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Socio-economic factors contributing to the prevalence of sexually transmitted infections among women attending Mukono General Hospital in Mukono district. A cross-sectional study.

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Abstract

Background:

Globally, the burden of STIs remains a great public concern. The study aimed to assess the socio-economic factors contributing to the prevalence of sexually transmitted infections among women attending Mukono General Hospital in Mukono district.

Methodology:

A descriptive cross-sectional study design to collect quantitative data. All women with a diagnosis of STI and those being treated for STI who attended Mukono general hospital during the study period were interviewed and recruited to participate in the study, with a sample size of 75 respondents using a simple random sampling technique.

Results:

40 (53%) were from rural while the remaining 35 (47%) were from urban areas. 39(52%) had their lowest education level of primary, while 7(9%) of the respondents were highly educated. 39(52%) were of low household level while the least 12(16%) were of high household level. 48(64%) believed that early marriages are the cause of STIs, while at least 2(2%) believed it was circumcision ceremonies. 45(60%) exchanged sex for money while the minority 30(40%) did not exchange sex for money and 25(56%) out of 45 still doing it while 20(44%) nolonger exchanging sex for money.

Conclusion:

The study revealed that cultural practices such as early marriage and poverty were the major socio-economic factors contributing to the prevalence of STIs.

Recommendation:

The government should also revise the acceptable cultural practices in society by engaging the cultural leaders to see which rituals should be abolished in society that are putting people's lives at risk, like early marriage. The District Health Officer should conduct close monitoring and supervision of health facility staff to assess the quality of services.

Keywords: *Socio-economic factors, Prevalence of STIs, Clinical conditions, Mukono general hospital.*
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Background of the study

Globally, the burden of STIs remains a great public concern. It is estimated that more than 1 million curable STIs are acquired every day worldwide, and 376 million new cases occur each year. The burden of STIs is disproportionately higher in low and middle-income (LMIC) settings, where an estimated 75-85% new cases occur globally (Ssekamatte et al, 2021). In 2016, the global annual incidence of four of the eight most prevalent STIs (i.e., Chlamydia, Gonorrhoea, Trichomoniasis, and Syphilis) among people 15-49 years of age was estimated to be 376.4 million infections and these infections are curable unlike viral infections such as HIV, Hepatitis B, Herpes simplex virus (HPV) requiring longer term management (Akaninyene et al, 2021). The term sexually transmitted infection (STI) is used to denote a variety of clinical conditions that are caused by pathogens that can be acquired and transmitted by sexual activity (Megersa, 2017). The prevalence and risk factors associated with sexually transmitted infections among women of reproductive age in Swaziland revealed that prevalence of STIs is high among single women 26.4% and low among the married women 11.2 %, prevalence was also high among those aged 20-24 years (29.2%), 25.2% rate among the pregnant and prevalence of STIs was 18.3% among the non-pregnant mothers (Ginindza et al, 2017).

There is a trend for increasing STIs in the African population across the globe, including Sub-Saharan Africa (SSA). In SSA, the region accounting for more than 70% global burden of HIV infection, the emerging epidemic of STIs occurs in parallel as the life expectancy in the population, including those living with HIV (Killewo et al, 2023). The overall prevalence of STIs among clients in East Africa (EA) was 54.14%. The majority of STIs, including HIV, are transmitted through unprotected sexual contact. Having

more than one sexual partner contributes to STIs (Siyoum et al, 2022). In another study on relationship between socio economic status and risk of STIs in Uganda revealed that of the 9256 respondents were in the richest quintile of wealth index and 18% were in the poorest quintile, prevalence in woman was 80.4% at individual level being in the richest wealth quintile was associated with 14% lower risk of STIs, middle wealth quintile was associated with 22.3% with higher risk STI and 39.3% highest risk prevalence in the poorest quintile (Anguzu et al, 2019).

According to the study on socio-culture correlation and risky behaviour influencing prevalence of HIV/AIDS and STIs in Uganda Karamoja revealed the perceptions of karamajongs on sexual and reproductive health where 87% showed that there is still engagement sex by male just capturing adolescents and rape them, 50% of respondents showed that the community still take girls as a source of wealth and force them into early marriage (Achen et al, 2021). The study aimed to assess the socio-economic factors contributing to the prevalence of sexually transmitted infections among women attending Mukono General Hospital in Mukono district.

Methodology

Study design

The researcher used a descriptive cross-sectional study design to collect quantitative data from respondents. This study design was used because it was affordable, less costly, and suitable for a short timeframe.

Study area

Mukono district has a total area of 2,986.47 sq km, lies in the Central region of Uganda, sharing borders with the Buikwe District in the East, Kayunga along River Sezibwa District in the North, Luwero in the North West, Kampala and Wakiso in the South West, and Tanzania Lake Victoria in the South with the Islands of Buvuma district. Coordinates 00°28'50"N32°46'14"E.

The study was carried out at Mukono General Hospital, Mukono district. It has medical and non-medical staff such as Clinical officers, Midwives, Nurses, Doctors, with cleaners and security guards as non-medical staff.

It offers a variety of services, including inpatient, outpatient, maternity services, theatre services, reproductive health services, etc.

Study population

All women with a diagnosis of STI and those being treated for STI who attended Mukono general hospital during the study period were interviewed and recruited to participate in the study.

Sample size determination

The sample size of the client will be determined using Burton's formula, which was formulated as;

$$n = \frac{QR}{O}$$

Where n = sample size of the study

Q =Number of days data was collected.

R = Number of patients.

O = Time spent on each respondent.

$$n = \frac{30\ x\ 100}{40}$$

n = 75

Therefore, the researcher used 75 respondents in the study.

Sampling technique

The study was carried out using a simple random sampling technique because it gives equal chances to all members to be selected, reduces research bias, and is cheap.

Sampling procedure

The researcher obtained the list of clients willing to participate in the study. The researcher then got 20 pieces of paper and wrote words YES/NO, then put them into a box, shook them well, and asked the respondents to pick the papers. Only those who picked YES proceeded with the interviews of the study, and those who picked NO were excluded from the study. The researcher repeated the procedure until obtaining a total of 75 respondents.

Data collection technique

The data was collected using the questionnaire method, which is because it is cost-effective, saves time, safeguards confidentiality, and provides sufficient time to respondents to answer questions.

Data collection tool

A semi-structured self-administered and researcher-guided questionnaire containing closed-ended questions was used to collect data from the respondents because respondents felt more comfortable expressing their true opinions in the questionnaire, direct straight forward to the analysis, and was interpreted in the local language to the illiterate clients.

Data collection procedure

After getting permission from the school administration through the principal, the researcher went ahead and presented the letter to the person in charge of Mukono General Hospital, who introduced and gave him permission to access the respondents. Before data collection, each participant was given an explanation of the objectives of the study and was asked to sign a consent form.

The respondents were also being briefed on the importance and purpose of the study. The researcher will explain clearly that there were no incentives offered to respondents after data collection. Questionnaires were independently distributed to literate respondents and researcher-guided illiterate respondents, and each filled questionnaire will be thoroughly checked for accuracy and completeness by the researcher.

Study variables
These include the dependent and independent variables.

Dependent variables
The dependent variable is Sexually transmitted infections among women attending Mukono General Hospital.

Independent variable
These include Socio-economic, Demographic, and Behavioural factors contributing to the prevalence of STIs.

Quality control
Pretesting of the research tool
The relevance, reliability, and suitability of the research tool will be assured through pretesting of the questionnaire on respondents at Goma Health Centre III. Thereafter, the questionnaire will be edited to fill in all the missing information, and all ambiguous questions will be removed, training of the research assistant to avoid many errors, and humble time was given to collect the data.

Piloting the study
The researcher visited the facility before the study, sought permission from the responsible people, checked on the conditions in the area to see if they are relevant to the research study, obtained available research and information about the study from the clients within the health facility, and determined if the study area qualifies for the research before carrying out the research.

Inclusion criteria
The clients who attended Mukono General Hospital with STIs, consented and were mentally stable on research days, participated in the study.

Exclusion criteria
The clients who attended Mukono General Hospital with STIs were mentally stable and did not participate in the study.

Ample time for the collection of data from one client
The literate client took 15 minutes, and the illiterate client used 20 minutes in the collection of data.

Adherence to SOPs
Confidentiality and privacy of respondents were maintained while not affecting day-to-day health facility activity schedules.

Data analysis and presentation
The researcher tallied the information manually using a pen, paper, and tally sheets. The information was analyzed using Microsoft Excel and later presented in the form of frequency distribution tables, pie charts, and bar graphs with narratives following to make meaning of the results.

Data management
To ensure that there are no mistakes or uncovered areas, data editing was done accurately before leaving the field, and the mistakes found were corrected before leaving the study area. The data obtained was stored in notebooks and a flash disk as backup to avoid the risk of data loss during report writing. Questionnaires were kept in safety locker under a key and lock until data analysis, and for privacy and confidentiality.

Ethical consideration
After getting permission from the school administration through the Research committee, the researcher went ahead and presented the letter to the person in charge of Mukono General Hospital, who introduced and gave him permission to access the respondents. He then obtained consent from the respondents, assuring them of the utmost privacy and confidentiality of the information that he got from them.

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Results

Demographic factors contributing to the prevalence of STIs among respondents.

Table 1: Showing the distribution of respondents according to the demographic factors contributing to the prevalence of STIs. (n=75)

Variable	Response	Frequency(f)	Percentage (%)
What is your age?	18-24 years	29	39
	25-30 years	23	31
	31-35 years	16	21
	Above 35 years	7	9
	Total	**75**	**100**
What is your place of residence?	Rural	40	53
	Urban	**35**	47
	Total	**75**	**100**
What is your highest education level?	Primary	39	52
	Secondary	10	14
	Tertiary	7	9
	Not educated	19	25
	Total	**75**	**100**
What is your marital status?	Single	30	40
	Married	35	47
	Divorced	10	13
	Total	**75**	**100**

Table 1 shows that most of the respondents, 29 (39%), were aged between 18 and 24 years, while the least, 7 (9%), were aged above 35 years. It was revealed that most of the respondents were from rural areas (40, 53%), while a significant number, 35 (47%), were from urban areas. More than half of the respondents, 39(52%), had their lowest education level of primary, while less than half, 7(9%), of the respondents were highly educated. Most of the respondents 35(47%) were married, while the least, 10(13%) were divorced.

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Socio-economic factors contributing to the prevalence of STIs among women.

Figure 1: Showing the distribution of respondents' responses on the rating of household wealth. (n=75)

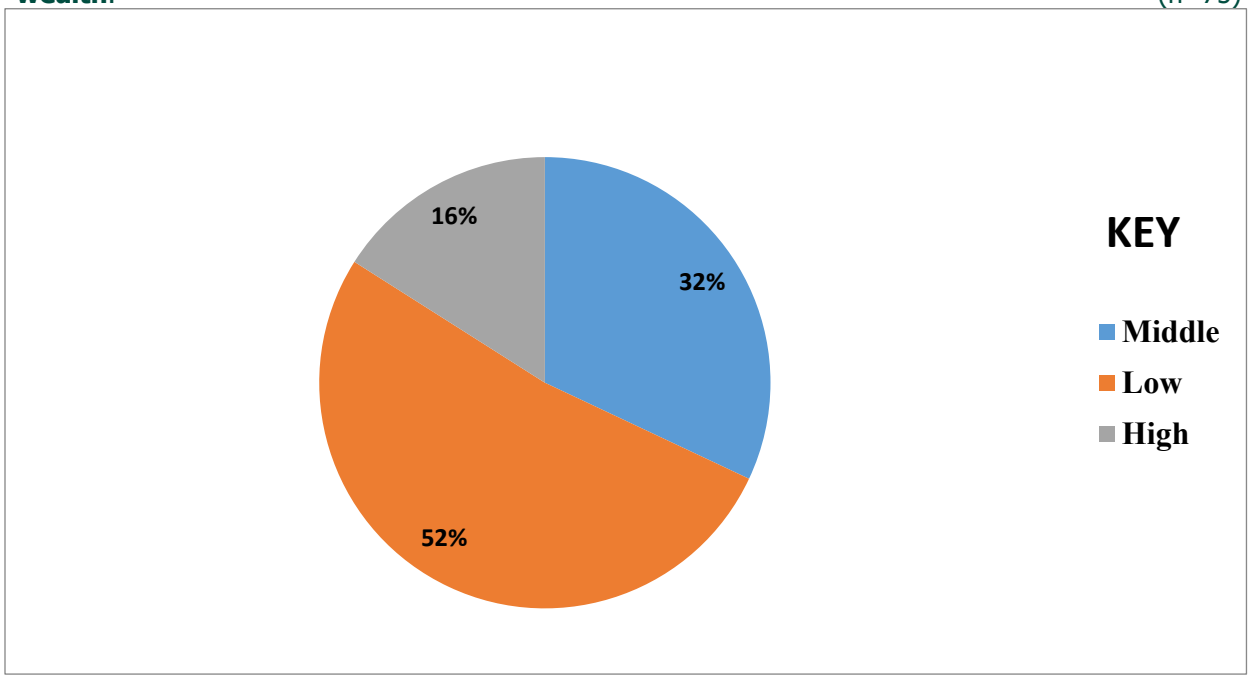
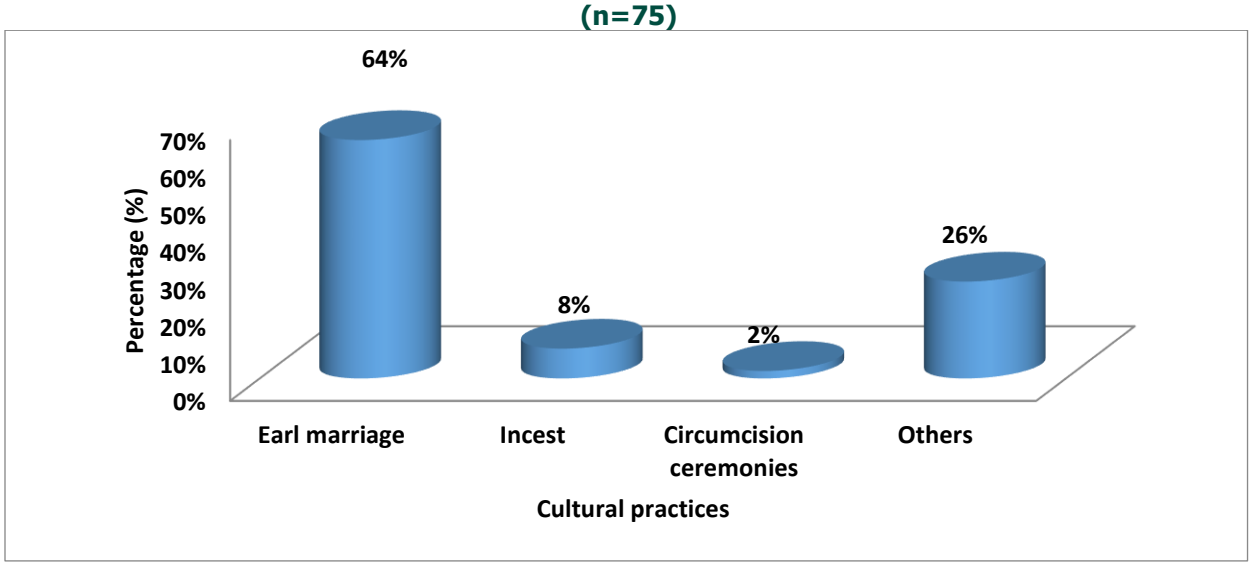


Figure 1 shows majority of the respondents, 39(52%), were of low household level, while the least were 12(16%) were of high household level.

Figure 2: Showing the distribution of the respondents' responses on cultural practices they believed could have contributed to the prevalence of STIs.
(n=75)



In figure 2, 48(64%) believed that early marriages are the cause of STIs, while the least 2(2%) believed it was circumcision ceremonies.

Table 2: Showing the distribution of the respondents on whether they exchange sex for money. *(n=75)*

Variable	Response	Frequency(f)	Percentage (%)
Have you ever had sex for money?	Yes	45	60
	No	30	40
	Total	**75**	**100**
If yes, are you still doing it?	Yes	25	56
	No	**20**	44

Table 2 indicates that the majority of the respondents, 45(60%), exchanged sex for money, while the minority, 30(40%), did not exchange sex for money, and 25(56%) out of 45 were still doing it, while 20(44%) no longer exchanged sex for money.

Discussion

Socio-economic factors contributing to the prevalence of STIs among women.

Based on the household wealth, the study revealed that more than half of the respondents 52% were of low household wealth. This indicates poverty among respondents. This is because most were from rural areas, which are dominated in house hold of low socioeconomic status. This is in line with the study on relationship between socio economic status and risk of STIs in Uganda that revealed that of the 9256 respondents were in the richest quintile of wealth index and 18% were in the poorest quintile, prevalence in woman was 80.4% at individual level being in the richest wealth quintile was associated with 14% lower risk of STIs, middle wealth quintile was associated with 22.3% with higher risk STI and 39.3% highest risk prevalence in the poorest quintile (Anguzu et al, 2019). Poverty led to the spread of the infections, whereby some respondents were unable to approach good health facilities for treatment due to the high cost charged.

Regarding the cultural practices that could have contributed to the prevalence of STIs, results show that most of the respondents 64% believed that early marriage caused STIs. This implies that girls involve into sex and childbearing, more so within polygamous marriages. This is probably due to a culture that believes that girls should get married when they develop mature features like breasts, and also due to poverty, to get money. This is in concur with the study on socio-culture correlation and risky behaviour influencing prevalence of HIV/AIDS and STIs in Uganda Karamoja that revealed the perceptions of karamajongs on sexual and reproductive health where 87% showed that there is still engagement sex by male just capturing adolescents and rape them, 50% of respondents showed that the community still take girls as a source of wealth and force them into early marriage (Achen et al, 2021). Early marriage of girls was noticed to cause STIs spread this was because of having little knowledge by the girls due to being young on how to control and prevent the infections.

Furthermore, regarding the places of residence, the study also showed that the majority of the respondents 53% were from the rural setting. This implies that there is little information about how to prevent and control STIs in rural areas. This could be because in the rural areas, people do not usually participate in health-related programs due to being far from a health facility. These findings are in agreement with those of a study on the impact of socio-economic and demographic factors on reproductive tract Infections among the reproductive age in South Asian showed a high prevalence of STIs of 60%, and the most affected women were from the rural population, that is, 80% (Vasudha et al, 2019). Being far from a health facility caused people in rural areas not to actively participate in health-related programs concerning diseases, and hence ended up spreading the infections unknowingly.

Conclusion

Regarding the socio-economic factors contributing to the prevalence of STIs, the study findings revealed that cultural practices such as early marriage and poverty were the major factors.

Recommendation

The government should also revise the acceptable cultural practices in society by engaging the cultural leaders to see which rituals should be abolished in society that are putting people's lives at risk, like early marriage.

The District Health Officer (DHO) should conduct close monitoring and supervision of health facility staff to assess the quality of services.

The DHO should also encourage persistent training camps in society to create awareness in the community. Most of the respondents stopped at the primary level, where there is no adequate information on STIs education and its prevention.

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Finally, I would like to acknowledge the effort of my research supervisor, **NAKAGIRI OLGA,** for her continuous encouragement and support throughout my research activity.

List of Abbreviations

HIV: Human Immunodeficiency Virus.
HPV: Human Papillomavirus.
SSA: Sub-Saharan Africa.
STIs: Sexually Transmitted Infections.

Source of funding

No source of funding reported.

Conflict of interest

There's no conflict of interest declared.

Data availability

Data was available upon request.

Informed consent

Written informed consent was obtained from all participants prior to their inclusion in the study. Participants were informed about the purpose of the study, procedures involved, potential risks and benefits, and their right to withdraw at any time without penalty.

Author Biography

Bagenda Jovan, a student offering a Diploma in Clinical Medicine and Community Health at Kampala Institute of Health Professionals.
Nakagiri Olga is a lecturer at Kampala Institute of Health Professionals.

Author contributions

Bagenda Jovan is the researcher, did data collection, and designed the report.
Nakagiri Olga assisted in timely supervision at all levels of the research project

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