

**SCHOOL OF PUBLIC HEALTH
COLLEGE OF HEALTH SCIENCE
UNIVERSITY OF GHANA, LEGON**

**AWARENESS AND KNOWLEDGE OF SEXUALLY TRANSMITTED
INFECTIONS AMONG FEMALE PORTERS IN MADINA**



BY

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**THIS DISSERTATION IS SUBMITTED TO THE UNIVERSITY OF GHANA,
LEGON IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD
OF MASTER OF SCIENCE IN APPLIED HEALTH SOCIAL SCIENCE DEGREE**

JULY 2013

DECLARATION

I, Gifty Ayoma Blay declare that apart from references to other people’s works which have been duly acknowledged, this dissertation is as a result of my own independent work, and that this dissertation has not been submitted for the award of any degree in this or any other university elsewhere.

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DEDICATION

This dissertation is dedicated to the Lord God who counsels me, my husband, Mr Ketiboa Blay, my children Ewulay Blay, Arhizah Blay Abiti, Gifty Alima Blay, Kessie Kabenlah Blay and my grandchildren Bertrand and Ketiboa Abiti for their kind blessings, support and encouragement throughout the study period.



ACKNOWLEDGEMENT

I bless the name of the Lord God who protected and counselled me throughout this study. I wish to acknowledge and appreciate some individuals for their special efforts and assistance during the study period.

I am very grateful to Dr. Mercy Ackumey, my supervisor, for her guidance, encouragement and support throughout this work.

To Dr Philip Baba Adongo, Head of Department, and staff of the Department of Social and Behavioural Sciences of the School of Public Health, University of Ghana, I say thank you for the knowledge and skills you imparted to me.

And to my wonderful respondents, the female porters of Madina, I say a big thank you.

I am thankful to everyone who was of assistance to me in any way.

Thank you, all.



ABSTRACT

Sexually Transmitted Infections (STIs) are infections or diseases that are passed on from person to person through sexual contact. The presence of an untreated ulcerative STI increases the risk of both acquisition and transmission of HIV. Low or lack of education of has been shown to be associated with low STI awareness and knowledge.

In Ghana clients with STIs are mainly young people of age 19-24 years, and female porters fall within this age group. In order to protect these young adults it is important to assess what they know about STIs. Therefore the aim of this study is to assess awareness and knowledge of STIs among this group of females. But due to very limited time of six weeks and material resources, the research (study) area has been necessarily limited to Madina township in the La-Nkwatanana Madina Municipality of Greater Accra Region.

The study design was a cross sectional explorative and qualitative research using focus group discussions. The target population for the study were female porters within Madina. A purposive sampling was employed to carry out five focus group discussions in three languages. The sample of participants (50) was selected for who they were.

The study found that level of education, media, workplace, health facilities, friends and families and colleague workers were important factors that influenced awareness and knowledge of STIs among the female porters in Madina.

There is need to organise a national capacity building programme in the identification and prevention of other STIs so that vulnerable women such as the Madina porters in this study can upgrade their knowledge and awareness of such infections.

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LIST OF ABBREVIATIONS

AIDS	-	Acquired Immune Disease Syndrome
CDC	-	Centre for Disease Control and Prevention
CRHCS	-	Commonwealth Regional Health Community Secretariat
FGD	-	Focus Group Discussion
GSS	-	Ghana Statistical Service
HIV	-	Human Immune Virus
HPV	-	Human Papillomavirus
MOH	-	Ministry of Health
STD	-	Sexually Transmitted Disease
STI	-	Sexually Transmitted Infection
TV	-	Television
WHO	-	World Health Organisation

CHAPTER ONE

1.0 INTRODUCTION

Sexually transmitted infections (STIs) other than the human immune virus (HIV) are a major health problem affecting mostly young people, not only in the developing countries, but also in the developed countries. Studies have shown that diagnoses of STIs, especially syphilis, gonorrhoea and Chlamydia have been reported in several western countries especially among teenagers 16-19 years old (Samkange-Zeeb, Spallek, & Zeeb, 2011). STIs are infections that are spread primarily from person to person through unprotected sexual contact with an infected person (WHO, 2011). This sexual contact goes beyond vaginal intercourse it also includes anal genital and oral genital contact as well. There are more than 30 different sexually transmissible bacteria, viruses and parasites (WHO, 2011). Many of these infections, particularly the human immune virus (HIV) and syphilis, can be transmitted from mother to child during pregnancy and childbirth, and through blood products and tissue transfer.

STIs and their complications rank in the top five disease categories for which adults seek health care (WHO, 2011). The problem with most STIs is that they are asymptomatic (WHO, 2011). About 70% of women with gonococcal and chlamydia infections experience no symptoms at all and therefore STIs can thus be passed on unawares during unprotected sexual intercourse (WHO, 2011). The consequences of untreated STIs have adverse implications for reproductive and maternal health such as ectopic pregnancy, infertility, pelvic inflammatory disease and cervical cancer (WHO, 2011). According to estimates of WHO, 448 new cases of

curable STIs (syphilis, gonorrhoea, Chlamydia and trichomoniasis) occur annually throughout the world mostly in people aged 15-49 years. This does not include HIV and other STIs which continue to adversely affect the lives of individuals and communities worldwide. Majority of these infections occur in low and middle income countries in Latin America, Sub-Saharan Africa and Southeast Asia.

Nearly 19 million new cases of STIs are diagnosed each year in the United States, and more than 65 million Americans live with incurable STIs such as herpes and human papillomavirus (HPV). It is estimated that young people in particular are at a heightened risk of acquiring an STI and that those between the ages of 15 and 24 account for about one-half of the new STIs diagnosed every year, although this age group represents only one-quarter of the sexually active population (CDC, 2008).

In Zimbabwe STIs accounts for 6-10% of outpatient attendance and in Zvishavane a rural area in Zimbabwe, STIs were among the top five causes of outpatient consultations. Meanwhile statistics showed a continual increase in STI cases, from 66 per 1,000 in 2002 to 97 per 1,000 in 2005, a 31% increase in STI cases. The magnitude of the problem was likely to be higher as STI patients often sought care from private providers, from which there is no available data (Chadambuka, Chimusoro, Maradzika, Tshimanga, Gombe,&Shambira, 2011).

It is estimated that in Sub-Sahara Africa 69 million new cases of STIs are recorded annually and these infections play a major role in contributing to poor reproductive health, especially

in women.(WHO,2007) The disturbing feature seen in most developing countries is that since the emergence of HIV/AIDS so much attention has been placed on it leading to a situation where knowledge of HIV/AIDS within the population is high due to increased information and education through several media including mass communication media. This has, however, not been very well extended to other traditional STIs of which there is still a great deal of ignorance. (Adler, Cowan, French, Mitchel, & Richers, 2004).

It is estimated that among females aged 15-44 years STIs (excluding HIV) were the second commonest cause of loss healthy life after maternal morbidity, other studies have estimated that 5% of the total healthy life years lost in Sub- Saharan Africa are caused by STIs excluding HIV, and that HIV alone accounts for 10% of healthy life years lost (Adler, et al 2004). The lack of proper awareness and knowledge regarding other STIs may leave a large population of women (including female porters) vulnerable to contract infections. Awareness and knowledge regarding STIs are a general prerequisite for the prevention of STI infections.

It has now been recognized that there is a synergy between most STIs and HIV infection, particularly ulcerative and inflammatory conditions such as genital ulcer and syphilis. Research studies in both the developed and developing world have shown that HIV transmission and acquisition are enhanced by the presence of STIs probably because of inflammatory effects of STIs in the genital mucosa. HIV acquisition increases by two fold in the presence of STIs, and ulcers disrupt mucosa integrity and increase the presence or activity

of both HIV and non-ulcerative STIs such as gonorrhoea, Chlamydia, trichomonas vaginalis and bacterial vaginosis (Adler, et al 2004).

The Ghana Statistical Service stated in its 2008 Ghana Demographic Health Survey that 20.6% of females aged 15-49 years had some form of STI 12 months prior to the study. Majority were aged 12-24 years, and 40% of women with STIs did not seek medical attention. The Ghana 2011 HIV Sentinel survey reported that 513 new cases of syphilis were recorded during the year among women who attended antenatal clinic (National AIDS/STI Control Programme, 2012). The issue that arises here is what happens to those who do not attend antenatal clinics? What information can be obtained on them, and how can they know their own status, since most STIs are asymptomatic?

1.1 Statement of the problem

Sexually transmitted infections are public health problems with no easy solutions because they are rooted in human behaviour and are fundamental societal problems. In this researcher's own experience as public health practitioner, it has been realised that many women (including female porters) have poor understanding of their own bodies and poor knowledge of the mechanism of STIs transmission and their levels of risk in unprotected sex with an infected person. This situation, it would seem, makes it necessary to investigate the awareness and knowledge in female porters, especially as their needy status seems to render them extremely vulnerable and exposed to unprotected sex.

As can be readily observed in the markets and car stations, female porters are mostly young girls (adolescents) with a few adult women who migrate from rural areas all over the country (but mainly from the northern part) to cities, especially Accra and Kumasi, in search of all sorts of jobs for a living. But largely due to lack or low levels of employable knowledge and skills, they end up in markets and commercial streets where carrying of head-loads (head-porting) is the only menial job they are readily able to do for money. Not all these porters leave home primarily in search of jobs. Some may flock to the cities to have a feel of city life no matter the hardship and consequences, or to escape forced early marriages traditionally common in their communities (Oral communication from some porters in Accra central and Madina, 2012). This is corroborated by Wilson (2012) and Opare (2003). These porters, majority of them being adolescents, have no homes in the city and so live on streets and in obscure corners. They are exposed to varied social influences including, indulgence in alcohol, drugs and promiscuous and convenience sex out of peer pressure and sheer financial need. As a result they become vulnerable and may be taken advantage of by males and forced into unprotected sexual activities.

In addition to being highly multi-ethnic but with the northern extraction being significantly high (Opare, 2003), many female porters arriving in Accra tend to head for Madina as a residential base (albeit on streets) or as operational area for their porter services. Like their colleagues elsewhere, female porters in Madina are faced with the fortunes of indulgence in alcohol, drugs and promiscuous and convenience sex that confront female porters out of peer pressure and sheer financial need.

In view of the potential high risks of teenage pregnancy, abortion and its complications, HIV/AIDS and other STI infections associated with unprotected sex, there is need to assess the awareness and knowledge of these Madina female porters to know their sources of information about STIs and how they protect themselves from them. This is the rationale for this study.

1.2 Research question

1. What are the levels of awareness and knowledge of sexually transmitted infections among female porters in Madina?
2. What factors account for these levels and how these factors can be improved?

1.3 Conceptual framework

The relationship to be explored indicating how the Social Ecological Model SEM will influence awareness and knowledge of STIs among female porters in Madina is presented in Figure 1.

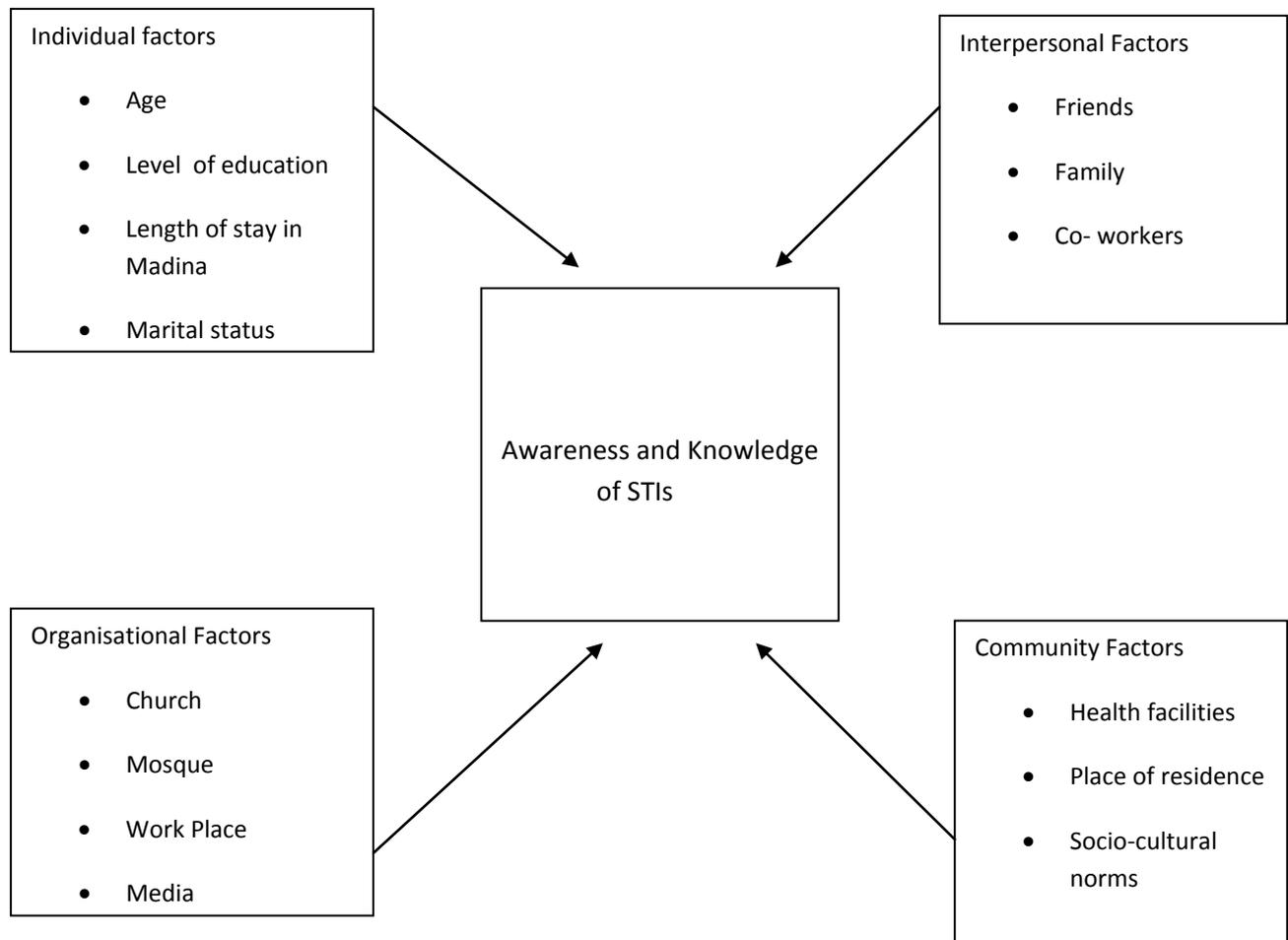
The study is grounded on the social ecological model as its conceptual framework which emphasizes the interaction between, and interdependence of factors such as age, level of education, family members, friends, workplace as well as place of residence, within and across all levels of a health problem. It highlights people's interactions with their physical and socio-cultural environment. McLeroy, Bibeau, Steckler, & Glanz (1988) identified five

levels of influence for health behaviours and conditions. These levels include: intrapersonal/individual, interpersonal factors, institutional/or organizational factors community factors and public policy factors. For the purpose of this study four of the factors or levels will be used, the fifth factor or level which is public policy has to do with local, state or federal laws and regulations but does not have direct influence on how the female porter will acquire knowledge about STIs.

The model recognizes the complex interplay between the individual, interpersonal, organization and community. It allows us to address factors that will contribute to the female porter becoming aware and acquiring knowledge about STIs. The model places the individual (the female porter) at the centre of the model. The other constructs of the (interpersonal, organisational and community) influence awareness and knowledge of sexually transmitted infections. These are explained below.

- The individual construct identifies personal factors such as age, level of education, length of stay in Madina, Accra and marital status could influence the female porters awareness and knowledge of STIs as well as their prevention.
- The inter-personal construct of the model examines close relationship that will influence the female porter's acquisition of information concerning STIs such as family members, friends, peers and people who influence their key decisions .For example a relative or friend who has ever suffered from an STI will play a role in providing information on STIs to the porter.

- The organizational or institutional factors comprises of primary inter-personal associations, such as the workplace- this will be the market place in the case of the female porter, places of worship such as the mosque and the church and any association that the porter may belong to. Through interaction with people at these places the porter could acquire information on STIs and their prevention.
- The community level is the fourth level which includes all institutions and organizations that collectively comprise the larger societal fabric. These factors such as health facilities, media, socio-cultural norms and place of residence increases the female porter's exposure and experiences in acquiring knowledge on STIs within the community. What the media presents to the public about STIs, information provided by health workers about STIs, socio-cultural norms and beliefs about STIs, what people who live with and around the porter know and say about STIs will all go a long way to influence her level of awareness and knowledge about STIs.
- For the purpose of this study the fifth construct discussed above does not apply.
- In essence, the interactions of these factors within and around the female porter will influence how she acquires knowledge and awareness about STIs.

Figure1. Conceptual Framework of the Social Ecological Model

Source: Researcher, 2013

1.4 Objectives of the study

1.4.1 Main objective

To assess awareness and knowledge of sexually transmitted infections (STIs) among female porters in Madina.

1.4.2 Specific objectives

The specific objectives of the study are:

1. To assess awareness of STIs among female porters in Madina.
2. To examine knowledge of STIs among female porters.
3. To examine source of information about STIs among female porters.
4. To examine knowledge on prevention of STIs among female porters.

1.5 Significance of the study

Female porters constitute one of the disadvantaged and underprivileged groups in the community: little attention is paid to their reproductive health needs. Unfortunately, the majority fall within the age group 15-24 and are likely to engage in risky sexual behaviour, which may result in unwanted pregnancy. Aside unwanted pregnancies many of them are at risk of STIs. It is therefore important that female porters obtain an appreciable level of knowledge about STIs. This study will reveal the level of awareness and knowledge of STIs among female porters in Madina. Furthermore it will also inform reproductive health programming that target adolescents and vulnerable groups in Madina such as street children and indicate gaps in knowledge and research.

1.6 Operational Definitions

Awareness - A respondent's ability to perceive and confirm an STI after a description or when shown a vignette.

Knowledge - A respondent's ability to describe signs and symptoms of an STI and describe the mode of transmission.

1.7 Definition of Terms

Female porters are migrant females who carry loads within the market for a fee.

STDs/STIs are Sexually Transmitted Disease/Infections.

1.8 Limitations on the Study

This is a project which could have taken considerable time to complete, but has had to be executed in 10 weeks (May-July). Thus time was a great constrain, and this restricted project area in size. Financial constraint also restricted the sample size to 50 respondents engaged on 10-porter-group basis,

1.9 Presentation of the Study

This study has six chapters. Chapter 1 provides the background information needed to appreciate the purpose and focus of the study. Chapter 2 surveys literature and other works on knowledge and awareness of STIs. Chapter 3 deals with the methods of the study while Chapter 4 reports the results (findings) of the study.

Chapter 5 discusses the findings of the study, while Chapter 6 conveys the conclusions and recommendations.

CHAPTER TWO

2.0 LITERATURE REVIEW

The essence of this literature review is to provide a better theoretical framework of understanding of the level of awareness and knowledge of STIs among female porters (mostly adolescents) within the context of the research question and the Conceptual Framework of this study (Sections 1.2 and 1.3) and the study objectives (Section 1,4). The key areas of focus are the global burden of STIs, awareness and knowledge of STIs, sources of information on STIs and prevention of STIs.

2.1 Global Burden of STIs

Sexually transmitted infections have been noted by many researchers owing to their health problems affecting mostly young people in both developing and developed countries. The level of awareness and knowledge with the exception of HIV/AIDs is a worry all over the world. The global burden of STIs is uncertain because of the lack of effective control and notification systems in many countries. As reported by (WHO,2007) an estimated 340million new cases of curable STIs occur in adults per annum worldwide mainly in South East Asia (151m), Sub-Saharan Africa (69m), Eastern Europe and Central Asia (22m and 17m) respectively and (71m) in Europe.

Adanu, Hill, Seffah, Darko, Anarfi, & Duda (2008) suggest that in Sub-Saharan Africa STI plays a major role in contributing to poor reproductive health of women. They also suggested that demographic characteristics such as level of education, occupation etc predispose women in Accra (Ghana) to experiencing STI symptoms.

2.2 Awareness and knowledge of STIs

A review of 15 studies to determine awareness and knowledge of STIs among adolescents revealed that those aged 13 to 20 years showed awareness and knowledge that varied among the subjects depending on gender (Sankange-Zeeb, Mikolajczyk & Zeeb, 2011). In general, the studies reported low levels of awareness and knowledge of STIs with the exception of HIV/AIDS and recommended that attention be paid to infections such as Chlamydia, gonorrhoea, and syphilis. It is therefore paramount to consider the study among female porters who are mostly adolescent and in this part of our world where dissemination of information is very poor.

In a study in rural North Vietnam, majority of females (15 to 49 years) examined were found lacking knowledge of STI. In this cross-sectional population-based study, about three-quarters of respondents did not know any symptom of STIs, one-half could not identify any cause of STIs and another one-half did not know that STIs can be prevented. Only one-third said that condom could be use to protect against STIs (Lan, Lundborg, Mogren, Phuc, & Chuc, 2009). The researchers indicated that respondents were young unmarried and married

women and concluded that low levels of knowledge of STIs were found among women of reproductive age in a rural district of Vietnam. In the same study proportions of unmarried and married women answered questions regarding STI knowledge. The most common signs of abnormal vaginal discharge, defined by the respondents, were odour and excessive amount (35.5% and 24.8% of responses respectively). Three-fourths of unmarried women did not know the common characteristics of abnormal vaginal discharge. Among suspected symptoms of STI, vaginal itching was the most frequently mentioned by the respondents (16%), followed by abnormal vaginal discharge (9.5%). Only 1.3% women considered urethral discharge in men as a suspected symptom of STI. Similarly, low abdominal pain (in women), and dyspareunia or dysuria were rarely mentioned by the respondents; 73% married and 93% unmarried did not report knowledge of any symptom of STI. Only five percent of the women knew that the possible causes of STI were micro organisms. Bad hygiene and having sex during menstruation or soon after delivery were mentioned as "causes" of STI by 11.5% and 2.8% of women, respectively. Two-fifths of the women said STIs were caused by being unfaithful to your husband . Half of the respondents did not know any "cause" of STI. The proportions of respondents who correctly answered the question concerning STI transmissibility and the necessity of partner treatment were 76.5% and 55.9%, respectively (Lan, Lundborg, Morgan et al 2009). With regard to STI curability, 16.3% women considered gonorrhoea and/or syphilis as curable diseases. Twenty one percent of the respondents mentioned HIV/AIDS as incurable while 14% women thought HIV/AIDS could be cured. Concerning sequel of untreated STI, the correct answer rates were very low while 59% of the women (54% married vs. 76% unmarried) did not know of any complication. There were

significantly more unmarried than married women who were unaware that STI could be prevented. The results also demonstrated significant differences in proportions of unmarried and married women who mentioned ways of STI prevention such as using condoms, avoiding injecting illicit drugs, and keeping good hygiene.

Tengia-Kessy & Kamugisha., (2006) argued that the information that adolescents have about STIs has been shown to be inadequate and inaccurate in many studies, especially from Africa. The researchers reported that in Burkina Faso, a large proportion of adolescent boys and girls did not know the symptoms of STIs or did not recognize them as STI symptoms. There were also inaccurate beliefs, including one held that one could contract gonorrhoea from urinating on the same spot where someone who was infected had urinated (CRHCS, undated). In Uganda, while 98% of teenagers reported some knowledge of different STIs, very few could recognize their symptoms (CRHCS, undated). Lan, Lundborg, Mogren and Phuc (2009) found that there was a low level of knowledge on STIs among women of reproductive age in a rural district of Vietnam and suggested an urgent need of health education for these women.

Commonwealth Regional Health Community Secretariat (undated) states that in Zambia, knowledge of STI symptoms and treatment was also lacking. Some young people did not only identify gonorrhoea, syphilis and several illnesses bearing local names, but also diarrhoea and malaria as affecting the “private parts” In many settings, girls were especially poorly informed and had difficulty recognizing STI symptoms, especially in distinguishing between normal and abnormal vaginal discharge. Lack of education and young age might

well play a role in STI knowledge levels. (Sogarwal and Bachani, 2009) In Colombia, for instance, 77% of young people without formal education were unaware of the main STIs and how they were transmitted. Among better-educated young people however, knowledge was much better. In Zimbabwe, only 50% of school-going adolescents had basic knowledge of STI symptoms, but knowledge increased with age (CRHCS, undated).

Adolescents' lack of knowledge of STI symptoms and mode of transmission must be seen as part of a wider problem, which comprises widespread lack of knowledge of all issues related to sexuality and reproduction, including normal bodily functions, how pregnancy occurs, and use of contraception, as well as STIs (Nzioka, 2001). The same study reported that, adolescent boys did not seem to understand the link between the risk of contracting STIs and contracting HIV. In fact, young people may acquire knowledge of risk of STI infection and symptoms or of reproductive health issues but not both. An evaluation of schooling experiences in Kenya showed that while many students were ignorant about when and under what circumstances pregnancy could occur, they were moderately well informed about AIDS and STIs, with girls slightly less knowledgeable than boys. (Nzioka, 2001).

A similar study in India by Sogarwai & Bachani (2009) on awareness of women about STDs, HIV/AIDS and condom use in 29 major states in India, revealed that awareness of females in the age group of 15-49 years about STIs excluding HIV was as low as three and a half percent where as HIV/AIDS awareness was seven percent. Surprisingly, forth-two- to-fifty

percent of the previously married women from four states of India namely Rajasthan, Jharkhand, Chhattisgarh and Uttar Pradesh were not aware of any STD including HIV/AIDS.

2.3 Source of Information on STIs

Tengia-Kessy & Kamugisha (2006) found that in Tanzania, young people received most of their information on STIs from the mass media with television providing 75% of the information. These young people would nevertheless have preferred to receive more information from their parents than from the media. Even though family life education has been integrated into the school curriculum teachers were regarded as the least source for information on STIs by student. Similarly in Nairobi, Kenya, the media is the main source of information on STIs such as gonorrhoea and syphilis, followed by teachers, friends and relatives (Nzioka, 2001). However, in Colombian school teachers were mentioned as the most common source of information on STIs, and girls also frequently mention their mothers; health services were only described as an important source of information by 5% of young people.

Commonwealth Regional Health Community Secretariat (undated) has it that in South Africa, friends were considered a valuable source of information, but nearly three quarters of young people indicated that they preferred to speak to an adult about sexuality. It continues that clinics would have been their preferred source of reproductive health information, services and products, but unfortunately most clinics did not have an environment in which young people felt comfortable to seek the advice and services they needed and wanted.

2.4 Prevention of STIs

It is common among generally healthy adolescents not to see health as an important issue. Among the various reproductive health issues, STIs (other than HIV) may not be seen as particularly important, and STI treatment may be of low priority to them (Brabin, 1998; Glanz, 1993). Adolescent girls are often far more concerned about preventing unwanted pregnancy and menstrual problems than about STI symptoms, while for boys sexual health concerns often outweigh reproductive health ones. This has recently been shown in Kenya, Sweden and Argentina. (Brabin, 1998.).

A study in Zimbabwe revealed that neither young men nor women in urban and rural areas were worried about STIs. While the young women had little knowledge of the signs and symptoms of sexually transmitted diseases, including AIDS, contracting an STI was strangely something to be proud of and seen as a symbol of manhood for boys (ZNFPC, 1996). In Zambia, boys believed that girls were the main carriers of STIs, and that it was normal for a boy to get STIs as part of growing up (Zambezi, Kambou, Nkhama & Shah. 1996). In Senegal, both adolescents and adult respondents believed that contracting a syphilis-like disease protected one against other illnesses. In Romania, focus-group discussions with young people revealed that during communist times, having an STI had been seen as a sign of virility and an expression of protest against the regime. Indeed, the tendency to associate the experience of STIs with masculinity is a serious obstacle to the adoption of prevention strategies (Nzioka, 2001).

Ohene & Akoto (2008) have found that adolescents often experience feelings of guilt and shame when they realize that they have contracted an STI and many may not have acquired the skills needed for telling someone that they have a sexual health problem.

Prevention may not be the only issue for health providers to be concerned about. Some infected persons may not be seeking care and advice and therefore may be inadvertently frustrating prevention in society by harbouring their infections. In a study on STIs and health seeking behaviour among women in Accra, Adanu et al., (2008), found that only 35% of the women with STI symptoms sought and received care or advice. The study found that seeking care or advice was strongly associated with wealthy respondents who felt bothered or embarrassed by an offensive vaginal odour, for example. The challenge in STIs prevention is that a woman may know that her partner has several other sexual partners, she may be helpless. Asamoah-Odei (1996) reported that even when women knew their spouses had several partners, most lack the ability to negotiate for safer sex.

Shamsu-Deen (2013), examined the challenge of STI prevention and finds that social hardship such as accommodation and poverty made female porters operating at Agboloshie in Accra to often have to give in to sexual harassment and even demand for unprotected sex in order to have a place to sleep within or around the market.

Summary of Literature Review

The body of evidence on the global trend revealed a low level of awareness and knowledge of STIs with the exception of HIV/AIDS among young people. Studies have reported that most young people do not know the cause or symptoms of STIs. Their source of information on STIs was mainly from the mass media and friends, nevertheless they would have preferred receiving information from parents and health staff than from the media. The literature also revealed that, generally healthy young people do not see health as an important issue, therefore, reproductive issues STIs (other than HIV) does not seem important to them. Hence due to their lack of knowledge on STIs its prevention is not an issue to them. The Social Ecological Model (SEM) was adopted in this study to illustrate the concept on awareness and knowledge of STIs among female porters.

CHAPTER THREE

3.0 METHODS

This chapter presents the methods of the study in the framework of study design, study area, study population, sampling method, data collection procedure, data analysis and ethical considerations.

3.1 Study Design

This study is a cross sectional explorative and qualitative research that used focus group discussions (FGD). FDG was used to understand the participant's meanings and interpretations they have concerning sexually transmitted infections. This approach would explore their points of view and beliefs concerning sexually transmitted infections. It was conducted between the months of May to July, 2013 in Madina.

3.2 Study Area

Madina is the administrative capital of the newly created La-Nkwatanang Madina Municipal. It is located north of Accra the national capital. It shares boundaries with Ashaley Botwe to the north, Legon to the south, Ogbodjo to the east and Agbogba to the west. It has an estimated population of 114,981.(source; Ga East Municipal Health Directorate Annual Report[GEMHDAR],2011). Legend has it that the original settlers came from Nigeria through northern Ghana hence the name Madina.

Population

The population of Madina is largely made up of traders, artisans and drivers. There are public sector workers as well as those who commute between Madina and their places of work.

There are two main religious denominations Christianity and Islam with a few traditionalists. There is little order to the spatial arrangement of both commercial and residential buildings and Madina is saddled with congestion, problems of high accommodation rentals, poor sanitation and drainage.(source; GEMHDAR,2011)

Traditional and Political structure

Traditionally Madina is part of the traditional stool lands of the people of Labadi, now referred to as La of the Greater Accra Region. Even though the early settlers were mainly Muslims from Nigeria, with the passage of time people from different ethnic groups also came to settle and with the rise in population Madina gained the status of a town. Madina is a commercial town and boasts of a large market which serves as a major food distribution centre. Farm produce from neighbouring places like Dodowa, Aburi and Amanfro en route to Accra are commonly sold here. Gradually Madina has evolved from a small homogenous village into the heterogeneous township of today.(source; Madina Zongo Chief, December 2012).

The Municipal Chief Executive is the political head. He together with the assembly members ensures that government policies are implemented as intended through the various decentralised agencies

Transport and Communication

The main trunk road through the town is tarred serving both private and commercial vehicles. Madina boasts of a television station (NET 2), a radio station (Oman Fm), a post office and several mobile telecommunication facilities. Madina enjoys hydroelectric power and pipe borne water.

Education

There are over one hundred and thirty (130) private and public schools distributed across the Madina township. These schools include senior high schools (SHS), junior high schools (JHS), primary and pre-schools. They are managed by the municipal education directorate which also reports to the regional directorate.

Health Administration and Services

The town has two public polyclinics and nineteen private hospitals, clinics and maternity homes, several pharmacy and chemical shops. The Municipal Health Directorate is responsible for the coordination, monitoring and supervision of all health care services within the municipality.(GEMHDAR,2012)

3.3 Study Population

The study population were female porters aged 15 years and above resident within Madina. This is because they fall within women in the reproductive age.

Scope of the Study

Inclusive criteria: all female porters 15 years and above residing within Madina

3.4 Sampling Method

A purposive sampling method was used to select female porters from different locations within Madina namely La-Nkwatanang, Redco and Atima. These are mainly the residential locations for the female porters in Madina.

3.5 Data collection procedure

Porters in Madina were identified as living and working in groups largely on ethnic basis which they explained to this researcher as fostering effective communication, social cohesion and a spirit of being one another's helper. Thus the focus group interviews were conducted in the groups' tribal languages or in a language a group commonly preferred to be interviewed in. Audio recordings were done in the specific languages and transcribed in English later. Five groups of ten (10) porters each were interviewed. There were two Dargati groups, two Dagbani groups and one Gonja group. In all 50 porters were in the five groups interviewed. The five focus group discussions (FGDs) were conducted using a focus group discussion guide to elicit information on the theme *awareness and knowledge of STIs, sources of information regarding STI, and prevention of STIs*.

In this focus group discussion, questions asked were thrown to all members of a group at the same time. Every group member was free to volunteer a response. Responses that were not objected to or contradicted by others or majority of group members were noted. Where a response was contradicted, the group was allowed to do a review discussion of the question and response until a consensus response was agreed by the group members.

Four pictures of sexually transmitted infections were shown for identification and answers to questions in each group interview. These infections were Gonorrhoea, Abnormal Vaginal Discharge, Genital Ulcers, and Genital Warts. Questions were also asked on HIV but without pictures because the researcher knows that there are no visual signs of HIV.



Two of the pictures of Signs of STIs shown the respondents

3.6 Data Analysis

The nature of data from the FGD required a qualitative analytical framework. Initially, the translations were read several times in order to be familiar with the contents to enable them to be aligned with the themes generated for the study. The responses were then reviewed and sorted out in accordance with the theme.

3.7 Ethical Considerations

Ethical approval was sought from the Ethical Review Committee of Ghana Health Services, Research and Development Division, Accra and the Municipal Health Directorate of La Nkwantanang Madina before the commencement of the research. Permission from the individual porters within the various groups was sought during the fieldwork. The details of the study were explained to them in the various languages for them to give their consent. They were also informed of their right to withdraw from the study at any point in time. The data collected was held in confidence and personal identities of respondents were not disclosed.

CHAPTER FOUR

4.0 RESULTS

4.1 Introduction

This chapter presents the results of the study. The main aim of this study is to assess awareness and knowledge of sexually transmitted infections (STIs) among female porters in Madina. The chapter is organised under the following headings: (a) to assess awareness of STIs among female porters in Madina (b) to examine knowledge of STIs among female porters (c) to examine source of information about STIs among female porters, and (d) to examine knowledge on prevention of STIs among female porters.

4.2 Background characteristics of respondents

The majority of respondents were youthful and were aged between 15 and 30 years; the average age was 24 years. Over 60% of respondents said they were married, but had only come down from northern Ghana to the south here in Madina (Accra) to work a short while for money to support their own nuclear and extended families. This would enable them to set up some micro-trading businesses or acquire equipment for sewing or some other light manufacturing businesses.

Except for 2 (8.0%) of the 50 respondents who had been to primary school, the rest (92%) had never been to school. The respondents have resided in Madina, Accra for at least 12

months. It should be noted, however, that respondents frequently visited their home towns, in the Northern and Upper East regions. Table 1 presents the demographic characteristics of the FGD groups.

Table 1: Demographic characteristics of respondents

Ethnicity of FGD Groups	Number of participants	Age Structure	Marital Status	Highest Educational Level	Length of stay in Madina (Months)
1 (Gonja)	10	18-25 years	8 married	One person, primary five	6-24
2 (Dagbani)	10	21-30 years	6 married	One person, primary three	2-36
3 (Dagbani)	10	21-27 years	7 married	Nil	7-24
4 (Dagari)	10	17-24 years	7 married	Nil	5-18
5 (Dagari)	10	15-21 years	2 married	Nil	2-12

Source: Field data, 2013

4.3 Awareness and knowledge of STIs

When pictures of signs of four infections, namely Gonorrhoea, Abnormal Vaginal Discharge, and Genital Warts were shown to the groups, majority of them were able to identify the signs as conditions in women, but they did not associate sex with acquisition of these conditions. For gonorrhoea they merely described it as a “white water” disease in the “private part,” a description of the physical manifestation of the infection which is a whitish or creamy liquid (here described as white water) that comes out from an infected woman’s vagina. For abnormal vaginal discharge they described it as the starting stage of the white disease. In the case of genital ulcers they described them as sores that have developed from an untreated white disease after scratching the vagina. The Gonja FGD group mentioned *Nchufufu* as the local name for what was seen in the three pictures. The Dagbani FGD groups called it *Kpapelgu* and the Dagari called it *Konpien*, all associated with the “white water” disease. Many of the porters, for example, a 26-year-old Gonja woman said:

This is only a “white water disease,” except that it has become serious because perhaps it has been neglected for so long.

She was referring to a sign of gonorrhoea infection.

The Dagari group called genital warts *Taska* which literally means rashes; and the Dagbani group referred to it as *Tahaga* which means serious rashes. Both groups did not demonstrate any fear for the conditions they saw since none of them was able to identify the signs and symptoms.

They attributed the causes of the infections to wearing of dirty pants, eating of polished rice and exposing the private parts to heat that emanates from public pit toilets. FGD participants also attributed the condition to drinking too much milk. This was based on the ‘milky’ vaginal discharge which is characteristic of many STIs. Only three porters in one of the groups (Dagari group) said the conditions seen in the pictures represented sexual infections. One woman (19 years) from the Dagbani groups said:

The disease actually looks like milk when it deteriorates. Everyone must avoid eating too much rice and milk.

Another woman (Dagari 22 years) claimed:

Yes, polished rice gives “white”, and that is why we Northerners prefer brown rice to white rice.

Many respondents felt that all females were at risk of acquiring the infections shown in the pictures, and that the infections were caused by behavioural and environmental factors. Some of these behavioural factors are the use of public toilets, drinking of milk, eating of polished rice and urinating at same spot where an infected person had previously urinated. According to respondents from the Dagbani FGD, these infections shown in the pictures are not obtained through sexual intercourse; instead transmission was based on a superstition of urinating continuously in a public facility that is shared by infected persons. As regards how the infections can be treated, the majority of FGD participants (approximately 80% of respondents) said they self- medicated in the treatment of the conditions. In their own words,

“We buy drugs from drug stores and take.” However, most respondents of the Gonja FGD group said they sought formal treatment from health centres whenever they had an infection.

When asked about their knowledge of HIV, all respondents said:

Yes, HIV/AIDS, we know it. It kills and it is said to be incurable.

Respondents attributed several risk factors to HIV transmission. These include having multiple sexual partners, sharing infected blades, and sharing underwear. No picture was shown on HIV because HIV symptoms are not unique. They are similar to symptoms of other infections. Respondents who were married said they did not think they were at risk of HIV infection because of their marital status and were in Madina to work and not engage in sexual promiscuity. This was a very clear indication that they understood the main risk factor for HIV infection which is sex.

This demonstration of knowledge and awareness of HIV necessitated and prompted questions on condom use. All FGD respondents knew that condoms were used during sexual intercourse to prevent HIV infection and pregnancy. This response again emphasised respondents' awareness of HIV as compared to other STIs.

4.4 Sources of information about STIs

The findings of the study suggest that respondents relied on traditional sources of information such as friends and family conversation and discussions in local social engagements on STIs. All group members said they knew a number of infections in their own communities and that

is why they have local names for some of them. Some of these names have already been mentioned in Section 4.3 of this study.

Radio and TV, drug peddlers, clinics and friends were mentioned as sources of information by all respondents. Narratives suggested that when porters are less busy, they listen to local frequency modulation (FM) stations, through huge speakers positioned at vantage points in the market or watch TV in market shops. During work, they encounter drug peddlers in the markets and at bus terminals. These peddlers claim that their drugs can cure all sorts of STIs. Respondents mentioned *babaso* as a popular name peddlers use for gonorrhoea. Respondents receive information at health centres on STIs, especially on prevention of HIV. Asked whether they get adequate information on STIs from the above-mentioned sources, respondents said they were unable to determine what information they needed to have, and so were unable to say whether or not they were getting adequate information. One woman in the Dagari group said:

I think what we need most is education. But can we afford to leave our work and go to clinics for such education?

The desire and concern expressed by this Dagari woman is an indication that the women recognised that not only the information they were getting might not be adequate but also that there was need to be sure of what information was needed. This certainty, she seems to suggest, lies in “education.”

4.5 Prevention of STIs

The study sought to find out from the porters what they knew as ways of preventing STIs. In response they mentioned the need for personal cleanliness, being faithful to one's sexual partner, minimising the consumption of polished rice and milk, and not urinating on spots where infected persons had previously urinated.

With particular reference to HIV which the porters generally associate with sex, one Gonja woman (unmarried 20 year old) said:

You need to know your sexual partners and limit their number. One partner at a time and you must know him well. You cannot be safe if he cannot control himself and goes after every woman he sees.

She caused laughter among her colleagues when she further said:

I have heard that the form or style of sexual act can be a problem. You must not allow your man to take you in certain ways, otherwise you can get AIDS. Some men are bad, and they may ask for anal sex. That will give you AIDS. You will even offend God with that.

A Dagari woman (22 years) wanted to know whether HIV could be prevented with vaccination. She asked:

Is it true that there are some hospitals that offer injections that can protect against HIV AIDS? What kind of hospitals are those; where are they?

CHAPTER FIVE

5.0 DISCUSSION

This chapter reviews the research question, methods employed and the results obtained. The chapter provides interpretation of the findings and explains their significance. The study reports findings that are similar to what others arrived at in other studies as reported in the literature reviewed. The findings of this study have been reported under three themes: Awareness and knowledge of STIs among female porters in Madina, sources of information on STIs, and porters' knowledge in STIs prevention.

5.1 Awareness and knowledge of STIs

In this study majority of the respondents identified the labelled signs of STIs such as gonorrhoea, abnormal vaginal discharge, genital warts and genital ulcers in pictures shown them as ill-health conditions of women, but sexual intercourse was not considered a risk factor because they commonly attributed STIs to drinking a lot of milk and sharing toilets with infected persons. CRHCS (Undated) reports a similar study in Uganda where inaccurate beliefs including one held that one could contract gonorrhoea from urinating on the same spot where an infected person had urinated.

The majority of respondents had not been to school. This may have accounted for respondents being unable to read the labels on the pictures shown and identify the signs

correctly. This is consistent with findings from a study by Tangie-Kessy and Kamugisha (2006) in Tanzania to assess the levels of knowledge on STIs. In that study they found that education influences knowledge and awareness of HIV/AIDS. Lan et al., (2009) report a similar finding in a study in Vietnam where about three quarters of respondents did not know any symptoms of STIs because they had very little or no education.

Majority of porters (80%) in this study said they self-medicated whenever they had an STI. Baah-Ennumh, Amponsah & Owusu (2012), also report that 85% head porters obtained health care from drugs stores, pharmacy shops and drug peddlers. This shows their concern about the infections and willingness to seek cure. This may be an opportunity to give them some education for STI awareness. The fact that most of them felt that all females were at risk of being infected may be a pointer to their being well disposed to be educated on the infections.

The negative impact of lack of education manifests in wider dimensions. Respondents in this study attributed the causes of the infections to wearing of dirty pants, eating of polished rice and exposing the private parts to heat that emanates from public pit toilets. FGD participants also attributed the condition to drinking too much milk. This was based on the 'milky' vaginal discharge which is characteristic of many STIs. Only three porters in one of the groups (Dagaari group) said the conditions seen in the pictures represented sexual infections.

But this same study provides a contrary observation. The fact that all respondents acknowledged HIV and talked freely about it, mentioning its factors of transmission, even without pictures being shown them is an indication of their knowledge and awareness of the condition. Respondents attributed several risk factors including having multiple sexual partners, sharing infected blades, and sharing underwear to the transmission of HIV. Is it not the same respondents who misidentified the other signs of STIs? How come they were right in the case of HIV? The overwhelming (all 50 respondents) show of awareness and knowledge of condom as an instrument for HIV prevention in sex is a resounding indication of the porters' knowledge and awareness of HIV as an STI.

Respondents attributed several risk factors to HIV transmission. These include having multiple sexual partners, sharing infected blades, and sharing under wear. This was a very clear indication that they understood the main risk factor for HIV infection which is sex. This is in contrast to the result of a similar study in India where about 50% of the respondents of similar rural and peri-urban background were not aware of any STIs including HIV and the use of condom in their prevention due to lack of education (Sogarwai & Bachani, 2009). This contrasting evidence raises issues respecting the relevance or nature of education.

5.2 Sources of information on STIs

The study found that respondents' sources of information were traditional institutions, the media, drug peddlers, friends, colleague porters, markets, and bus terminal. Local knowledge on sexual and reproductive health was obtained from family members and friends and at

traditional gatherings prior to their departure for Accra. In Accra the porters live and work in tribal groups to foster effective communication and social cohesion. van den Berg (2007) and Zaami (2010) report similar situations in Accra and Madina. While in Accra they depend largely on information from the market place where they work. Their encounters with some of the people whose goods they carry in and around the markets and car stations result in what may be described as “compassionate counselling”. Some female clients out of concern, engage porters in conversations about their sexuality. These female clients warn them of the dangers of unprotected sex and the possibility of being sexually harassed by other males (both young and old), in the market. In a study in South Africa, 75 % of respondents reportedly preferred to speak to an adult in matters regarding their sexual health CRHCS (Undated).

Study findings suggest that respondents generally preferred the media as a source of information. These findings are consistent with findings from a study in Tanzania (Tengia-Kessy & Kamugisa, 2009). In this study, young people preferred radio and TV as sources of information on STIs. The challenge here is that porters are either too poor to acquire their own TVs or radio sets. They may not even have a safe place to keep such media sets. Narratives have it that when porters are less busy on days of less demand for their services they take advantage and watch TV or listen to radio from nearby shops. It is quite a common practice for many shop owners to keep a TV or radio in their office for news and entertainment. The limitation here, as in many cases, is that majority of the porters are neither able to understand English or Twi well enough to benefit adequately from what they may

hear. In addition, lack of timeliness of access is also a considerable limitation as the porters cannot watch or listen to TV or radio programmes at will.

The study established that porters often encounter itinerant drug peddlers. These peddlers advertise the effectiveness of their wares and provide information on all sorts of infections including STIs. It is not clear if information provided about STIs is credible. Nevertheless, these drug peddlers speak mostly in twi (a local Ghanaian language) which unlike English is, at least, partially understood by some of the porters.

As by nature porters are private individual head-load contractors, they work in dispersed situations until they close from work and go to their sleeping places. The study found that they share and exchange information among themselves during the evenings after work or on Sundays. These rest and social sessions are an important source of information as a lot of briefing and debriefing and commentary take place on the day's activities and encounters.

5.3 Porters' knowledge in STIs prevention

This study found that though the porters did not identify the signs in the pictures shown them as STIs, they were still worried about them as diseases of women. They worried about the disease but not necessarily as STIs. A study in Zimbabwe blames low education and lack of knowledge for young men and women being less worried about STIs and their signs (ZNFPPF, 1996). Since in this study the pictures were labelled, the porters would have been able to identify the infections as STIs if they could read and understand English.

That they misidentified the pictures is an indication that language – literacy – was the limiting factor in the identification process. This outcome is consistent with the assumption made in Figure 1 of Section 1.3, representing the conceptual framework for the study. The assumption is that the level of education of porters influences awareness and knowledge of STIs in the sample of porters in the study. The study reveals that such misidentification could mislead respondents to formulate all sorts of erroneous phenomena and the causes of such phenomena. Wrongly naming the signs in the pictures as infections not attributed to STIs, poses an educational challenge in STI prevention.

In the case of HIV, even though no picture was shown the respondents were able to speak about the subject as an STI and were eager to ask questions and discuss its mode of transmission as well as prevention. The lesson derivable from this focus group outcome is that pictures may not sufficiently serve an identification purpose unless they are labelled and the target audience (viewer) are literate in the language of conveyance. So a mass literacy education campaign may be necessary for all porters and women who find themselves in similar socioeconomic situations.

Findings in this study seem to suggest that low perceived vulnerability to STI arose due to limited STI/HIV knowledge and overreliance on obvious symptoms. However, STI risk exposure also occurred among those with good knowledge who had intentions to minimise risk or believed they were adopting appropriate risk-reducing strategies (Sihavong et al.,

2011). Even STI experiences did not always lead to a re-evaluation of strategies or consistent condom use.

With regard to the challenge of female porters protecting themselves against STI, this study found that female porters may know the dangers of multiple sexual partners and unprotected sex, but lack of accommodation at Madina and financial hardship sometimes compelled some porters to succumb to sexual pressure of men who owned kiosks, sheds and uncompleted houses around the markets where they work. The situation is not different from that of porters in Agbogboloshie in Accra where according to Shamsu-Deen (2013) general social hardship and lack of accommodation forced female porters operating at that market to often give in to sexual harassment and even demand for unprotected sex in order to have a place to sleep in or around the market. This shows that knowledge of STI would not necessarily make STI prevention effective so long as some women have to yield to unprotected sex for survival including having somewhere to sleep. The issue of difficult living arrangements in Madina and Agbogboloshi are not different from those of Nima in Accra (Oberhauser & Yeboa, 2011).

5.4 Application of the Social Ecological Model to Awareness and Knowledge of STIs among Female Porters in Madina.

The Social Ecological Model SEM since its inception in 1988 by Mc Leroy et al has not been used much, but is currently experiencing much interest as health practitioners and researchers are applying the concept to emerging health issues, due to its multi-level approach to issues.

This model has been used to examine contextual influence on contraception and condom use in women (Bull & Shlay, 2005), and STI risk behaviors in adolescents (Voisin, DiClemente, Salazar, Cosby & Yarber, 2006).

Though the originators of the model identified five levels or constructs; Individual, Interpersonal, Organization, Community and Policy, for the purpose of this study the first four were used. The fifth level does not have any direct influence on the porter's awareness and knowledge of STIs and therefore is not discussed in this section.

Individual Level

This study revealed that at this level, factors such as age, length of stay in Madina, and level of education had some influence on the level of awareness and knowledge of STIs among the porters, marital status had little or no influence. Even though the pictures shown them were labeled, they could not identify them because they could not read due to their lack of formal education. Level of education has been found to influence condom use in the prevention of STIs (Oladosu, 2005) and prevention of unwanted pregnancy (Tehrani, Farahani & Hashemi, 2001).

Interpersonal Level

Interpersonal factors have also been shown to impact on persons knowledge and behavior. In the Philippines, as reported by Chaio, Morisky, Rosenberg, Ksobiech and Malow, 2006, alcohol use by female sex workers before sex, was related to increase likelihood of having STIs. Results from this study revealed that, at this level factors such as, friends or family members who might have heard of or have had an STI as well as co-workers with similar

experience had an influence on the level of awareness and knowledge of STIs among the participants.

Organizational Level

Factors at this level which include the workplace which is the market for the porter and the media had an influence on them. Whatever that is put out for public consumption by the media, as well as some conversations that transpire between them and some of their customers has some influence on how they get information on STIs and their prevention. On the other hand factors such as the church or mosque where the porters worship had no influence, according to them matters concerning sex are not discussed there.

The community Level

The community level factors like health facilities and the health staff, places of residence and socio-cultural norms seem to play a role in their awareness and knowledge about STIs. At the health facilities, health staffs give information on STIs and its prevention, thus creating awareness for the benefit of the clients including the female porter. From this study, the female porter's socio-cultural belief is that STIs are contracted when one urinates at a spot where an infected person has already urinated so she does not attribute unprotected sex as the main cause of STIs. Although the place of residence may expose the female porter to unprotected sex by unscrupulous men, it does not influence how they acquire knowledge on STIs and their prevention. On the other hand a study by Kathryn (2010) in Guatemala on Contraceptive use and intent revealed that place of residence was significant in contraceptive use.

In conclusion, the factors within the four levels of Socio-ecological model in one way or the other have influence on the female porters' awareness and knowledge on STIs.

CHAPTER SIX

6.0 CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

The study set out to assess the level of awareness and knowledge of STIs among female porters in Madina. The process had the object of determining whether or not some important factors such as level of education, friends and families, co-workers, the workplace (market), health facilities, the media among others, affected and influenced the awareness of the porters. Both the literature review and the FGD and the findings thereof have established that these factors do really influence the awareness and knowledge of the porters.

The literature review abounds in examples where level of education affects awareness and knowledge of porters regarding STIs as well as attitudes and practices of women in general and porters in particular in seeking information on STIs and their prevention. A lesson derivable from the FGD is that pictures may not sufficiently serve an identification purpose unless they are labelled and the target audience (viewers) are literate in the language of conveyance.

The FGD has shown that the porters have a lot of knowledge about HIV as an STI. They even know the importance of condom in HIV prevention. But they are limited in knowledge about many other STIs, for example, gonorrhoea, abnormal vagina discharge, genital warts and genital ulcers. These STIs are seen as “white water” diseases of women but are not sex

related. The FGD has revealed that lack of knowledge and awareness has made majority of porters perceive and describe some STIs as non-sex related. This may predispose them to some STIs and suffer from them for needlessly long time without seeking appropriate medical attention.

6.2 Recommendations

6.2.1 For lack of knowledge the porters described as “white water” diseases clear STIs signs shown them. Therefore any measures to deal with such diseases at the public health level would need to first orient the women to know and appreciate the fact that the conditions are really sex related.

6.2.1 There is need to organise functional literacy programmes for porters to build their capacity in basic literacy and numeracy so they can identify and understand some basic STI issues and behave appropriately towards infection prevention.

6.2.3 Researchers and health workers need to understand that no matter how suggestive pictures may be, their target audience may not be able to interpret them accurately. The researcher may have to go beyond the pictures to enhance understanding of the issues of discussion.

6.2.4 There is need to organise a national capacity building programme in the identification and prevention of other STIs so that vulnerable women such as the Madina porters in this study can upgrade their knowledge and awareness of such infections.

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APPENDICES

APPENDIX 1: CONSENT FORM

Project Title

Awareness and Knowledge of Sexually Transmitted Infections among Female Porters in Madina

Institutional Affiliation

School of Public Health

College of Health Sciences

University of Ghana, Legon

Background and Personal Introduction:

The lead investigator is Gifty Ayomah Blay, currently a Master's Student of the School of Public Health, University of Ghana, Legon and conducting a study on awareness and knowledge of STDs among female porters in Madina. This study is for academic purposes and a requirement for the award of Master of Science Degree in Applied Health Social Science and Supervised by Rev. Dr. Mercy Ackumey of School of Public Health, University of Ghana, Legon.

Procedure:

A focus group discussion will be held. The discussion will be tape-recorded with your permission. This tape-recording will be kept until after the Degree has been awarded; then it will be destroyed.

Risks and Benefits:

There are no reasonably foreseeable harm that may arise from participation in this research while benefits that may arise include a contribution to the development of reproductive health policies. It will also create personal awareness and knowledge of STDs among female porters in Madina.

Right to Refuse:

Although there are no known risks associated with the research protocols, if you feel uncomfortable you have the liberty to opt out. You are also at will to withdraw from participation if you desire to do so.

Anonymity and Confidentiality:

You are assured that the information collected will be handled with the strictest confidentiality and will not be shared with third parties not directly involved in the research and thus will be used purely for academic purposes.

Before Taking Consent:

Do you have any questions that you wish to ask? (If yes, questions will be noted.) If you have questions you wish to ask later, or anything you wish to seek clarification regarding the research, please do not hesitate to contact the principal investigator (Gifty Ayomah Blay) on:

Telephone number: 0244509388

Email: gifty.ablay@yahoo.com or

The Academic Supervisor on: 026-8040891

Interviewer's Statement:

I have explained the procedure to be followed in this study to the client in the language that she understands best and she has agreed to participate in the study.

Signature of Interviewer.....

Date.....

APPENDIX 2

FOCUS GROUP DISCUSSION

General introduction

It should be noted that in this focus group engagement, questions asked were thrown to all members at the same time. Every group member was free to volunteer a response. Responses that were not objected to or contradicted by others or majority of group members were noted down directly. Where a response was contradicted, the group was allowed to do a review discussion of the question and response until a consensus response was suggested by one or more group members.

GROUP (INTERVIEW) #: (In.....)

Date of Interview:

Name of Interviewer:

Interview Assistant:

Group characteristics (demographic data):

Introduction of subject to the group

Good morning. Please we would like to ask you a few general questions on health and what you know about sexually transmitted infections (STIs). Your cooperation with us and your helpful answers would be very much appreciated. We believe this engagement will be beneficial to us and you, as we will both learn from it. Thank you for your cooperation.

Questions

1. As you are here in Madina, what are the general health problems that worry you?

2. Where do you go for treatment when you are ill?

3. I am going to show you some pictures, see if any of you knows what kinds of diseases they represent (Pictures of 4 STIs shown).
 - 3.1 What do you call this disease in your local dialect?
 - 3.2 What are its symptoms?
 - 3.3 What do you think causes this disease?
 - 3.4 Who is likely to acquire this disease?

- 3.5 How can it be treated?
 - 3.6 From where do you usually obtain information on STIs?
 - 3.7 Do you get adequate information from there?
 - 3.8 What additional information would you like to have?
-
4. How can one protect oneself from getting infected?
-
5. Have you heard about HIV?
-
6. How does one get infected with HIV?
-
7. Have you ever heard about condoms?
-
8. What are they used for?
-
9. Why are they used (probing knowledge of need to use condom)?
-
10. Do you use condom, why (probe reason for using or not using)?
-
11. Do you have any questions or contributions to make?