SEXUALITY AND USE OF CONDOMS IN KENYA: IMPLICATIONS FOR AIDS CONTROL

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Abstract

The increasing number of HIV positive persons (8%) and many deaths (77,000) due to AIDS in Kenya render more urgent the study of condom acceptability and use. This paper reports on a research project that concentrated on both anthropological methodology and a survey to look at condom acceptability and use between 1994-6 from the perspective of the user. The research was carried out in two market centres in Kenya, namely, Burnt Forest and Malaba. While Burnt Forest is on the outskirts of the fast growing Eldoret Town, Malaba is a truck stop community on the Trans-African highway which is at high risk of infection in Kenya. Findings are reported for a sample of 174 respondents (94 in a survey, 45 in focus group discussions and 35 key informants). In 1994, over twenty four million condoms were distributed in Kenya. Two million condoms every month are hardly adequate for a population of 11 million sexually active users. In addition, use is low mainly because condoms are not acceptable. This is as a result of cultural beliefs, technological issues, moral values and economic realities which make condoms less acceptable.

A: INTRODUCTION

Condoms are, in the 1990s, the only contraceptives which serve the multiple purposes of preventing HIV/AIDS transmission, prevention of sexually transmitted diseases (STDs) and family planning (Carey, 1992). The benefits which can be accrued from increased condom use are immense for a country like Kenya. Today, HIV prevalence rates are estimated to exceed 7.14%. Such a figure would suggest that Kenya has in excess of 1.4 million HIV cases (Kizito and Johnson 1991; Ocholla-Ayayo, 1992). By the year 2000, the country will have 2 million cases (NASCOP, 1998). Most of the AIDS victims and healthy HIV carriers are aged between 17 and 50 years and, therefore, the most economically productive. Unless HIV/AIDS transmission is curtailed, Kenya and many African countries will lose some of their most productive work-force.

Despite educational efforts aimed at halting the spread of HIV, the AIDS causing virus, use of condoms in Kenya remains low. While the knowledge of contraceptives exceeds 96% among Kenyans aged between 19 and 50 years, only 26.9% use modern methods. Out of these 26.9%, only 0.4% of all women and 0.5% of all currently married women use condoms. Why are these rates very low? Is it because condoms are not acceptable? This study investigated condom acceptability and use in Kenya. The basic assumption of the study was that condom use is low in Kenya because condoms are not acceptable.

Acceptability of technological packages

Acceptability is the quality or state of being welcome, satisfactory, pleasing or adequate to approved standards. It is about the perception of inherent attributes as well as the perceived attributes of technological packages in this context. For condoms to be acceptable, people have to know about them, and have to understand why they need them. Condoms can only be acceptable if there is a felt need for their function. Zatuchni and Marshall (1980) see acceptability of

technological packages as centring on the perception of an innovation (in this case condoms) which is not viewed as a material object, but rather as a cluster of perceived attributes. Scrimshaw (1980) adds that the measurement and discussion of acceptability of technological packages should include not only attributes, but also actual behaviour, and an estimate of the relationship between attitude and behaviour. She adds to the concept of acceptability, the attitudinal and behavioural facets, in addition to the theoretical one.

Condom acceptability

Bledsoe (1990) and Caldwell *et al.* (1989) argue that condoms are not acceptable because they contradict the cultural purpose of marriage which is reproduction. In addition to suppressing fertility, condoms intensify suspicion among couples when one partner requests their use. Women who ask to use condoms are seen as promiscous, while condom usage signals a desire to end a relationship. Mwendwa (1993) and Ulin (1992) suggest that AIDS prevention and condom promotion campaigns in Africa have not been successful because they do not take into account the cultural, social and economic constraints on African women's ability to comply with advice to limit partners and use condoms. Karim (1992) concludes that high school students in South Africa do not use condoms much because they reduce sexual pleasure, they reveal a lack of trust in the partner s faithfulness, they stand in the way of the males to prove their manhood through conception and are associated with the presence of sexually transmitted diseases. Nyonyo and Shapink (1997), FHI/AIDSCAP (1997), Kamau (1996), Nzila (1991), Ngugi *et al.* (1988) Mbizvo and Admchak (1992) and Ocholla-Ayayo (1992) attribute low condom use to misconceptions about condoms.

Methodology

The study was carried out between June and September 1996 in Malaba and Burnt Forest, both of them in Kenya. Malaba, located in the western part of the country, is a border town with Uganda. It is also the major outlet to the landlocked Uganda. As such, it has a heavy transit population and a well established sex industry. During office hours, from Monday to Friday, business booms. There is also a fair amount of sex during and after office hours as well as on weekends with the entertainment industry, and this is pegged on prostitution.

Burnt Forest is a town with a population of 1000 people, the majority of whom are Nandi. Most of the commercial sex workers, however, are Agikuyu. The town lies on the Trans-African highway between Nairobi and Malaba. Due to its central location, most of the truck drivers from Nairobi or Malaba make stop-overs in this town. Like Malaba, the town has a great number of prostitutes who cater for the truck drivers. During weekends, men from Nairobi and the nearby towns of Nakuru and Eldoret come here to take a break from their wives and the stresses of the city, as one of them put it. Students from a nearby high school and villagers also support prostitution. To both Malaba and Burnt Forest, the availability of condoms for HIV/AIDS and STD prevention is of central importance. Due to the unique interaction between the international community at both centres, everyone is at risk of acquiring HIV/AIDS.

Qualitative and quantitative methods of data collection were used. A sample of 100 was drawn from both sites. Each site was divided into six clusters according to occupation, sex and level of education. The clusters consisted of truck drivers and their assistants, money changers and suspect drug dealers, bar patrons, professionals, commercial sex workers and regular citizens. Systematic sampling from a random start was used within each cluster (after every four

persons) to draw a sample of 94. Each of the 94 were exposed to 55 formal and informal questions. In addition, 45 respondents took part in seven focus group discussions. Four discussions took place in Malaba while three took place in Burnt Forest.

Informal interviews were conducted with the personnel in the condom distribution network, beginning with senior Ministry of Health officials to pharmacists and shop assistants. Reliance was also made on secondary resources of data such as hospital STD treatment records, National AIDS and STD Control Programme (NASCOP) publications, records of the National Council for Population and Development (NCPD), those of the Central Medical Stores, Logistics Unit of the Ministry of Health as well as those of two NGOs dealing in condom promotion in the sites.

During each activity, observations were made and recorded in the process or immediately after. Content analysis of the field report was done after every incident and in the final analysis. The quantitative data were analyzed using SPSS PC+software.

Characteristics of the selected sample

The results in the initial part of this section are drawn from the 94 respondents interviewed. Their mean age is 28 years. Two thirds of them (64 cases or 68.1%) have had primary school education or less. A majority of the sample (89%) reported earning less than Kshs.1000 (which at the time was US$20) per month, and which is low considering the high inflation rates. Most of the respondents are Christians (34% are Catholics while 44.9% are Protestant). A small number (14.9% and 6.4%) are Muslims and atheists, respectively. About a half of the respondents (47.9%) are living with a sexual partner(s). These partnerships take several forms, including traditional marriages, civil or church marriages, consensual unions and visiting unions. Polygynous unions account for 11.7%. During the two weeks before the interview was conducted, 41 (43.6%) had no sex, 29 (30.1%) had sex with one partner while 5 (16%) had sex with two partners. Eight respondents had sex with three or more different partners. Respondents having more than two sexual encounters are commercial sex workers (16) and truck drivers (7).

B: FINDINGS

Condoms acceptability is discussed in the light of knowledge about HIV/AIDS, its transmission and prevention mechanisms. It is, however, important to note at the outset that condoms are available through three major types of outlets in Kenya. First is the Ministry of Health through the Department of Family Health and Maternal and Child Health (MCH) programme which runs family planning clinics all over the country. The second source is Non-governmental Organizations (NGOs). There are about 25 NGOs which give out condoms while teaching clients how to use them. The third source is through the commercial enterprises such as super markets, pharmacies, shops, and hotels. The Ministry of Health and NGOs receive most of their condoms from donors such as USAID and the World Bank, while the commercial enterprises import theirs mainly from Europe. The condoms acquired through these channels are not enough for Kenya, as slightly over two million are given in a month for a population exceeding 10 million (Mwendwa 1993). The procurement process also lacks privacy, thus making condoms less acceptable if one were to conduct cost-benefit analysis.

Knowledge about AIDS

Most respondents have heard about AIDS (98.9%). However, 81.9% of the sample do not know that the disease is caused by a virus. Only 11.7% who know that AIDS is caused by a viral agent have secondary school or higher levels of education. Six respondents believe that AIDS does not exist. Most of the 6 are

Muslims who believe that Allah cannot bring something as bad as AIDS to his believers. Another one, who is of a Somali origin, told me that people of his ethnic origin have been thin and emaciated since the times of his ancestors, and so if HIV/AIDS makes people thin, then there is nothing like it. The others who do not believe there is AIDS argue that there have been similar diseases in their villages since time immemorial. All the people who do not believe in the existence of AIDS are males. Other than for the poor knowledge regarding the viral agent causing AIDS, general knowledge about AIDS is good.

Knowledge of HIV transmission

High knowledge levels of HIV transmission were noted. For example, 90.4% (85) of all the respondents know at least one way in which HIV can be transmitted. They stated that it could be transmitted by unprotected sex or through the exchange of body fluids. A few (2.1%) respondents erroneously thought that HIV could be transmitted by sharing space with victims, while 7.5% do not know how HIV is transmitted. There is a high correlation between education level and knowledge of transmission (r=72). Insignificant gender and occupation differences in the distribution of knowledge about how AIDS is transmitted were noted.

Knowledge of HIV transmission prevention

Most of the respondents (85.1%) have a good knowledge of how transmission can be prevented. However, only 30.9% associate condom use with HIV transmission prevention. This is a fairly low percentage. A third of the respondents (30.3%) mentioned abstaining from sex while 22.3% mentioned maintaining one faithful partner as a way of curbing HIV transmission. A small percentage (14.9%) do not know how HIV transmission can be prevented. Among them are 37.3% of all commercial sex workers, the highest risk group as shown in Table I below.

Table I:Methods of protection from HIV

Prevention method cited.

Occupation	Use condoms	Abstain from sex	One faithful partner	Doesn' t know	Total
Housewife/ farmer	1 12.5%	4 50%	3 37.7%	0 0%	8 8.5%
Truck drivers and assistants	9 37.5%	6 25%	8 33%	1 4.16%	24 25.5%
Commercial sex workers	15 36.58%	14 34.14%	3 7.3%	9 37.5%	41 43.6%
Teacher/clerk	1 8.3%	3 25%	5 41.66%	3 35%	12 12.28%
Petty business/other	3 33.3%	3 33.3%	2 2.22%	1 11.11%	9 9-8.6%
TOTAL	20 30.9%	30 30.31%	21 22.35%	14 14.9%	94 100%

Cultural and popular beliefs associated with HIV/AIDS

About a half of the respondents (47.9%) said there are no cultural beliefs associated with AIDS, meaning they adhered to the biomedical model of causation. This is good for AIDS prevention. However, there are a number of cultural beliefs associated with knowledge of AIDS/HIV, its cause, transmission and prevention. Some respondents (12.8%) think there is no AIDS or AIDS has been present since time immemorial, while 3.2% think AIDS is caused by witchcraft. Angry gods or ancestors, and punishment for sins accounts for 16% while those who see AIDS as caused by scientists, either intentionally or through a mistake, account for 5.3%. More men (20%) than women (7%) are likely to say that AIDS does not exist, while more women (7.1%) than men (0%) are likely to say AIDS is caused by witchcraft.

Perception of AIDS

Most of the respondents (85.1%) are worried about getting AIDS because it is deadly and incurable. Other reasons behind the worry are mistrust for spouses, for hospitals, or because they have had unprotected sex before. More women (89%) dread AIDS than men (70%). It is notable that 14.9% of the women are not worried of acquiring HIV/AIDS because they are faithful to their partners, or are not promiscuous, or because life is predestined, or because they do not believe AIDS exists.

Given high HIV/AIDS knowledge levels, and perception of AIDS as a deadly disease, it would be logical to expect that condom use would be high.

Knowledge and perception of condoms

Almost all the respondents have heard about condoms (98.9%). Locally, condoms are known by a number of different names. This is evidence that condoms have been integrated in the local culture. Table 2 below shows condom names and their meanings.

Table 2: Knowledge and naming of condom brands

Name	Meaning
Kondom	Swahili word for condom.
Mpira	Rubber. Condoms are called rubbers because they are made of latex.
Socks	Condoms are called socks because the act of wearing them is quite close to wearing socks.
Peremende ya watu wazima	Candy for adults. Condoms are nicknamed candy because their size and repackaging resembles that of candy.
Missile	Condoms are called missiles because when unwrapped, they look like missiles. Further, missiles are used to hit a target.
Kofia ya mzee	Hat for the old man . A condom tip resembles a hat. A hat is used to cover the old man's head, which is the male reproductive organ.

Knowledge of condom brands is, however, poor, with 60.6% not knowing any brands despite commercial advertisements in the mass media regarding condoms. When asked which condom brands they preferred, 54% did not have adequate exposure to make a choice. Knowledge about condom source is high for 72% of the respondents knew where they could be obtained. When respondents were asked where they usually obtained their condoms, 24.5% obtained condoms from health centres. This would be contrary to expectation as health centres are the major distributors of condoms.

Respondents are well versed with the advantage of using condoms, with each citing at least one, and 43% citing at least three (family planning, HIV and STD

transmission prevention). Seven respondents said there were no advantages of using condoms while 15% said they did not know the advantages of using condoms.

Compared to the knowledge about condoms, the level of condom use is fairly low considering that 80.9% of the interviewees have had sex without using condoms during the previous month, while 19.1% had not had sex at all. All respondents who said they ever used condoms were irregular users; thus, most people have at least one unprotected encounter per month. Asked the circumstances under which they did not use a condom, 60% said they never used a condom irrespective of the circumstances, 7.5% said they used every time they had extra-marital affairs or when having casual sex, while 2.1% used condoms for family planning. As a result of unavailability of condoms, 5.3% did not use them.

Respondents were further asked how many times they had used a condom during the last one month. Many of them (56.38%) reported that they had not used a condom during that period, despite being sexually active, 10.6% had used a condom once, 8.5% had used a condom twice, 7.4% had used a condom 4 times while 17% had used them more than 4 times. Among condom users, condom use was inconsistent. Most of the people who had used condoms did so with a stranger or for casual sex. Fewer truck drivers (45.8%) compared to commercial sex workers had used condoms in the last one month. This is higher than for other occupations. The frequency of condom use per month by occupation is given in Table 3 below.

Table 3. Frequency of condom use per month

Number of times a condom was used

Occupation	0	1	2	4	More than 4	Total
Housewife /Farmer	8 100%					8 100%
Truck drivers and assistants	13 54.16%	2 8.3%	2 8.5%	3 7.3%	4 21.95%	41 43.6%
Commercial sex workers	19 46.34%	4 9.75%	6 14.63%	3 7.3%	9 21.95%	41 43.6%
Teacher/clerk	10 83.3%	2 16.66%	0	0	0	12 12.8%
Petty business/other	4 44.44%	2 22.22%	0	1 11.1%	2 22.22%	9 9.6%
TOTAL	54 57.4%	10 10.6%	8 8.5%	7 7.4%	15 16.6%	94 100%

Women are more likely to use condoms than men as indicated by the findings that 65.38% of all men had not used a condom compared to 42.5% of all females interviewed. The most frequent users of condoms are women

(30.95%) compared to men (19.23%). This is probably the case considering most women in the sample comprise commercial sex workers. However, their condom use level remains too low to guarantee protection all the time.

Most respondents think their friends use condoms, but they themselves do not. As such, it is concluded that respondents view condoms as something meant for the other. Such denial is common in AIDS studies. About half of the respondents felt that their spouses disliked condoms, while 37.2% did not have an idea of what their spouse thought about condoms, an indication of low usage.

To the majority of the people (78.10%), condoms are not acceptable in a steady relationship because, they are perceived as being meant for prostitutes, they reduce sexual pleasure, and, finally, because the primary purpose of a steady relationship in the African culture is reproduction (Caldwell and Caldwell 1989). In some, levels of condom use are low, and attitudes towards condoms are mixed (50:50). What do people think about condoms?

Disadvantages of using condoms

Most respondents said they did not like condoms during sex because they reduce sexual pleasure. One cheerful truck driver asked me if I ate candy, and I told him I did. He offered me one. I took it, thanked him, unwrapped it and I started to eat it. he looked at me smiling, and asked me why I wanted him to eat his candy unwrapped. I told him that sex was not candy, then he continued, *"Je, kuna utamu gani kula peremende ikiwa ndani ya karatasi?"* (...what sweetness is there to eat candy while and when it is in its wrapping?). He told me that the logic behind "buying a woman" for a night is to enjoy sex with her, and the best sex is flesh to flesh.

A half of the sample (50%) who are uniformly distributed across occupation and gender said they had no idea of the disadvantages associated with condom use. However, most of the other people had many reasons why they did not use or prefer condoms. A major factor cited by both male and female was that condoms burst during sexual intercourse. Ocholla-Ayayo (1992), Bailey (1991), Mwendwa (1993), Ulin (1992), Nzyuko *et al.* (1991) have reported similar findings among other Kenyan communities. The major reason why condoms burst is because none of the respondents knew how to use them properly. None of them mentioned that the tip should be held when wearing to avoid trapping air inside which might lead to the condom bursting. A very big percentage (80%) opened the condoms using their teeth or a sharp object when I asked them to demonstrate how a condom should be used. This is likely to put holes in the latex when wearing it. Trussel (1992) also found high rates of condom slippage and rupturing to be associated with poor use.

Environmental reasons might also explain the rupturing of condoms. All condoms used in Kenya are manufactured in temperate countries. There is no documented study showing how condoms are affected by tropical light, heat, humidity and poor storage facilities. The rupturing of condoms during intercourse cannot fully be blamed on poor usage. Russel-Brown (1992) argues that the pass/fail laboratory tests commonly used to evaluate the quality of condoms inadequately reflect the likelihood of condom failure during actual use.

Most members (80%) of the female sample thought condoms were essentially useless because men had a tendency of piercing them, and making the female think that they were using them properly, especially, if the female had insisted that a condom be used. On asking the females why men would do that, some said that most men never liked using condoms because they reduced sexual pleasure. Also when malicious men have a disease they want to pass to the client, they are likely to pay more, not to use a condom, or

puncture the condom. Members of one group discussion reported that there had been a man in town who was paying Kshs.400 to have sex for a short duration. The normal charge was Kshs.20. He slept with very many women, and for a long time before the local health authorities alerted people that he had AIDS. Unfortunately, there are many men like him.

In another focus group, it was indicated that ejaculating to a woman reinforces the man's sense of masculine pride and proves manhood. Sperms are viewed as sacred, meaning they should not be wasted, and are seen as giving the woman essential vitamins. When a girl is growing breasts, she needs sperms to activate their growth. Sperms are also seen as essential in helping a baby develop.

Other respondents felt that condoms were small in size and, therefore, uncomfortable. On further investigation, a medical officer informed me that there were some condoms in the country before, which were manufactured in Asia, and were actually smaller in size than those manufactured in America.

Other reasons why people do not accept condoms have to do with the physical characteristics of the contraceptive. Some female respondents expressed the opinion that condoms smelt bad. On probing further, they said condoms smelt like poison, or something which should not come into contact with the human body. Other females said that condoms are clumsy and dirty, while others would not use condoms because they are lubricated with a chemical which they believe makes people sick or which they have heard is lubricated with HIV. A few respondents expressed disgust with the colours of condoms. Those coloured red make them feel like the woman was menstruating. Red colour symbolizes blood, or danger or devil among the Iteso and Nandi.

A genocide theory, that condoms are from America which is also the origin of AIDS and are meant to infect people with HIV, was cited as a reason why people did not accept them. One felt that because the whites had failed to reduce the numbers of blacks through family planning, they now wanted to kill them to achieve their mission. On further probing, it was said that the Americans got the virus from the moon or created it in some laboratories. Another one thought that the white men were simply out to create a market for condoms which they solely produced. Apparently, this respondent was not aware that condoms are also produced in Asia.

Six women respondents observed that they would get rashes and abdominal pains every time they used a condom, and get well when they stopped using it. Using expired condoms was one reason why they thought they got the rashes. The other reason may be the fact that some people are allergic to latex and the non-water base lubricants used in condoms. These allergy claims need further investigation.

For moral reasons, condoms are not liked because they are perceived as encouraging immorality. Condoms empower women to have extra-martial and pre-marital sex which is evil. The Church, with the support of the state, are the major proponents of this.

Prostitutes do not like condoms because when their male clients use them, they take a longer time making love. If a prostitute has 5 clients a day, she will be bruised by the end of it all, forcing her to go out of business for days. Because of economic need, she would rather not use them. The danger with this is that prostitutes having many partners in one day are the most dangerous, yet they do not want condoms because they will wear their vaginal walls out. Also, when someone has bruised genitalia, the more is the likelihood that they will contact HIV.

The fact that a condom can only be used once was another reason why people did not want to use them. With some men going on having sex after ejaculating,

slippage and leakages were high, yet stopping to change was disruptive of the sexual act, another reason why condoms are not preferred. Other people have a tendency of recycling condoms due to lack of knowledge and this discourages use.

Many women (69%) feared the condom would slip out during sex and remain in their uterus, therefore they did not like using them. These women perceived their bodies as a tunnel running from the mouth to the abdomen. When women prostitutes accepted money, it meant that they had given up their bodily rights to the men, and breach of this unwritten contract led to many occasions of battering. The fear of violence or rejection when women suggest that they use a condom in a society which approves of wife beating and where women's access to right is constrained, may be preventing many women from using condoms. In three instances, men applied pepper on condoms to discourage women prostitutes from using them.

Another reason why people do not use condoms is because Kenyans do not talk about sex and AIDS, especially if they are not of the same generation. None of the members of my sample who had children aged over 15 years (29%) had talked to them in their capacity as parents about AIDS and condoms. The Church, as earlier stated, discourages the use of condoms. However, no one failed to use a condom because of the teaching of the church among the members of my sample.

Most of the participants in the study are aware that AIDS is a deadly disease transmitted mainly through unprotected sex, and that having safe sex or abstaining from sex is a preventive measure. The more educated the members of the sample were, the better were the knowledge levels. It was expected that high knowledge levels would translate into high rates of condom usage. This is not the observed case. Condoms are very unacceptable. While most people have heard about them, only a few have used them. Knowledge about the sources of condoms is good. Inhibitions towards condom use are cultural, technological, economic, attitudinal and practical/processural.

Conclusions

Knowledge about AIDS and condoms is very high in the general population. People perceive AIDS as a dangerous disease and are afraid of it. Contrary to what the rational activity model (Catania *et al*.1990) predicts, high knowledge levels and the right perception have not translated into increased condom usage.

About 50% of the respondents accept condoms, although everyone interviewed strongly felt that condoms reduced sexual excitement, are not natural, they burst during use and can remain in the womb. Lack of correct and detailed information about condoms and a "don't care" attitude compared to the cultural beliefs associated with AIDS is the main factor accounting for the low acceptability rates. But this is by no means the only reason why condom usage is low. Religion preaches against condoms because they are perceived as dirty and immoral to the degree they enable value free sex to take place, and thus corrupting the morals of the faithful in a region, where over 90% of the people uphold religion, and therefore discouraging use.

There is cultural pressure to have many children in most African societies, while the fear of a witch getting someone's semen is as great as the fear of punishment from ancestors for not bearing children. This discourages condom use. Most people's attitudes towards condoms are negative, while others find them smelling badly, and having evil colours (red).

Making condoms acceptable in Kenya is one way of combating AIDS. However, AIDS prevention is a political, medical, economic, social, religious, technological and a communication problem. All these

issues are intricately connected to compound the problem of AIDS. For effective control of HIV/AIDS, the points of intersection between and amongst the variables need to be unveiled.

Recommendations

Condoms can be made more acceptable if:

1. People are given more information and education regarding condoms and their use, as well as information regarding HIV/AIDS and STD prevention.
2. The extent of latex allergies is established, and appropriate measures are adopted.
3. Public figures and role models participate in the promotion of condoms.
4. Efforts to demystify condoms are continued so as to make them more acceptable.

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