aspects, namely true value, applicability, consistency and neutrality, can enhance the trustworthiness of qualitative data. True value was enhanced through prolonged engagement with the participants before the interview. Increased applicability was achieved through conducting focus group interviews with adults and adolescent males across the age ranges. The texts were read by both the field co-researcher and other two members of the research team in order to enhance neutrality. Consistency was achieved by selecting eight of the specific group interviews and checking that the transcribed data reflected what had actually transpired during these interviews. Trustworthiness was achieved through the constant comparison among different aspects of the data throughout the entire analysis process.

The studies in this thesis are published.



FINDINGS

In both studies, the findings were presented according to the identified themes and categories. In the first study (Study I), the findings were presented according to the five identified major themes: family planning views and reasons, methods of contraception, children out of wedlock, views of family planning programmes and policy on male contraception.

Family planning views and reasons

According to the participants, their views on and reasons for family planning have certain similarities. They perceived family planning as having the number of children one is economically able to provide for in terms of education, food, clothing and health, considering the cost of living. Some stated that the size of their land was one of the deciding factors. They said that their properties are small, and if one had many children there would be no land for them.

Decision-making regarding number of children, birth interval and the woman's health was a concern for both husband and wife. Other participants felt that family planning is God's plan, because He can do as He wishes. Others considered education, peer influence and the intention to build the nation, as well as helping others, reasons for family planning. Some participants had no idea what family planning meant; even their actual level of understanding was difficult to determine, and they lacked the correct information. According to them, planning meant "having children with some kind of plan" They had heard about it, but had not conceptualized the meaning. The knowledge they had was indicated by their perceptions, but no probing was carried out to ascertain the source of information.

Methods of contraception

The participants identified various methods of contraception, which portrayed their knowledge of modern, traditional and future method preferences.

For the modern methods, the participants demonstrated knowledge of both female and male contraceptive methods, and could easily name the most common ones. Some participants stated that they had only heard about some of the female methods, such as Norplant, female condoms and female sterilization. Some participants mentioned the coil (intrauterine contraceptive device), but others were not familiar with it. Adverse side effects of the modern methods were said to include the development of very serious diseases from unknown sources, women suffering from backaches and headaches, and bleeding continuously for those on the pill.

Regarding male methods, every participant knew of condoms but had only heard about vasectomy. The use of condoms was associated with extramarital affairs and was commonly used outside marriage. Participants revealed that when condoms are unavailable or too expensive, thin polythene bags are used as an alternative. Some participants mentioned that condoms reduce sexual pleasure. Regarding vasectomy, participants said it is not used because it is likened to castration, which they believe makes them “less a man” and would encourage women to start seeing other men.

Regarding traditional methods, participants had a great deal of knowledge concerning practical methods, including sleeping on different beds or on the floor, sleeping with one’s clothes on, withdrawal and abstinence. Some men mentioned another method, “safe/unsafe days”. Concerning this method, the men unanimously agreed that they depend totally on their wives. This method caused some confusion among the men, as they did not know what constituted safe days. Other approaches the men termed as methods of family planning were getting drunk or using herbs, a few drops of kerosene or a special type of onion in your food. There was disagreement regarding whether these methods reduced or increased sexual desire. One participant told of a unique method used in the early days: A girl’s grandmother takes some of the girl’s menstrual blood and locks it away somewhere, and as long as it is locked up, the girl cannot get pregnant. The participant who explained this method seemed to be the only one who knew of it. The participants were in agreement that traditional methods are commonly used because they have no side effects and no cost, but they admitted that withdrawal and safe days do fail at times.

For the future, participants preferred injectables for the older men and pills for the young. The idea of a law limiting family size was met with different reactions from the participants, as most of them believe in large families.

Children out of wedlock

The participants were in agreement regarding the fathering of children out of wedlock, with the most common reasons stated as sexual desire, the children's gender and attraction to women other than their wives. They said that men were born with an appreciation of and attraction to women, and thus male blood burns inside them as far as women are concerned. Another reason mentioned for having children out of wedlock was considered accidental because of being away from one's wife. Another reason mentioned, albeit less common, involved a man wanting more children than his wife does, and being in search of love and romance.

Views on family planning programmes

Most of the men indicated that a lack of proper information in relation to family planning and a lack of acceptance of the concept of family planning by some health workers have contributed to its low impact. Rumours, forgetting the men who are the heads of household, and a culture that regards children as wealth have also contributed negatively to the impact of family planning. The participants are of Luhya tribe who stated that the people of Luhya land believe that children translate into wealth. The more children you have, the wealthier you are. If you have many daughters, you will receive a lot of wealth in the form of dowry.

Policy on male contraception

Most participants revealed that there is a need for information and education, for both men and women. They suggested that the government give a mandate to the opinion leaders to organize seminars for them. Another idea was that education on access to the methods, for instance condoms, be provided and that jobs be given to the unemployed so that they will be engaged in other activities. Policies focusing on female family planning do exist in Kenya, and it was in light of this that men stated that if it is put into law, men must also get involved. Some men stated that there was a need for several male family planning methods, but that these should exclude vasectomy as a male method

The participants proposed that, as there is money set aside for HIV/AIDS programmes, money should also be set aside for family planning so that men will be able to teach each other in deeply rural areas using the local language. They also felt that they needed to be given equipment and financial assistance.

In Study II, three major categories were derived from the focus group interviews: consciousness of STIs; risk of and protection of STIs; and marital relationship and STIs.

Consciousness of STIs

The participants were conscious of STIs and mentioned names such as syphilis, gonorrhoea, genital herpes and HIV/AIDS, which were said to be common in the society. The participants also named some of the medically defined symptoms of STI, such as pain when urinating and the urethral discharge of pus. They also mentioned some of the non-medically defined symptoms, such as the passing of red urine. Ethnic names, “*eduwas*”, were used for conditions such as swelling of the testes and boils on the penis, and these swelling and boils were only stated as hearsay. Also reported to be an STI symptom was occasional stomach problems. From the participants’ point of view, the occurrence of symptoms was expected on the third day. Some participants had not heard of these symptoms, and reported that they were hearing this for the first time. Others had only heard of certain specific signs and symptoms that could supposedly occur on the third day.

Most of the participants had some consciousness in regard to treatment. They were aware that, once infected, one should seek treatment regardless of the source of treatment. Participants mentioned a variety of treatment options. Hospital treatment was sought either alone or with one’s wife or partner. Hospitals normally prefer that both partners be treated in order to avoid re-infection but participants cited difficulties in tracing a casual partner, and also said that this could reveal a husband’s unfaithfulness to his wife. The demand for one’s partner or wife to be treated made hospital treatment unpopular, facilitating the popularity of traditional herbalists as they do not demand that someone’s partner accompany him. Not requiring a

person's partner to accompany him was viewed as a reasonable way of keeping the person's infection secret. The hospital's demand for sexual partners to be treated as well forces many to seek treatment from herbalists instead, because they will keep your secret. The herbalists prefer to treat each partner separately because they are in business. Most of the men found it difficult to ask their wives to accompany them to the hospital because the wife's response would be that she is not sick. This supports the choice of herbalists. Self-treatment with herbs was the third option participants discussed, and with this option one was assured of keeping the STI infection secret.

Risk of and prevention of STIs

Regarding the transmission of STIs, the participants associated this with the culture of risky sexual behaviour. They mentioned that transmission was the passing of infection from one person to another, which was associated with unfaithfulness, which could emanate from men's sexual drive and irresponsible behaviour. Men reported that safer sex meant having sex with a young girl, whom they said could have no infection since she is only a child. Being promiscuous meant having unprotected sex with multiple partners, increasing the chance of infection transmission. Men's sexual behaviour can be viewed as a threat because they can expose women to transmission risk due to lack of protection. There was a concern about asymptomatic carriers, i.e. people who have an STI but show no symptoms, being at risk of transmitting STIs due to lack of protection. Some men revealed that they inspect women for signs and symptoms of an STI before having sex with her.

According to the participants, condom use could be an effective method when it comes to protection from the risk of STIs. In extramarital sexual relationships, condom use would be the prevention method of choice. Some participants feared condoms and had a mistrust of them. Their fear concerned the condom bursting or being left in the woman's body. Participants were suspicious of the lubricant on the condom, which they believed may contain HIV. They also had a mistrust of the quality of condoms, especially those offered for free. Condoms were associated with a reduction in sexual sensation and pleasure, and this contributed to non-use of condoms, as stated by the participants. Some men said they used thin polythene bags as an alternative when condoms were unavailable, but other men reacted

to this as they believed that polythene bags have small holes that grow bigger during sexual activity due to friction. If one had extramarital sex without protection, one would wait a number of days before having sex with one's wife while watching for signs and symptoms of an STI.

Marital relationship and STIs

Most of the participants stated that discussing conditions concerning their sexual activity with their wives was rather difficult; therefore a majority of the men would opt not to tell the truth if they contracted an STI. According to them, wives should only be told about general illnesses that are commonly known, like malaria. From these participants' point of view, anything to do with sexual activity should never be revealed to one's wife. If any treatment was sought it should only be reflected as being for a general illness; and any document indicating an STI should be unavailable to the wife.

Other participants argued that the man's wife should be well informed of the contracted disease so that both the husband and wife could be treated. Some were of the opinion that after an extramarital sexual encounter, one should watch for signs and symptoms of an STI before engaging in sex with one's wife. A wife would search for signs and symptoms on her husband before engaging in any sexual act when there was mistrust; thus some participants mentioned that in order to prevent the wife from knowing about the infection, she would be sent to her parents' home.

Drunkenness causes fear in a family, particularly the wife. In order to fend off sexual demands from one's wife, the participants were of the opinion that one could easily use alcohol to keep her at bay. Abstinence was viewed as a preventive method which could be achieved by sleeping in different beds. Most men were in agreement that the truth of the matter was that the infection would be from an extramarital affair; therefore, telling the truth was meant to relieve one's guilty conscience. From their point of view, the man should be expected to take responsibility when this happens.

DISCUSSION

A qualitative approach was used to describe the perceptions of family planning and the cognizance of STIs, which fall under sexual and reproductive health care. The strength of qualitative methods lies in understanding meanings or the participants' perspective, understanding contexts in which participants act. The flexibility of the qualitative method made it possible to extract cues of information during the study.

The two studies generally focused on men of low-income, meaning earning less than one US dollar per day (equivalent to 80 Kenyan Shillings). To earn this, these men either run all types of small-scale errands or work in low-paying jobs such as the manual harvesting of sugar cane.

The men discussed issues regarding family planning, and their views and reasons for family planning differed. Economic ability was an aspect that influenced their perception of family planning. Cleland et al. (2006) state that in developing countries, the promotion of family planning has the potential to reduce poverty as well as decrease maternal and childhood mortality. The findings from their discussion of STI revealed that men had some consciousness of STIs, as they were able to name some of the medically defined conditions and were in agreement that they were perceived as common in the society.

On the issue of knowledge, the men had poor knowledge regarding contraception, and they also had misconceptions. They were found to have an interest in family planning issues, but the information was more easily conveyed to women than to men. The assumption here is that women suffer more consequences related to childbearing. Even with this assumption, men are interested in being involved in discussions and information regarding family planning (Kaida et al., 2005). What is interesting about these men is that they do not seem to put their knowledge into practice. One may wonder whether this is due to attitude, culture or the need for quality health care.

Regarding knowledge about STIs, there were several misunderstandings on the issue of signs and symptoms. Most men stated that their consciousness was that signs and symptoms occurred on the third day after one has contracted an infection, regardless of the type of STI. Other participants stated that their consciousness was hearsay, while others were hearing

about the specific symptoms for the first time. According to Nuwaha (2006), laypeople in Uganda had information about symptoms and the modes of transmission of common STIs, which were believed to be naturalistic diseases. In the current study the men's knowledge about signs and symptoms can be called into question, as well as regarding those hearing about them for the first time. In Ndulo et al.'s study from 2000 it was shown that participants had a basic knowledge of STIs, which were perceived as a major health problem. It could thus be argued that participants, those hearing about STIs for the first time and those having a basic knowledge of them, could be considered to have some kind of information but its depth and expression cannot be ascertained.

James et al. (2004) report that the sources of information are found to adequately raise knowledge and understanding, as evidenced by high levels of knowledge about the causes and transmission of STIs among people in South Africa. In our study, the participants' sources of the information were not explored. Other studies have shown that even with adequate information about STIs and HIV/AIDS, most participants were not aware of modes of transmission and prevention, symptoms and risk factors for infection (Longfield, et al., 2003; Ndulo et al., 2000). Our findings indicate that even though the participants were conscious of STIs, their depth and influence on the participants' sexual life may differ. Basic knowledge and awareness do not necessarily translate into practice (James et al., 2004; O'Hara et al., 2001). The participants in this study could only name signs and symptoms in local terms. These terms could be difficult for health care workers, as they make different interpretations which could hinder their dialogue with patients.

Knowledge of family planning is said to be almost universal, with 96% of women aged 15-49 and 97% of men aged 15-54 having known at least one modern family planning method. These men, together with women, are able to develop a rational approach to planning their families (Central Bureau of Statistics, 2003). The contraceptive pill would be more effective in the prevention of pregnancy than followed by injectables and condoms. The pill was associated with negative effects, because women who took it would bleed continuously and men would suffer serious illnesses with no known causes. This was regarded as hearsay, although study findings on Swazi men reported an association between modern contraceptives and ill health and abnormal infants (Kaida et al., 2005).

Our findings show that condoms were an issue in contraception because they are not accepted within marriage. There is a fear that the condom may be left in the woman's body, and an

uncertainty of the effects the lubricant on the condom has on the user. Men admitted that condoms are generally used outside marriage. If condoms were used in marriage, this would probably be a preventive measure against STIs. Glasier et al. (2006) stated that the condom has a high failure rate for pregnancy prevention when not used properly and consistently. The health professionals on their part were reluctant to promote condom use as the main method of contraception. This may be viewed as bias or cultural consideration. Some men reported that when condoms were unavailable or unaffordable they used thin polythene bags as an alternative, while others said the polythene bags have small holes. The use of polythene bags can be said to be considerate in a way.

From the findings of the STIs study, condoms were unpopular for various reasons. Men reported a reduction in sexual sensation and pleasure when a condom was used. The quality of condoms was questionable, especially the free ones offered for the prevention of STIs. Married couples are less likely to use condoms because they are specifically associated with promiscuity and marital infidelity. This finding is in accordance with the results of a study from Zimbabwe, reporting that a common practice is that condoms are used only with prostitutes and not within the marriage or with steady sex partners (Moon et al., 2002). These findings are a challenge for the staff at health care centres to inform people about condoms and bring about a change in attitudes and use. A study of health care facilities like health care centres and pharmacies found that condom promotion was low (O'Hara et al., 2001). According to Hawken et al. (2002), spousal use of condoms was low but increased with casual and commercial sex partners. Dalhback (2006) found low condom use among youths in Zambia despite a high rate of multiple partners. In Sweden, migrant youths use condoms with strangers but not with their known multiple partners (Christianson, 2006). This is consistent with a Cameroon study that found low condom use among youths despite a high rate of multiple partners (Meekers, et al., 2003).

On the issue of vasectomy, the men's opinion was that vasectomy was the same as castration. This comparison makes the method unpopular because men assume that with vasectomy, they will be 'less men'. With vasectomy, one is not protected from STIs. Although men were not keen on the modern methods, they were involved in family planning practice in their own ways, as the most practical methods reported in the findings were sleeping with their clothes on, placing a child between them and their wives, or sleeping separately.

The promotion of male-oriented methods such as vasectomy and condom use discussed in our findings would be one way to foster male involvement in family planning (Bunce et al., 2007). Vasectomy is a safe, simple and effective method that is relatively unknown and unused throughout much of the world (Aradhya, et al., 2005; Pollacket al., 2004). According to Bunce et al., 2007, vasectomy stood for merely 7% of all modern contraceptive use worldwide in 2002.

The men talked of safe days as a traditional method of family planning but admitted that they depend on what their wives say because they do not know how women's bodies work.

Extramarital sexual activity resulting from uncontrolled sexual desire was associated with the transmission of STIs. The reported sexual behaviours were mostly facilitated by a culture that normalized the behaviours. Traditional beliefs perceived young girls as STI-free, resulting in a lack of prevention. According to Chacko et al. (2007), sexually active adolescents are at risk of acquiring STIs because they engage in unprotected sexual activity with different men. The findings of a study in Kenya indicated that men were viewed as a 'bridge population' that transmits HIV and other STIs from non-regular partners such as female commercial sex workers to the general population (Ferguson et al., 2004). With regard to the 'abstain, be faithful, use a condom' strategy ('ABC'), it would be difficult or even impossible to have abstinence and condom negotiations with an intimate partner if there is no revolution in power relations between men and women. Being faithful to one partner does not guarantee immunity to STIs if the partner portrays risk behaviour (Ferguson et al., 2004). The findings reported that participants talked of abstinence and being faithful, but this would be questionable because promiscuity was cited as a means of transmission as it meant unprotected sex with multiple partners. Alcohol exposed men to sexual behaviours. In other studies, alcoholic men are reported to be more likely to engage in infidelity (Hall, et al., 2008).

Diagnosis and treatment form are an important component of STI control programmes. According to Mayaud and McCormick (2001), symptom-based treatments are used in developed countries today. With regard to developing countries, these treatments are expensive, and accessibility to appropriate and effective treatments for STIs is limited. Most health care facilities in developing countries have no reliable laboratory facilities and, when available, laboratory diagnosis is expensive. Clinicians have hence made presumptive clinical diagnosis by identifying particular clinical features related to various agents. This method has often proven inaccurate or incomplete (Alder, 1996). To improve on this approach to

management, WHO has developed and advocates the syndromic management approach. The STI-associated syndromes are easily identifiable groups of symptoms, and are clinical findings on which the health care providers can base their presumptive diagnosis (Mayaud & McCormick, 2001).

On the issue of treatment, the findings revealed that there were three preferences for sources of treatment of STI symptoms. Normally, hospitals offer better services by treating both partners to avoid re-infection but their demand that both partners visit the hospital together limits the utilization of services because tracing a casual partner would be difficult and would also expose a husband's infidelity to his wife. According to our findings, males are more likely to seek treatment for their symptoms; this is consistent with research conducted in Nairobi, Kenya (Voeten, et al., 2004). The demand that one's partner be treated at the same time with the spouse made hospital treatment unpopular. Traditional herbalists were more recommended in the community and were even certified at some Kenyan Universities, but it is difficult to assess the efficacy of STI treatment by traditional herbalists.

The likelihood that traditional medicines may do more harm than good is a cause for concern. In their research, Mmari, et al., (2010) reported that men seeking STI treatment were more likely to go to informal sources, particularly traditional healers, whereas females seeking treatment were more likely to go to formal sources like government health clinics. Herbalists are more popular because they do not require that a person's partner accompany them.

In our findings, herbalists were regarded as good at keeping a person's infection secret, and other studies indicate that there is a widespread belief that traditional medicine is more effective in treating STIs than Western medicine. Men found it difficult to ask their wives to accompany them to the hospital because, indeed, their wives were not sick. This reinforces the choice of an herbalist. The third treatment source was reported as self-administered treatment with herbs. This kind of treatment has not been proven to be effective and could therefore likely be dangerous or deteriorate one's condition. At the same time, the affected individual may delay seeking treatment or not seek treatment at all due to a fear of shame or stigmatization, or both. Since Kenyan law is silent on STI treatment in the general population, individuals take personal decisions as to when, where and how to seek treatment (Wakasiaka et al., 2003).

Culturally, marriage in broader terms is seen as a product of sexuality that people tend to protect. Generally, there are reasons as to why men refuse to inform their partners of their STI status. They are also not ready to jeopardize their position in the family; STIs are associated with immorality. Therefore, neglecting to inform one's wife would be a way to keep from being viewed as unfaithful. This non-disclosure behaviour could be explained as a way to avoid dissolving one's marriage in order to maintain a stable family. It can also be termed as a violation of women's rights, and reflects the strong control a man has over his wife, which is mainly a matter of gender inequality (Krishnan et al., 2008). The practice of not talking about infections, symptoms and STIs within marriage is a risk to the whole family, including children. A cycle of re-infection which could be difficult to prevent results from many people's failure to inform their partners of the infection. Therefore, untreated partners continue to serve as a reservoir for pathogenic organisms; such a scenario complicates the prevention and control of STIs. From other studies, the stigma associated with STIs discourages patients from discussing their infections and sexual behaviours with their partners, especially concerning extramarital sexual relationships (Clark et al. 2007; Wakasiaka et al. 2003). Mehta et al. (2003) reported that a significant proportion of gonorrhoea cases at a Baltimore City public STD clinic were attributable to reinfection. The risk for gonorrhoea reinfection was associated with sex, young age and high risk behaviours. The same study also reported that the exploration of interaction terms showed that coming to the clinic as an STD contact was generally protective from reinfection, but among patients with high risk behaviours this was a risk factor for reinfection.

During the establishment of family planning programmes the focus was basically on women, while men were forgotten although they head the households, thus making them feel belittled. During the implementation people's culture could have been considered, because in the community children translate into wealth and even more so in the case of daughters because of the payment of dowry. Family planning programmes believe that women need privacy and autonomy in reproductive health matters, and in this case serving men is neglected. After all, health care programmes designed for women do specific things for women (obstetrics) that cannot be done for men. Thus far there is no policy on male family planning. This lack of policy may have contributed to the men's non-participation in family planning.

Gender-related policies tend to overlook the concept of equality and men's role in promoting women's access to services and development opportunities. According to Walston (2005),

implementing agencies that choose to actively involve men in their services receive little technical or financial support from the government. An opposition to male involvement often comes from men themselves, because they have feelings of embarrassment and a belief that reproductive health, particularly birth spacing, should remain the concern of women. Also, men's perception of risk limits their participation in reproductive health. Men's motivation to use condoms is not to prevent transmission but rather to protect themselves from infection. WHO (2007) advocates that the health system as well as health care professional must pay attention to men concerning methods of family planning. Men are very important clientele when it comes to the use of condoms and vasectomy. According to WHO, men have the right to access high-quality services and receive counselling in a respectful, supportive and acceptable manner as they are very important clients as regards the use of condoms and vasectomy (WHO, 2007).

Trustworthiness of the studies

Trustworthiness is described in various aspects, including credibility, dependability and transferability. In regard to transferability (Graneheim & Lundman, 2004) our findings emanated from eight focus group interviews, which means they cannot be viewed as representative of all men in Kenya. Nevertheless, they can possibly offer valuable insight into the preventive and promotive work at different health care facilities. On credibility (Graneheim & Lundman, 2004), a firm criterion was followed for the focus group interviews as well the analyses. It was considered a limitation that education level and marital status were not assessed, although these aspects are important variables and have also surely influenced the openness in the focus group sessions. The findings are significant because the focus group interviews were carried out with a target group of men, who are rarely or never in focus in either investigative or preventive services.

Conclusion and clinical implications

In conclusion, the studies demonstrated that men in Bungoma had poor, and sometimes misconceived, knowledge of contraception. They also had some consciousness of STIs as they could name at least a few, but also demonstrated difficulties regarding the prevention and treatment of STIs. Preferences regarding a child's gender were strong, but attitudes and cultural beliefs that would hinder this practice had not been explored. Preventive work should emphasize the importance of change in opinion regarding sexuality and trustworthy relationships between women and men, as well as the need for more information and understanding about male involvement in family planning and STI prevention.

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