

Healthcare Seeking and Sexual Behaviour of Clients Attending the Suntreso STI Clinic

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Abstract

Every year 340 million people are infected by four most important sexually transmitted infections excluding HIV namely syphilis, gonorrhoea, trichomoniasis and chlamydia. Sixty-nine million of these infections occur in sub-Saharan Africa. What people do when they have a symptom or a suspicion of STIs has major implications for transmissions and consequently for disease control. This study examined the reasons for patterns of health seeking and related sexual behaviours of patients who presented at the STI clinic in Suntreso, Kumasi. This was a cross sectional descriptive study. A study of clients with Sexually Transmitted Infections (STI) attending an STI clinic in Kumasi, Ghana found that of 185 patients, Sixty four percent (n=119) of them delayed for more than 4 weeks before seeking treatment at the clinic and another 61% (n=114) had sought treatment elsewhere and Eighty percent (n= 148) of the patients had sex while symptomatic.

Keywords: Disease, infected, health seeking.

1. INTRODUCTION

Sexually Transmitted Infections have become a major health problem globally, and their prevention has been a priority since HIV/AIDS emerged as a life-threatening disease (Wasserheit, 2001; World Bank, 2006).

Every year approximately 340 million people are infected by four most important STIs excluding HIV (WHO, 2006). These infections are syphilis, gonorrhoea, trichomoniasis and Chlamydia (Fonck et al., 2001). An estimated 69 million of these infections occur in sub-Saharan Africa. In the recent Demographic and Health Survey in Ghana, 3% of women and men who have ever had sex reported having had STI 12 months before the survey (GSS, 2009).

STIs and HIV/AIDS are spread through certain high-risk behaviours and both diseases share the same epidemiological risk factors. Because they are spread through similar behaviour, people exposed to other STIs are an easily identifiable group at high risk of HIV infection. The control of STIs is therefore an important step in slowing the spread of HIV infection. Successful interventions have shown that early detection and treatment of STIs decrease the incidence of HIV/AIDS. Grosskurth et al., in 2005 showed that improved STI treatment reduced HIV incidence by about 40% in a rural population (Mwanza) in Tanzania. The most convincing epidemiological evidence was a study that examined seroconversions rates among people with "comparable" sexual exposure and different incidence rates of STI. This study demonstrated that the risk of acquisition of HIV in the presence of ulcerative or non ulcerative STI is increased by a factor of two to six (Mensch et al., 2008).

One parameter determining the transmission dynamics of STI in a given population is the duration of time that an individual with STI is sexually active. Thus, inspite of the effectiveness of treatment regimens, the impact of an STI control programme also depends on when infected individuals seek treatment and the extent to which they have unprotected sexual activity during this period (McIlhaney, 2000).

Due to stigma surrounding sexuality, STIs remains a hidden epidemic (Wilkinson, 2002). The consequence has been sustained STI epidemics with increased spread of HIV, leading to huge personal and economic loss. The longer a person has an STI, the greater the chance of complications and the risk of infecting others. Factors that prolong the period of infectiousness are thus of great clinical and public health importance and early healthcare seeking is critical in the early detection and control of STIs (Ward et al., 2007).

Studies on health care-seeking behaviour concerning STIs showed that delay in seeking care is common among STI patients (Aral et al., 2009; Fonck et al., 2001). The prevalence of delay in seeking treatment for STIs in both industrialized and developing countries ranges from 23% to 73% (Pitts et al., 2000). The use of health facilities in developing countries is referred to as being complex compared to developed countries on account of the choices between different health care systems (Kroeger, 2003). In the developed countries patients tend to use health facilities more frequently thus about 85% will seek treatment for any illness as compared to developing countries where only 25% will seek treatment or even visit a health facility. A study in the Netherlands and China among clients with STI showed that 27% of the sample delayed seeking care by more than 4 weeks as compared to study in Kenya by Fonck et al., 2001 where 63% delayed in seeking care. Therefore it has been suggested that early health care-seeking behaviour be promoted as a part of STI health care (Aral et al., 2009). A better understanding of the factors influencing treatment seeking behaviour is critical for effective STI control.

Understanding these factors could assist in developing health education initiatives and public health programmes to control STIs and in turn, HIV.

This study aims to assess healthcare seeking behaviour and factors associated with care-seeking among patients attending a specialized STI clinic in Kumasi. The information will contribute towards the development of appropriate health education programmes to help reduce the spread of STIs and HIV/AIDS in high-risk populations.

The study however did not consider HIV patients unless they reported with other STIs.

Problem Statement

Suchman (2009) estimated that STIs constitute one of the ten main health problems responsible for loss of healthy life years.

A significant number of Ghanaians suffer from STI and many have multiple sexual partners but do not use condoms to protect themselves (Adu-Sarkodie et al., 2000). A study on the prevalence of STI among commercial sex workers in Accra and Kumasi showed prevalences of 75 percent and 80 percent respectively (Agyarko-Poku, 2001).

Furthermore what people do when they have a symptom or a suspicion of STIs has major implications for transmissions and consequently for disease control. Delays in seeking and obtaining diagnosis and treatment can allow for continued transmission and a greater probability of developing of adverse sequelae (WHO, 2006)

A review of patients' records at the Suntreso STI clinic from January to December 2000 showed that more than 50% had had symptoms for a week or more before reporting to a regular clinic and had spent another week before coming to the referral centre (Agyarko-Poku, 2001).

As most STIs are asymptomatic, infected people may continue to have sex thereby increasing the transmission cycle.

An understanding of the health seeking and sexual behaviour of STI patients is therefore important if STI control programmes are to be effective.

2. Literature Review

2.1 Health Care Seeking for STI

'Illness' means an unhealthy condition of body or mind. The term 'Patient' denotes an individual under medical treatment (Ward et al., 2007). Although an illness leads to a person seeking care, not all those with illness become patients. Symptoms are subjective evidence of illness, and according to Wilkinson et al., 2002 the way these symptoms are perceived, evaluated and acted (or not acted) on is defined as 'Illness behaviour'. Illness behaviour does not always lead to seeking health care. A person has to take action in order to get relief from a symptom or illness. Any attempt at finding a remedy for a perceived illness is defined as "health care-seeking behaviour" (Ward et al., 2007).

One of the interventions outlined in the WHO Global Strategy for STI is the "Promotion of early recourse to health services by people suffering from STIs and by their partners". This aims at promoting early healthcare seeking among clients.

Effective and accessible STI treatment and prevention programmes are key to reducing the global burden associated with STI.

The use of health facilities in developing countries is referred to as being complex compared to developed countries on account of the choices between different health care systems (Kroeger, 2003).

In many developing countries the patient's first encounter for STI is self medication and treatment in the informal health sector. Over-the-counter purchases of antibiotics at pharmacies (drug store or chemist shop) or from a drug vendor and quack doctors is almost universal despite laws that regulate the distribution (Darj, 2003). The treatment obtained from these sources is frequently inadequate or ineffective. Patients do not often receive the benefit of prevention education including condom use and their sexual partners are not treated or counselled.

In Ethiopia getting care from a government health clinic was often the last resort for therapy. Reasons cited by community members included the stigma of STI-only clinic, long waiting time, judgemental staff, consultation fee, social implication of being seen as an STI patient and lack of privacy (Laga et al., 1999).

Studies in Uganda and Kenya about healthcare seeking indicate that STIs are commonly held to be better treated by traditional healers (Darj, 2003; Fonck 2001). Such findings relate to the decisions about where to seek care.

A similar study carried out in Malawi showed that 53% of clients had sought treatment elsewhere with the frequent alternative source being the traditional healer (Mensch, 2008).

2.2 Potential Factors Influencing STI Health Care-Seeking Behaviour

There are three large categories of social and behavioural factors that influence clients to seek timely treatment for STIs (Aral et al., 2009). These are patient characteristics (behaviour) Provider characteristics (attitudes of health care providers) and the healthcare system (organization of the health care delivery system) (Aral et al., 2009). These factors influence the timely and appropriate care seeking of STI patients at various levels.

Knowledge of the factors that influence people's decision to seek treatment for STIs will provide a better understanding of where people go for treatment for an STI, and who goes where. For instance, where people choose to go for treatment could be influenced by provider characteristics like their previous experience with health care providers, as well as their perceived efficacy of the treatment provided by specific providers. Other factors that could influence where people go for treatment include patient characteristics, such as education, income, health insurance coverage, age, sex, race or ethnicity, religion and marital status. Characteristics of healthcare system could also influence patient choice, such as their geographic distribution, availability of support services, quality of care, convenience and privacy.

In a Kenyan study, 41% of 471 clients attending an STI clinic waited for 4 weeks, and 23% delayed for more than 2 weeks before seeking care stating reasons like attitude of staff, lack of privacy and clients' age as a major determinant of ability to seek care (Fonck et al 2001). Another study in Singapore showed that 73% waited for 4 weeks and 27% delayed for over 2 weeks before seeking care. Reasons for delay include: social stigmatization against sexual promiscuity, fear of public exposure, embarrassment, and lack of privacy (Leenars et al., 2003).

Delay in health care-seeking behaviour seems to be significantly associated with extreme age groups (Zachariah et al., 2002). Younger age groups often lack knowledge on STIs; this might cause them to underestimate the risks. In a study conducted among adolescents in the US and South Africa, ignorance of the seriousness of STIs was found to be associated to delay in seeking care. The subjects (54%) thought symptoms would subside and tended to wait longer than 10 days for a resolution. Also, fears of notifying parents served as a barrier to seeking care among 45% of the adolescents.

Among older study participants, those aged 45 years and above 68% tended to delay seeking care and the reasons for delaying were: waiting for resolution (34%) and embarrassment or fear of attending the STI clinic (24%). In another study in Uganda among STI clients, 74% of clients aged 50 years and over delayed more than 4 weeks before seeking care (Bearinger et al., 2007). The reasons cited were embarrassment (30%) and the social implication of been seen as STI clients (32%).

2.3 Sexual Behaviour

There is renewed interest in human sexual behaviour and the factors influencing it as a better understanding will help to lessen the formidable threat of the new and uniquely dangerous epidemic of STIs (Agnius et al., 2008).

Worldwide condom use is used by 5 per cent of couples and it accounts for 8 per cent of overall contraceptive use. The prevalence of condom use is higher in the more developed regions than in the less developed regions (13 % vs. 3 %). Condom prevalence is lowest in Africa (1 %) but in Ghana the prevalence of condom use increased from 0.3 per cent in 1999 to 2.7 in 2005 (UNAIDS, 2009). In Australia although consistent condom use remains moderately high, it is of some concern that condom use has not increased since 1997 despite related increases in sexual activity among the people who have experienced sexual intercourse and increased rates of STIs (Agnius et al., 2008).

A study carried out among clients attending an STI clinic in Malawi showed that 76% of clients had sex during the symptomatic period of STI (median 14 days) with the majority (74%) not using condoms (Zachariah et al., 2002).

Important skills are also required to engage in prevention behaviours which include the ability to effectively communicate with one's sex partner about safer sex, refusal to engage in unsafe sexual practices, proper use of barrier-method contraceptives, and the ability to exit a situation when prevention behaviours are not possible (Dubois, 2006, Hammerschlag, 2004).

A study conducted among college girls in the US found that the person who suggested the use of a condom was seen as somebody who was not romantic, yet more mature, than those persons who did not suggest the use of a condom. If the woman suggested a condom, the perception of her was that she was not as promiscuous as the women who did not suggest the use of a condom (Fortenberry et al., 2002).

In developing countries however the situation is different where women are often unable to negotiate for sex due to socio-cultural reasons and the fear of been seen as promiscuous.

Sexual behaviours also contribute to the STI burden in developing countries. These behaviours are heavily influenced by the socio-cultural, economic, and political contexts, which in the past two decades have deteriorated at an accelerated rate in many areas. Societal change has included rising levels of inequality within countries, growing inequality between countries, increased levels of globalization, increased proportions of people who live in cultures they were not born in and a larger proportion of the world's population living in post conflict societies (Aral et al., 2009). One effect of these changes is an increase in multipartner sexual activity, which in turn increases the rate at which infected and susceptible individuals are sexually exposed to each other and consequently the rate at which STIs spread.

2.4 Knowledge and Prevention of STI

The rising number of HIV infections and other STIs among patient population has called for behavioural interventions with the aim of empowering clients with increased knowledge as well as an increased perception of

risk of STIs.

Two of the most universally acknowledged issues are STI-related knowledge and stigma.

Possessing information about STI is essential to be able to recognize and correctly interpret one's signs and symptoms as manifestations of an STI for prompt care-seeking, a lack of knowledge does not always explain delays in care-seeking behaviour (Meyer-Weitz et al., 2000, Liu et al., 2003). For example, in a study of adolescents attending a public STI clinic in Chicago, greater levels of knowledge were associated with delayed care-seeking among females (Fortenberry, 2002). It is possible that fear of stigma or the emotional consequences of having an STI may supersede a person's concerns for their well-being when he/she suspects that they may be infected (Annang et al., 2007).

In addition to understanding what impedes or facilitates persons with or at-risk for STIs to access clinical care, it is also of public health importance to provide quality health education and counselling to those who do access care in order to prevent new infections (Fortenberry, 2002, Scoular, 2001, Amaro et al., 2001). However, research has shown that the opportunity for post-diagnosis STI-related prevention interventions is often missed. In a study in Brazil, post-test STI counselling does not appear to be universally offered or of consistently high quality based on research conducted. A study conducted by Giffin and Lowndes (1999) found that of 42 Brazilian women who were interviewed immediately after having received a positive result for Chlamydia in the context of routine gynaecological care, only two understood that the disease was sexually transmitted and only four knew the correct name of the disease. Approximately half of the gynaecologists interviewed in this study reported that they did not explicitly inform the patient that her condition was sexually transmitted. The primary reasons for not discussing the specifics of the STI diagnosis cited by providers were the desire to avoid causing potential relationship problems for the couple, particularly in the case that the patient was married, and feeling that dialogue regarding sex and sexuality were beyond the scope of their professional responsibilities (Giffin et al., 1999).

Another study carried out to better understand both the factors that influence STI care-seeking and the quality of health education and counselling received among heterosexual women, heterosexual men, and men who have sex with men (MSM) attending two large, public STI clinics in Nwanza, Uganda. The results indicated that upon presenting at a clinic not all individuals received adequate education and prevention counselling from health care personnel. Only a minority (23%) of participants reported having discussions regarding condom use or partner notification with their attending STI care provider calling into question the quality of health education efforts at these public clinics (Grosskurth et al., 2005).

3. DISCUSSION

An important determinant of transmission dynamics of STIs in a given population is the duration of time a person with an STI remains infectious and is sexually active. Hence apart from the effectiveness of the treatment regimen, the success of STI interventions to reduce transmission is also influenced by the time that infected individuals wait before initiating treatment and the extent of their unprotected sexual activity during that period. Understanding the factors influencing delay in health care-seeking behaviour among patients with STI is essential in the development of appropriate health education programmes for health workers involved in STI control.

This study examined a cross section of patients attending an STI clinic in Kumasi. These individuals constitute a high-risk group for transmitting STIs, including HIV and are a priority target group for interventions.

One limitation of this study is the fact that only those who experienced STI symptoms and sought care at the designated clinic were included in this study. Those who did not seek care may have different characteristics and this may limit the generalization of the study findings.

Also both sexual activity and condom use while symptomatic were self-reported. This may lead to recall bias and socially desirable answers. However, the study was conducted among new clients attending the clinic and it is possible that recall bias was minimal.

3.1 Healthcare Seeking Behaviour

From this study, 64.3% of the patients delayed for more than 4 weeks before seeking treatment for a possible STI (n=119), reasons cited for not reporting immediately symptoms started were embarrassment (38.7%), hope that symptoms will go away (16%), not knowing where to go (31.1%) and 5% thought symptoms were not important. The results of this study reassert previous studies' findings (Aral et al., 2009, Fonck et al., 2001) that delay between symptom recognition and health care seeking is a feature of STI-related illness behaviour. These were studies in Kenya and Uganda among STI clients, in which 63% and 56% respectively delayed for more than 4 weeks before seeking care. Reasons cited were lack of knowledge about the importance of seeking prompt medical care (36%), lack of information about available services (34%) and finally lack of financial resources (21%)

The results of this study point to salient determinants of the delay in health care-seeking behaviour of patients

with STIs that need to be addressed in health education programmes with a view to facilitate early diagnosis and treatment.

Delay in health care-seeking behaviour was significantly associated with whether client had heard of STI and specific STI symptoms. A significantly higher proportion of patients who had not heard of STI sought treatment late compared to those who had heard of STI

($p < 0.001$). Clients seeking care who had genital discharge sought care late as compared to clients who had sores over genitalia or dysuria ($p < 0.001$).

A study in Uganda among STI clients showed that the severity and nature of the symptoms may influence a person's decision to delay in health care-seeking behaviour. Having sores around the genital area was significantly associated with seeking care earlier and vaginal discharge was associated with a delay in seeking care ($p \text{ value} < 0.001$) (Nuwaha, 2009).

This reflects the influence of severity of the symptoms over health care-seeking behaviour. Thus patients' perception of genital ulcers as being more serious compelled them to seek care earlier as compared to vaginal discharge which was possibly not deemed serious. Similar observations were made in a study among female STI clients in the US in which persons with genital warts sought care early compared to those with genital discharge (Hook et al., 2007). Thus if the symptom does not intervene with a person's activity then these people may postpone seeking care.

Among the clients attending the clinic, 61.6% had sought care elsewhere citing the social implication (immoral behaviour) of being an STI client 32.5%, long waiting hours (21.9%), lack of privacy (21.1%) and stigma of STI only clinics (16.7%) as some of the reasons for seeking care elsewhere. A study in Ethiopia among 315 STI clients also showed that getting care from a government health clinic was often the last resort for therapy. Some of the reasons documented for the delay were the stigma of STI- only clinic (20%), long waiting time (15%), judgemental staff (10%), consultation fee (10%), social implication of being seen as an STI patient (25%) and lack of privacy (20%) (Laga et al., 1999). A similar study in Kenya among 471 clients with STI found that choice of an STI clinic was often the last option due to reasons like convenience of the location (25%), privacy (18%), affordability (18%) of the services and social implication of being seen as an STI patient (25%) (Fonck et al., 2001). Similar observations were made by Nuwaha (2009) in Uganda where 45% of patients reported late because they believed the symptoms were not serious.

In many developing countries the patient's first encounter for STI is self medication and treatment in the informal health sector. Over-the-counter purchases of antibiotics from pharmacy shops or from drug vendors and quack doctors is almost universal despite laws that regulate the distribution (Darj, 2003).

Self-medication (35.1% in this study) has been shown as a factor influencing delay behaviour from previous research. In this study 28 out of the 40 respondents who self medicated reported to the STI clinic late. Although this has reaffirmed what other studies have found in Kenya and Uganda (Darj, 2003; Fonck, 2001), quite a different situation was reported in Singapore where a similar study found a much lower proportion (9%-11.1%). This was attributed to the strict rules on the availability of antibiotics over the counter (Gordon et al., 2003; Irwin et al., 2007). Considering increasing cases of drug resistance to common STIs around the world, health education on the consequences of self-treatment has to be emphasized in health education programmes.

Age significantly influenced health care-seeking behaviour ($p < 0.05$). Those aged 26–35 years tended to delay seeking care compared with other age groups. There was no significant association between delay in health care-seeking behaviour and educational level or marital status. No association was also found between delay in healthcare seeking and occupation of respondents as well as gender. A study in Kenya also found that age was the only determinant of healthcare seeking with the other socio demographic characteristics playing no role in determining how long they waited. Clients aged 26-30 years delayed before seeking care as compared to the other age groups (Fonck et al., 2001).

A study conducted among adolescents attending an STI clinic found that clients aged 18-23 in the US reported that ignorance of the seriousness of STIs was associated with delay in seeking care (MacDonald et al., 2003).

There was no significant association between delay in health care-seeking behaviour and educational level or marital status. No association was also found between delay in healthcare seeking and occupation of respondents. Gender had no significant influence on health care-seeking behaviour ($p\text{-value} = 0.09$). There were however more women (70%) than men in the study. A similar study in Kenya among clients with STI found that although women delay in seeking care than men, they tend to report more often than men citing reason like women being more susceptible to STI and increased risk of complications in women.

In another study in Uganda, men more often than women report a different healthcare-seeking attitude when confronted with an STI. The men in this study reported attending the public health sector significantly more often for a STI than for other health problems. This implies that more of the men will have sought care elsewhere before reporting to the clinic thus if the symptoms persist afterwards. STI case management must be offered as widely and effectively as possible to have a significant impact on the STI epidemic.

3.2 Sexual Behaviour Eighty percent of the patients continued to have sex while they were experiencing symptoms suggestive of STIs. It has been suggested that reluctance of the patient to admit having an STI symptom (denial) or thinking that the symptoms were not a priority, may be the reason for continuing sexual activity with symptoms (Nuwaha, 2009). It is also suggested that the severity and nature of the symptoms may influence the delay in health care-seeking behaviour (Dubois, 2006, Wilkinson, 2002). This study found that severity of symptoms had significant influence over health care-seeking behaviour. Those who had severe and unpleasant symptoms like genital sores had sought care early compared to those with symptoms such as vagina discharge.

Sexual behaviours also contribute to the STI burden in many countries. These behaviours are heavily influenced by the socio-cultural, economic, and political contexts, which in the past two decades have deteriorated at an accelerated rate in many areas (Aral et al., 2009).

In this study twenty one percent of the respondents reported having had two or more sexual partners this asserts to the issues raised by Aral in 2009 that changes in socio-cultural, economic and political context leads to an increase in multi-partner sexual activity, which in turn increases the rate at which infected and susceptible individuals are sexually exposed to each other and consequently the rate at which STIs spread.

About 80% of the respondents continued having sex while having STI symptoms. Among those who had sex while having symptoms of STI, a majority (89%) did not use condoms and this is in agreement with the national estimates of decreasing trends of condom use. It is estimated that just about 2.7 of the population use condom as a form of protection against STI/HIV. A study carried out among clients attending an STI clinic in Malawi showed that 76% of clients had sex during the symptomatic period of STI with the majority (74%) not using condoms (Zachariah et al., 2002). In Ghana, a similar study also found that a significant number of Ghanaians suffer from STI (47%) and many have multiple sexual partners (54%) but do not use condoms (58%) to protect themselves (Adu-Sarkodie et al., 2000).

STIs and HIV/AIDS are spread through certain high-risk behaviours and low condom use is one of such behaviour. Because they are spread through similar behaviour, people exposed to STIs are an easily identifiable group at high risk of HIV infection. Thus the number of people exposed to STI in this study could all have contracted HIV through this risky behaviour. Grosskurth et al., in 2005 showed that improved STI treatment reduced HIV incidence by about 40% in a rural population (Mwanza) in Tanzania. Promoting condom use is therefore essential in reducing the spread of this silent epidemic alongside HIV.

The sexual partners of the clients seeking care at the clinic were mostly their girlfriends or boyfriends (57.5%). Three percent of the clients had sex for cash and 39.8% with their spouse. There was no significant association between perceived source of an STI with delay in health care-seeking behaviour. The presumed sources of infections for these clients were: spouse (10.8%), casual partners (24.9%) and girlfriends/boyfriends (13.5%). About half (50.8%) of the patients did not know the source of the suspected STI. This is an issue worth looking into because if these respondents cannot tell the source of infection then partner treatment becomes difficult and this only means that they can easily go back to get infected increasing risk of complications and treatment failure.

Partner notification is important for interrupting the transmission of STIs and preventing possible eventual reinfection, but in practice there are obstacles. Patients may not inform their sex partners out of fear, embarrassment, or unawareness of the importance of doing so. In resource-poor settings, it is usually impractical for notification to be done by the health sector (WHO, 2006). Clients' level of education did not affect their decision about having sex while symptomatic (p value >0.05). Also clients' level of education did not influence their decision to either use condom or not use one. This goes on to show that important skills are required to engage in prevention behaviours which includes the ability to effectively communicate with one's sex partner about safer sex, refusal to engage in unsafe sexual practices and proper use of condoms and these skills have nothing to do with one's level of education (Dubois, 2006, Hammerschlag 2004).

3.3 Knowledge on STI

Ignorance or misinformations are powerful obstacles to resolving problems, and this is particularly true where STIs and HIV/AIDS issues are concerned. Ignorance of STIs and AIDS can exist in all types of people and all age groups. However it is more widespread among adolescents and young people, the very people who are likely to be more sexually active than others, unlikely to be in stable sexual relationships, and who have poor access to STD care services (Dubois, 2006). In this study (79.9%) of the participants were below 35 years of age. The level of knowledge of clients on STI was good as 77.8 percent of the patients had ever heard of STI. Among the respondents, 20.5% reported that they had heard about HIV or AIDS. The majority (77.8%) had heard about STIs and knew the common STI names such as: gonorrhoea, syphilis, herpes and chlamydia. Gonorrhoea (35.1%) and syphilis (17.8%) were the most common names reported by the respondents, with 20.5% unable to mention any STI which was a bit disappointing especially since clients were interviewed when they were exiting the STI clinic. Respondents were asked about ways in which STI can be transmitted and effective methods of

protecting themselves from STIs. A few misconceptions were cited as the cause of STIs: sharing toilets (4.9%), by sharing under pants 8.6%. The majority however correctly reported by having unprotected sex (64.9%). Level of education was significantly associated with knowledge of the methods of prevention of STIs ($p < 0.001$) as well as ability to name any STI ($p = 0.01$). On the other hand, level of education was not significantly associated with respondents' knowledge on how STIs can be contracted (p value > 0.13). This reiterates the fact that level of education does not necessarily mean people are informed about issues and so it is necessary to educate such people about STI and the importance of seeking early treatment. A study conducted by Giffin and Lowndes (1999) found that of 42 Brazilian women who were interviewed immediately after having received a positive result for Chlamydia in the context of routine gynaecological care, only two understood that the disease was sexually transmitted and only four knew the correct name of the disease.

4. Conclusion

A significant proportion of STI patients (64.3%) delayed in seeking care at the STI Clinic for over 4 weeks. This was due to reasons such as embarrassment (31%), symptoms will go away 38% and 16% did not know where to go. Eighty percent were sexually active whiles symptomatic and 89% of them did not use any condoms during this period. Fourteen percent also had more than one sexual partner. STI knowledge was good as 77.8% had ever heard of STI. Among the respondents, 20.5% reported that they had heard about HIV or AIDS. The majority who had heard about STIs knew the names of common STIs such as gonorrhoea, syphilis, herpes and chlamydia. A few misconceptions were cited as the cause of STIs. Some of these were sharing toilets and under pants. The majority however correctly reported by having unprotected sex. Twenty four percent had no knowledge about prevention of STIs. The importance of seeking care early for STI and abstaining from sex during and before treatment, consistent condom use and improving symptom recognition have to be incorporated in the existing prevention intervention programmes. Those who seek care for STI should be considered as a primary target for renewed prevention efforts. Since they are already in the STI clinic, personalized counselling emphasizing the importance of safe sex and early health care-seeking behaviour should be given.

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