ABSTRACT

Schistosomiasis is a chronic disease and a leading cause of morbidity and mortality in sub-Saharan Africa. Globally over 240 million people are infected while more than 700 million people living in endemic areas are at risk of infection. In Kenya, about 9 million people are infected with schistosomiasis. Endemic areas are found around the shores of Lake Victoria (Western Kenya), coastal strip and some pouches of Eastern Province. In Western Kenya, Kisumu West District (currently Seme Sub-County) has the highest prevalence (average of 19%) among school going population with moderate of 10-24%. Schools are recognized as conducive environments for schistosomiasis control through MDA hence school health teachers can be key implementers with minimal supervision from health professionals. Although WHO recommends the school-based delivery strategy which focuses on children, schistosomiasis affects all populations. Knowledge, sources of information and health-seeking behaviour for schistosomiasis among target adult populations, such as teachers can help scale-up control. However the knowledge, sources of information on MDA and health-seeking behaviour for schistosomiasis control by health teachers, who implement MDAs in schools remain unknown. This study was thus undertaken in Kisumu West District (currently Seme Sub-County) to explore knowledge, sources of information on MDA and health-seeking behaviour for schistosomiasis control by primary school health teachers. A total of 250 health teachers participated in the study. A descriptive cross-sectional study design was used in which both qualitative and quantitative approaches were employed. Saturated sampling was used for participants’ selection and data collected by use of exploratory survey and focus group discussions. Qualitative data was analysed by Atlas ti through thematic decomposition while quantitative analysis was done using Chi-square and logistic regression. Statistical significance was tested at $P \leq 0.05$. Results on knowledge demonstrated that 117 (56.80%) did not know correct signs and symptoms, and 169 (82.04%) did not know mode of transmission for schistosomiasis. Additional results revealed that 87 (42.23%) of the participants obtained information on bilharzia from the print/media, 61 (29.61%) got information from professionals during trainings or seminars and 58 (28.16%) from awareness meetings done by chiefs (also reported as others). Those obtaining information from the media had a 99.7% likelihood of seeking healthcare relative to those who obtained the information from professionals (OR, 3.2177, 95% CI, 1.4878-6.9592, $P=0.003$). Findings for associations revealed that participants knowledge of signs and symptoms and mode of transmission was insufficient for health-seeking behavior (OR, 0.6592, 95% CI, 0.2652-1.6235, $P=0.362$) and (OR, 0.4853, 95% CI, 0.1581-1.4898, $P=0.206$). Association of drinking water and health seeking behaviour showed that those whose drinking water was treated had a 90% likelihood of health-seeking behaviour for schistosomiasis control relative to those who did not (OR, 1.1027, 95% CI, 0.0184-0.0575, $P=0.010$). Likewise, those whose source of drinking water was safe had about 58% likelihood of seeking healthcare for schistosomiasis control (OR, 0.4259, 95% CI, 0.01829-0.9917, $P=0.048$) relative to those whose source of drinking water was unsafe. Findings from qualitative analyses supported these trends and the fact that schistosomiasis was not perceived as a threatening condition by the primary school teachers. Collectively results demonstrated that despite implementing MDA in schools the teachers’ knowledge for schistosomiasis control was low hence the need to be strengthened; print and media play a big role in information despite preferences for health professionals. Findings will help MDA providers and other schistosomiasis agencies to review training content and help provide basis for design and execution of health education on schistosomiasis if control and elimination is to be achieved.