HEALTH SEEKING BEHAVIOUR IN RELATION TO SEXUALLY TRANSMITTED INFECTIONS AMONG YOUTH AGED 15-24 YEARS IN BARIADI DISTRICT – SHINYANGA

BY

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A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF PUBLIC HEALTH OF THE UNIVERSITY OF DAR ES SALAAM.

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CERTIFICATION

The undersigned certifies that he has read and hereby recommends for acceptance by the University of Dar es Salaam a dissertation titled: ***"Health –seeking behaviour in relation to sexually transmitted infections among youth aged 15-24 years in Bariadi district,Shinyanga Region,"*** in partial fulfillment of the requirements for the degree of Master of Public Health.

Supervisor signature: .....

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Date: 20th September 2002.....



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I, Timothy Kibaje Chunga, declare that this dissertation is my original work and that it has not been presented and will not be presented to any other University for similar or any other degree award.

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DEDICATION

This work is dedicated to my father and my mother, my beloved wife, my loving children, Jacqueline, Julieth, Sengiyumva & Masabo.

ABSTRACT

A cross-sectional survey was undertaken in Bariadi District during May-June 2002 to explore health seeking behaviour in relation to STI among the youth. A total of 456 youths were interviewed.

The results of this study indicate that 67.4% of the youth mentioned microorganisms as a cause of STI while 97% of the youth mentioned sexual intercourse to be the route of transmission, but when asked who were the type of people who get STI they said anybody (87.4%) and promiscuous 21.2%. On the meaning attached to STIs, the majority reported that they would be worried if their friends or they themselves contracted an STI.

Regarding STIs prevention, 55.8% of all the respondents identified the condom as a preventive measure of STIs. Abstinence was mentioned by 51.3% of the respondents, but only 18.3 percent mentioned faithfulness. Among those who had had an STI, 18.4% sought treatment from the traditional healer while 81.6 percent sought treatment from the formal health sector. Among those who had had no STI but knew people with STI said 43.5% had sought treatment from the traditional healer while 56.4% had sought treatment from the formal health sector. These findings indicate a need to develop educational media on STI and a further research on factors affecting utilization of health services in relation to STI.

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LIST OF ABBREVIATIONS AND ACRONYMS

DANIDA	Danish International Development Agency
DHMT	District Health Management Team
DMO	District Medical Officer
GUD	Genital Ulcer Disease
HIV	Human Immunodeficiency Virus
MUCHS	Muhimbili University College of Health Sciences
NACP	National Aids Control Programme
PID	Pelvic Inflammatory Disease
STI	Sexual Transmitted Infections
WHO	World Health Organization

CHAPTER 1

INTRODUCTION

This chapter explains the background to the problem. It also states the broad as well as specific objective and rationale of the study.

BACKGROUND

STIs are highly prevalent; they cause considerable morbidity, increase the risk of HIV infection and are costly to the individual and the society in general (NACP, 2001). The extent of STIs amongst youth is generally unknown but given the large number of them who indulge in unprotected sexual intercourse, STIs appear to be among the major problems they may have to cope with.

One study involving 1,253 STI patients drawn from various areas of Tanzania revealed that nearly 75% of them were less than 30 years old (Msamanga, 1986) as quoted by Leshabari (1994). The most seriously affected age group among males was those aged 20 – 24 years. Data from STI clinics in Dar es Salaam show the youth to be highly vulnerable to chronic STI (Mhalu, et. al., 1992, Mwakagile et. al. 1992)

Although there are no reliable data for STI incidence in the country if extrapolation from a small study area in Mwanza is made, it can be estimated that between 1 and 1.5 million

symptomatic STI cases occur each year (NACP, 1998). Most of the STI cases occur in the youth group. Persistent infections in the youth may lead to these diseases or syndromes: -

- PID in women,
- Ectopic pregnancy in women
- Infertility in women and men
- Urethra stricture in men

These infections may also cause abortion, premature rupture of membranes, congenital syphilis, congenital anomalies and mortality. The inability to get the proper care at the right time may make the above conditions worse.

The utilization of the health services does not reflect the true magnitude of the STI problem. For example a total of only 39,385 episodes of new STI syndromes were reported in 1999 and 149,222 episodes in 2000. Of all the diagnosed individuals 22,158 (14.8%) reported back for follow up and 31,087 contacts were traced. The age group 20 – 29 years had the highest prevalence of STI including syphilis when compared with other age categories. The reasons as to why there is low utilization of the health services by those affected by STI are not known, especially in the rural areas as few if any studies have been published on health-seeking behavior in relation to STI among the youth at the community level in Tanzania.

Research question:

Why is there poor health seeking behavior in relation to STI among the youth?

PROBLEM STATEMENT

Sexually transmitted infections and their sequlae have contributed significantly to morbidity and mortality. The problem is to a large extent determined by health seeking behaviour. No community-based studies have been published in Tanzania to determine the health seeking behaviour in relation to STI among the youth. This study looked into the symptoms recognition, the meaning attached to them, the lay referral system, sources of known health care and the sources of the health care accessed by the youth.

RATIONALE:

It was important to do this study so as to understand the pattern of the health seeking behaviour of the youth. These results may help the DHMT and other interested partners in health services delivery to develop appropriate and effective approaches for educating the youth on STI, as well as designing appropriate educational material and health educational methods of STI control.

OBJECTIVES

Broad objective

To explore health-seeking behavior in relation to sexually transmitted infections among youth aged 15 – 24 years.

Specific objectives

1. To determine how knowledge of STI varies with the social demographic characteristics
2. To determine the youth's perceptions on the meaning of STI symptoms.
3. To determine the lay referral system among the youth
4. To determine the youth known sources of health care
5. To determine the source of health care accessed by the youth

CHAPTER 2

LITERATURE REVIEW

This chapter gives the explanation of what is known and what is not known about the health seeking behaviour of the youth in relation to sexually transmitted infections. It also tries to explain the gaps that have to be filled by this study.

Many studies have been done on the control of sexually transmitted infections with a focus on proper diagnosis and adequate treatment of cases attending general or specialized medical services and in recent years much attention has been given to the development of treatment algorithms for patients attending general health facilities in third world countries (Dean. 1994). However, very few studies have been conducted on factors that influence health-seeking behaviour and especially among the youth.

What deserves particular consideration and attention is the fact that many people with symptoms of these infections do not seek proper medical care. One research (Temu et al) 1998(a) found that the private pharmacies and drug stores in Dar es Salaam were the popular sources of care for these infections. The study did not report whether adolescent also patronize these pharmacies to the same extent as adults (Muhondwa,. 2000).

However WHO and the AIDS Control Programme of Tanzania acknowledge the important role which private pharmacies play in the treatment and care for STI and have produced guidelines for the syndromic management of these infections. What is most worrying however is the tendency of the pharmacies to give the people what they want even if that is not good for them as long as they can pay. There is therefore a great deal of under dosage because people may not be able to afford to pay for the full dose or they may not bother to continue with medication once the symptoms subside (Temu et. al. 1998(b)). This raises the question, do they know the consequences of not complying with the treatment schedule.

Furthermore Outwater et al 2001 did a study in Morogoro Township Tanzania. The purpose of the study was to explore the health seeking behaviour among commercial sex workers. The study revealed that once they acquired a symptomatic STI they pursued different avenues of treatment including self-treatment with known herbs, traditional healers (herbalists), injectionists, pharmacies, governmental hospital's and private clinics. On prevention of STI, they ate nutritious food to enhance immunologic status, using condoms and vaginal washing after each contact of intercourse (Outwater, et. al., 2001), which clearly shows that there was a misconception on treatment and prevention of STI. Another community-based study of treatment seeking among patients with symptoms of STI was done in rural Uganda. The results were from 9,662 people seen during the survey, of which 30.4% of women and 9.7 percent of men experienced genital tract symptoms. Women commonly reported vaginal itching 15.4%, pelvic pain 14.7%,

watery vaginal discharge 9.4% and genital ulcers 5.5%. Men reported genital ulcer 4.3%, dysuria 4.2% and urethral discharge 1.7%. Over 40% reported they had done nothing to treat symptoms or prevents transmission. Overall only 59.1% of symptomatic men and 55.4% of women sought treatment (Paxton et. al. 1998).

Again in Uganda a study was done to determine the rate and risk factors for GUD and to describe sexual and treatment seeking behaviour. A longitudinal study in a population based clinical cohort over 9 years was done. The rate of GUD in this population was 16/100 person years and 30% of the participants reported an episode during the follow up period. Half of the participants with a regular sexual partner reported engaging in sex while symptomatic and only 16% informed their partner. Treatment was sought for only 12% of the GUD episodes despite open access to doctors at a free clinic. A self-diagnosis of genital herpes did not affect treatment seeking or sexual behaviour (Morgan 2001). Lack of knowledge on the implications of these findings for STI control is a cause for concern. However, this study did not assess their knowledge on the implications of the STI and their factors.

A cohort study conducted in Uganda's Masaka district indicated that vaginal discharge tends to be perceived as a normal condition and drug treatment is sought only as a last resort. When first confronted with vaginal discharge, women relied on herbs (oral and intravaginal). If this regimen was ineffective, they turned to traditional healers for herbal medicine or clay or purchased drugs from a shop. Only if this also failed was a

woman likely to seek treatment from the formal sector. In 1990 56% of women with a vaginal or urethral discharge took no action, 19% sought help through the informal sector and 25% utilized formal sector services, in cases of genital ulcerative disease, these rates were 29%, 30% and 42% respectively.

The vaginal discharge was most likely to be perceived as serious if accompanied by pus, pain and a visible ulcer. The findings highlighted the need for culture – specific information on perceptions of STI and the determinants of treatment – seeking behaviour (Mulder. 1994). In Tanzania, no such study has been published so far. There is a need to conduct such study. Sexually transmitted infections remain major causes of reproductive health and socio-economic problems worldwide particularly among adolescents who do not take adequate preventive and appropriate curative measures. Part of the problem is that very little is known about their health – seeking behaviour especially where they lack access to adequate medical facilities.

A comparative study of 200 male and female adolescents aged 15 – 24 years was conducted in Oyo State, Nigeria. The findings revealed that about two third of young people do not immediately seek qualified medical attention once they become aware that they are infected. Similarly, while only 15% of males and 19% of females who were confirmed infected notify their partners about the infection, less than 10% of males and 12 of females were willing to procure treatment for their partners. In spite of these

attempts, a smaller proportion of the partners only 1 out of every 5 male partners and 2 out of 5 female partners, were willing to turn up for treatment (Adedimeji 1999.).

Meyer-Weitz 2000 conducted a study on the determinants of health care seeking behaviour of adolescents attending STI clinics in South Africa. The study investigated the determinants of delay behaviour in health care seeking in a sample of 292 adolescents patients (20 years and younger) with sexually transmitted infections symptoms. He noted that 56% of the adolescents sought health care within the first 6 days of noticing symptoms, 23% waited between 7 – 10 days and 21% waited longer than 10 days before seeking health care. Early health care seeking was determined by perceived seriousness of STI, an absence of self-treatment prior to seeking care and positive attitude regarding personal autonomy in condom use behavior. The author's concluded that facilitation of early health care seeking remain critical in curbing the threat of AIDS among the South African youth.

A survey in Kenya was done to identify health seeking and related behaviours relevant to controlling STI. It was found out that Western medical practitioners were consulted for STI only when herbalists and traditional healers failed to provide relief. On the average women sought treatment three months after the onset of the problem (Mulder, 1994).

The study does not give reasons why the Western medical practitioners were consulted when the herbalists or traditional healer failed to provide relief. Faxelid. (1998) Conducted a study on STI in Zambia. He noted that a number of factors influence which treatment sources people seek when symptoms of morbidity occur and a person alone or with the advice of others, decides that the condition warrants additional attention. Some such factors are related to social structures such as kinship, social network, gender and economic status while others are related to belief systems, which define how people conceptualize the etiology of disease. He interviewed 479 patients seeking health care for STI symptoms. The patients had experienced STI symptoms for 1 – 2 weeks before coming to the clinic. During that period two third in the urban and one-third in the rural areas had had sexual intercourse. 60% of the patients in the urban and 50% in the rural settings had taken some kind of medicine before coming to the clinic.

However, more people had used modern rather than traditional medicine, especially in the urban area. Market places, other clinics, physicians, friends and relatives were common treatment sources, although 10% had received medicine from a traditional healer. Attitudes towards STI infections are complex. Some young men take pride in having acquired sexually transmitted disease. Getting infected is a mark of having grown up and of virility. The diseases are therefore not accorded the significance they deserve.

Good care for these infections require that an individual identifies and notifies sources of his or her infection so that they too may be treated. It may be difficult for young men who consort with other men's wives to bring them into care. Furthermore it has been reported that some men continue with sexual activities even when they have genital sores thereby exposing themselves and their partners to new infections (Muhondwa. 2000).

Health-seeking behaviour is often complex particularly in circumstances of medical pluralism in which both traditional and modern health care systems co-exist [Young 1981]. The decision to seek care from a particular source, within the range of therapeutic options is determined by at least two broad factors: culturally determined knowledge about illness and treatment and access to treatment alternatives (Young 1981). The purpose of this study was to explore among the youth symptom recognition especially the significance attached to STIs symptoms, the lay referral system, youths known sources of health care and their access to health care.

CHAPTER 3

METHODOLOGY

Study setting

The study was conducted in Bariadi district. It is one of the seven districts of Shinyanga Region. Other districts are Maswa, Meatu, Shinyanga urban and rural, Kahama and Bukombe.It was selected for convenience. The principal researcher was more familiar with socio-cultural setting and it was expected this familiarity would easy the process of collecting data. Bariadi distrct is bounded on the west by Magu and Kwimba, districts Bunda on the north, Ngorongoro on the east Maswa and Meatu on the south It covers an area of 9445.7 sq.km Administratively it is divided into 4 divisions, namely Dutwa, Ntuzu, Kanadi and Itilima, It has 26 wards and 124 villages. According to 1988 population census projection there are 500000 people. The annual population growth rate for the district is 2.5 (Bureau of statistics, 1988). The health facilities in the district include one district hospital, 5 health centres and 41 dispensaries. There are 170 Primary schools and 7 Secondary schools. There are 5 Government and 2 private secondary schools). The indigenous tribe is Wasukuma. The major occupations are agriculture and livestock keeping. Cotton is the major cash crop. There are two ginneries at Kasoli and Luguru villages where cotton is ginned before being exported.

Study design

Cross-sectional descriptive study was used.

Study population

Youth aged fifteen to twenty four years old in Bariadi district.

Sampling procedure

A stratified random sampling procedure was done. The stratification was done according to the type of community of residence, i.e. urban, trade centres and villages along the main road and rural villages. Because of the absence of known proportion of the population distribution in the community the researcher decided to take an equal proportion of 152 youths for each strata.

Urban Area

In the urban community a multistage sampling procedure was used. First, a list of all streets was obtained from the Ward Executive Officer. Using table of random numbers 5 streets were selected. Then a list of households in the selected streets was compiled. It was assumed that in each household there were about 2 youths. Therefore a total of 75 households were selected, also using a table of random numbers. All the youths in the selected households regardless of their marital status were interviewed.

Trade centres

As regards the trade centres and villages along the main road, these were also listed. Using the table of random numbers two villages were selected. The help of the leaders from the villages was sought in order to make a list of households in the selected villages. Using a table of random numbers a sample of 75 households was selected assuming that each household had about 2 youths. All married and single youths in the selected households were interviewed.

Rural villages

The last stratum was of rural villages. Using a table of random numbers one out of the four divisions in the district was selected. From the selected division a list of rural wards was made. Using a table of random numbers one rural ward was selected. From the selected ward a list of villages was made. Using a table of random numbers 2 villages were selected. With the help of the village chairman, a list of households was compiled and 75 households were selected using a table of random numbers. Each household had about 2 youths and all married and single youths in the selected households were interviewed.

Sample size determination

The sample N was determined by using proportional formula by Kish and Leslie, used in the statistics calculator programmed of EPI-info 6 such that

$$N = \frac{Z^2P(100-P)}{E^2}$$

When Z = 1.96 (Corresponding to the confidence level at 95%)

E = Absolute precision will be taken at 4.5%.

P = Proportion of youth with gonorrhea 40.1. %

From this sample a total of 456 youths to be included in the study was obtained.

Methods of data collection

A Structured interview schedule was used to collect the information. The schedule consisted of both open and closed ended questions. The data collection was done on every day of the week including the weekends. Time for data collection was considered at interviewee's convenience. Four research assistants were employed and they were oriented on the interview schedule and skills in order to establish good rapport before and during the interviews. The interview schedule was written in English then translated into Swahili for easy understanding .The interview was conducted in Swahili language.

Selection and training of research assistants

The four research assistants were trained after a brief overview of the purpose of the study. The training was on how to conduct the interview after requesting informed consent from the interviewee. One medical assistant, one trained nurse and two nurse midwives were used. They all had been trained in counseling skills before.

Pilot testing

Pilot study was done on 10 youths outside the research area .The principal researcher and the research assistants conducted the pilot testing. The interview schedule was pre-tested. Pretesting to the closed questions was done before data collection.

Data collection

The principal investigator made constant visits to the field as part of supervision for data collection. The consistence of the data collected was regularly checked. Every day after data collection the principal investigator and other interviewers discussed and problems faced during the day clarified and made sure that the questionnaires were adequately filled. The principal investigator also did a rapid check up of all the information collected and if the questionnaires were all filled correctly.

Data presentation

Frequency distribution tables and cross tabulations and graphs was used to present most of the data.

Ethical issues and research clearance

Permission to conduct the study was obtained from the Director of Postgraduate Studies in Muhimbili University College of Health Sciences (MUCHS) and Bariadi district. For each selected participant the aim of the study was explained in detail to him or her.

He\she was informed that participation was voluntary and only those who provided informed verbal consent participated in the study .On top of that they were assured of confidentiality and anonymity. No participants name appeared on the interview schedule. The first portion of the interview elicited sociodemographic information in an attempt to create relaxed atmosphere. In case a participant had an STI, he or she was referred to the DMO for management as prior arrangement had been done. Counseling was also done for those who developed psychological effects.

Limitation of the study

Talking about sexual issues in African culture was a very sensitive issue. A total of eight respondents refused to answer the substantive questions, which related to sex and sexual transmitted infections.

Operational definition of terms to be used in the study

Health –seeking behavior is defined as any activity undertaken by individuals who perceive have a health problem or to be ill for the purpose of finding an appropriate remedy (Ward et al 1997)

Division - A district administrative unit, which is composed of a cluster of Wards.

Ward - A district administrative unit, which is composed of a cluster of Villages. Each village is again composed of clusters of 10 cell units

Marital status - A state of being single married, divorced widowed or cohabiting.

Youth - The World Health Organization (WHO) defines adolescents as those aged between 10 – 19 years, the youth as 15 – 24 years and young people as 10 – 24 years.

Sexually transmitted infections are a group of communicable diseases that are transferred predominantly by sexual contact.

CHAPTER 4

RESULTS

This part presents the results of a study done in Bariadi district, Shinyanga. The design of the study was cross-sectional. It was a descriptive study

Socio-demographic characteristics of the study population: -

A total of 456 youths aged 15-24 years were interviewed. The mean and median age was 20.1 and 20 respectively. There were 266 (58.3%) males and 190 (41.7%) females. Interviews were conducted with 151 youths in the urban, 151 youth from the trade centers and along the main road and 154 youths from the rural villages. Regarding religion seventy seven point three percent were Christians, 20.3% had traditional religious beliefs and few 3.3% Muslems. Over 68.3% were single, 30% married and less than 1% were divorced or widows. Table 1 gives the summary of the characteristics of the sample.

Table 1: Socio-demographic characteristics of the sample population

Characteristics	Male	%	Female	%	Total	%
Age						
15-19	111	(55.5%)	89	(44.5%)	200	(43.8%)
20 – 24	155	(60.5%)	101	(39.5%)	256	(56.1%)
Total	**266**	**(58.3%)**	**190**	**(41.7%)**	**456**	**(100.0%)**
Sex	266	(58.3)	190	(41.7%)	456	(100.0%)
Education						
No formal education	19	(35.8%)	34	(64.2%)	53	(11.6%)
Primary education	203	(62.5%)	122	(37.5%)	325	(71.3%)
Secondary education	44	(57.1%)	33	(44.2%)	77	(16.9%)
Total	**266**	**(58.3%)**	**190**	**(41.7%)**	**456**	**(100.0%)**
Occupation						
Student	74	(64.3%)	41	(35.7%)	115	(26.0%)
Peasant	128	(63.1%)	110	(36.9%)	238	(53.8%)
Employed	3	(27.3%)	8	(172.7%)	11	(2.5%)
Petty business	51	(65.4%)	27	(34.6%)	78	(17.6%)
Total	**261**	**(59.0%)**	**181**	**(41.1%)**	**442**	**(99.9%)**
Religion						
Roman catholic	94	(59.9%)	63	(40.1%)	157	(34.4%)
Protestants	107	(40.5%)	84	(45.6%)	191	(41.9%)
Muslims	7	(46.7%)	8	(53.3%)	15	(3.3%)
Pagan	58	(65.9%)	35	(34.1%)	93	(20.3%)
Total	**266**	**(58.3%)**	**190**	**(41.6%)**	**456**	**(99.9%)**
Marital status						
Single	204	(65.6%)	107	(34.4%)	311	(68.3%)
Married & Cohabiting	61	(45.2%)	76	(54.8%)	137	(30.1%)
Divorced & Separated	1	(33.3%)	3	(75.0%)	4	(0.9%)
Widowed	0	(0.0)	3	(100.0%)	3	(0.7%)
Total	**266**	**(59.1%)**	**189**	**(40.9%)**	**455**	**(100.0%)**

Variation between some youth, socio-demographic characteristics and STI knowledge

One of the aims of this study was to determine how knowledge of STI varied with the socio-demographic characteristics of the youths. The main characteristics in question were sex, age and area of residence.

To determine knowledge of STI, respondents were asked if they were aware of STI as a big problem in the community, what they knew to be the cause of STIs, how STI were transmitted, if STIs were curable and finally what was the methods of STIs prevention. Most respondents were aware of STIs as big health problem. However they had different views on the causes of STIs. Ninety-two point nine percent said it was due to microorganisms while 3.7% said it was due to curses. This knowledge varied slightly among the age groups

Sexually transmitted infections was said to be by sexual intercourse by 97% of the respondents Other ways mentioned were abstinence 0.2% and mere casual contact 2.7%.

Regarding cure of STIs 73.5% of all the respondents said they were curable. Prevention of STIs methods mentioned were faithfulness by 18.3% of the respondents, condom use by 58.8% of the respondents and abstinence by 51.3% of the respondents

Among the young adolescents microorganisms were mentioned by 62.5% while it was 71% in the other group. It was statistically significant.

Table 2: Proportion of responses mentioned as causes of STI by age: -

	Age groups		
	15-19	**20-24**	
Microorganisms	120 (62.5%)	182 (71.1%)	302 (67.4%)
Others	72 (37.5%)	74 (28.9%)	146 (32.6%)
Total	192 (42.9%)	256 (57.1%)	448

$X^2 = 3.69$ P value < 0.05

Similarly more males were knowledgeable than females. Their proportions were 73.5% for males and 58.7%) for females (Table3)

Table 3: Proportion of responses mentioned as causes of STI by sex

Cause	Male	Female	Total
Microorganisms	194 (73.5%)	108 (58.7%)	302 (67.4%)
Others	70 (26.5%)	76 (41.3%)	146 (32.6%)
Total	**264 (58.9%)**	**184 (41.1%0**	**448**

X^2 =10.8 P-value <0.05

Regarding site of residence those in rural areas were in much higher proportion 73.3% followed by those from trade centers 67,5%and urban areas 61.6%.

Sexually transmitted infections transmission

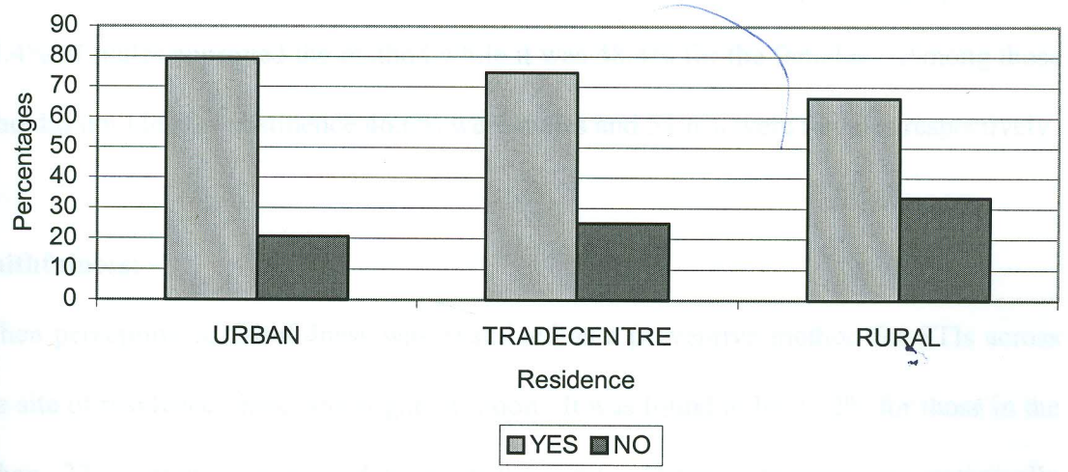
Sexually transmitted infections transmission was said to be by sexual intercourse by 97.0% of the respondents. Other ways were abstinence 0.2% and mere casual contact by 2.7%. It was observed that site had slight variation regarding transmission of STIs. However the difference observed was statistically significant.

Cure of STIs

Respondents were asked if they were aware that STIs were curable. 73.5% of all the respondents agreed while 26.5% disagreed. Among those who agreed a proportion of 63.3% were males while 37.7 were females. Among those who said the disease were not curable, males were 47.5% and females were 52.5%.

Regarding responses to whether STIs was not curable, there was variation according to the site of residence being 79.2% for the urban 74.7% for trade centers and 66.4% for rural. See figure 1 below.

Figure 1: Responses to whether STI's can be cured if treated by residence



$x^2 - 6.3$

P Value 0.04

Sexually transmitted infections prevention: -

Regarding STI's prevention, faithfulness, condom use and abstinence were the methods mentioned. Only 18.3% of all the respondents considered faithfulness as one of the appropriate method of STI prevention. Among the males 23.5% knew the method and among the female only a proportion of 10.7% knew.

On the question of condom use 55.8% of all the respondents identified the method while 44.2% did not. It was 64.7% among the males and 42.9% among the females. Among males who did not know their proportion was 35.2% while among the females it was 52.1%.

For abstinence 51.3% of all the respondents knew while 48.7% did not. A proportion of 53.4% of males approved the method while it was 48.4% for the females. Among those who did not identify abstinence 46.6% were males and 51.6% were females respectively.

Faithfulness: -

When perception of faithfulness was examined as a preventive method for STIs across the site of residence, there was slight variation. It was found to be 23.2% for those in the urban, 22.5% trade centers and 8.6% in the rural. These differences are statistically significant (Table 4).

Table 4: Perception of faithfulness as a preventive method

Faithfulness	**Urban**	**Trade Centre**	**Rural**	**Total**
Yes	35 (23.2%)	34 (22.5%)	13 (8.9%)	82 (18.3%)
No	116 (76.8%)	117 (77.5%)	133 (91.1%)	366 (81.7%)
Total	**151 (33.7%)**	**151 (33.7%)**	**146 (33.6%)**	**448**

$X^2=9.0$ P value < 0.05

Condom use

As for condoms table 6 shows that there was variation by residence: being 64.2% of urban residents 64.9% residents of trade centres and 37.7% for the rural sub sample. Their differences were statistically significant P-values < 0.05.

Table 5: Responses mentioned as ways of prevention by use of condoms by site

Use of condoms	Urban	Trade Centre	Rural	Total
Yes	97 (64.2%)	98 (64.9%)	55 (37.7%)	250 (58%)
No	54 (35.8%)	53 (35.1%)	91 (62.3%)	198 (44.2%)
Total	151	151	146	448

$X^2 = 28.9$ P value < 0.05

Abstinence

It was found that there was no much variation regarding responses of abstinence mentioned as a method of STI prevention by the respondents. However a slightly higher proportion of youths in the urban (53%) mentioned it.

The youths' perceptions on the meaning of STIs: -

In this study an attempt was made to know what it meant to have a STI.Did the youth consider STIs serious or something one gets as he grows or a sign of virility?

All the respondents irrespective of whether they had had an STI or not, were asked what would be their reaction if their friends got infected with STIs. The majority said they

would be worried. These formed 98.0% of all the respondents. Only 1.3% said they would be happy and 0.7% would just feel normal. When asked about them getting infected the majority (98.7%) said they would be worried and only 1.3% would feel happy. No variations by age, sex or residence in the youth's reaction to getting STIs were found.

The respondents were asked to mention the types of people whom they thought were susceptible to STIs. Only 21.2% of all the respondents mentioned those who indulge in sexual activities were susceptible while the large majority 87.4% said anyone was susceptible. Young adolescents and older youths were 26.0% and 17.6% respectively

It was observed that only 21.2% of the respondents said promiscuous people were susceptible to STI. Among this group 24.2% were from the urban, 29.5% from the trade center and 46.3% from the rural areas.

Lay referral system

Lay referral system was explored by asking the question who to tell first about an STI infection. Sixty nine point four percent of the respondents said they would tell first their friends or relatives, 1.6% would tell traditional healers and 29.5% would tell the practitioners in the formal health sector. Among those who said they would consult first their friends or relatives 62.9% were from the urban, 70.6% from the trade centres and

73.3% from the rural areas. These differences, however, were not statistically significant.

Among those who said would consult first the traditional healers 1.3% were from the urban, 2%from the trade centers and 1.6% from the rural areas.

Finally the respondents who said would consult first the formal sector 35.8% were from urban, 27.2% from trade centers and 25.3% from the rural areas.

Source of health care known by the youths:

In order to be able to seek for health services one of the requirements is to know the sources. Therefore one of the aims of the study was to determine the health care sources for STIs the youth knew about. All the respondents were asked to name the sources of health care they knew. It was noted that eighty one point four percent of all the respondents identified the formal health sector as a health source of care. The formal health sector included dispensaries, health centers, and hospitals either government or private owned. Their proportions were 82.2% among the males and 80.3% among the females.

Similarly it was noted that 35.1% of the entire respondents named a traditional healer as a source of health care. Their proportions were 36.4% among the males and 33.3% among the females.

Four percent of all the respondents identified the market and shops as a source of health care and comprised 4.2% among males and 3.8% among females.

Lastly, 0.9% of all the respondents identified friends and relatives as a source of health care. It was 1.1%among the males and 0.5% among the females. The variations in responses given by the respondents were not important.

Source of health care accessed by the youth

Knowing the sources of health care alone is not enough to make the youth be able to seek health services but being able to access to the services is very important too. Therefore all the respondents regardless of whether they had had an STI or not were asked to mention sources of health care that were accessed by the youths concerning sexually transmitted infections. Different areas were identified including traditional healers, relatives and formal health services facilities.

It was found out that 41.8% of the youths had access to the traditional healer. Among these 43.2% were males while 39.9% were females.

Concerning relatives and friends only a small proportion of 2% of the youth had access to them. They comprised a proportion of 1.9% of the males and 2.2% of the females.

It was observed that in the formal health services 62.5% of all the youths said they would have access to health care services. Their proportions were 62.1 males and 63.2%. There would be no marked variation in the access to the health care in relation to sex.

CHAPTER 5

DISCUSSION

This study was conducted in a rural district where STIs are a public health problem similar to other districts in the country .The study looked at perception of STIs in particular the causes, transmission, cure, preventive measures concerning STIs. The sample included 58.9% males and 41.1% female youths.

Causes of STIs

Findings of this study show that most respondents were aware of STIs. However a higher proportion of older youths than younger youths were found to be aware of the causes of STIs (Table 2).

The difference may be due to the fact that older youths have been exposed to more information through different educational media like radios, pamphlets, cinema and seminars on STIs. They also travel to different places where they learn and get experiences.

The young adolescents have little access to the educational media as most of the time they are at school. It should be noted that the young adolescents are becoming mature and have probably higher sexual drive, therefore because of low awareness on causes of

STI they may not take protective measures when they encounter sexual intercourse hence contract STIs easily.

WHO stated that low knowledge of STI was one of the major obstacles to the control of these diseases among adolescents Other obstacles mentioned were ignorance of young people on the causes and symptoms of STIs, the asymptomatic nature of some of STIs particularly in women and the reluctance of young people to ask for help because they expect to be met with anger and hostility (WHO 1993)

Similarly more males were more aware of STIs than females (Table 3). This may be due to the reason that usually males have access to different sources of information including listening to radios, reading newspapers, and attending STIs workshops and meetings. The females usually do not have power to express their feelings. They stay at home and perform different household chores, including looking after the children, and doing farm work. Due to this gender discrimination even if they attend a meeting they are not allowed to talk in front of men.

STIs transmission:

Although transmission of STI by sexual intercourse was mentioned by a higher proportion of youths in all the three areas of study, however among those who mentioned supernatural as ways of transmission of STIs, males were 5 (38.5%) while females were 8 (61.5%), 6 (46.2%) were from urban and trade centers while 7 (53.8%)

were from the rural. Nine (69.2%) had primary education while 4 (30.8%) had no formal education. The reason could be due to the less exposure to STIs information generally.

The implication of this could be that they do not practice safer sex and hence expose themselves to STIs.

In terms of cure of STIs, rural population had statistically significant differences in terms of proportions of people who knew whether some STIs were curable. The rural population had lower proportion compared to the urban and trade centers.

One of the reasons could be that some people in the rural areas have less confidence in modern medicine as a cure for their ailments. Typical expression of this included the following statement from one of the respondents: A female aged 18 **" Modern medicine does not cure the disease but suppresses it for some time, only to reappear later"** Therefore the implication could be that a patient may not seek medical treatment early. However syndromic management is recent innovation, which means there is a long history of incorrect management of STIs and the rural population have experience of this ineffective management.

This finding was also noted (Moss 1999) in an ethnographic research used to examine patterns of health seeking behavior for STI in Western Kenya in which some people

believed that even when a person went to the hospital, he would also go for traditional medicine at the same time. It was believed that traditional medicine cleans all the dirty left after the modern treatment.

Prevention

Regarding prevention, the findings show that the large majority of the sample were not aware of faithfulness as preventive method for STIs. The least proportions are those of the rural (8.9%) followed by trade centers (22.5%) and urban (23.2%) in that order. The reason could be due to inadequate sensitization on faithfulness as one of the preventive measure The implication of this is that people could be having sex indiscriminately. Condom is often promoted as the lead strategy in the fight against STI/AIDS. However the proportion of those who mentioned condom use as a preventive method for STIs was low in the entire sample. It was 64% for urban, 58% for trade centers and the least proportion was for the rural sub sample (37.7%). The reason could be due to inadequate promotion of condoms as a preventive measure.

Social marketing of condoms appear to be more aggressive in urban and trade centres.and therefore rural people are rarely reached

Lay referral system

This study noted that over fifty percent of the respondents said they would tell a relative or friend if they got an STI and about a 29.5% would tell a formal medical practitioner and 1.6% would tell the traditional healer.

The findings of this study are similar to the findings (Faxelid 1998) in a study conducted among young men in rural area in Zambia showed that a majority of them went to a traditional healer or some other person or relative who had knowledge about herbs if they had signs of a sexually transmitted infection (STI). Only a minority reported first going to the health centre.

In another ethnographic study (Moss et al 1999) it was noted that persons with STI would reveal their infection to only one confidant usually a relative or a friend. In the same study, nine out of seventeen informants who had STI revealed to a friend and four to a relative. Two informants said the illness was revealed to many friends while one informant claimed to have told no one.

Regarding sources of health care 81.4% for the respondents identified formal health sector as one of the sources, 35.1% identified traditional healer and 4% mentioned market and shops.

Source of health accessed.

Among the 38 people who had had an STI, 7(18.4%) sought treatment from the traditional healer while 31(81.6%) sought treatment from the formal health sector. Among 255 people who had had no STI but knew people with STI said 111(43.5%) had sought treatment from the traditional healer while 144(56.4%) had sought treatment from the formal health sector.

CHAPTER 6

CONCLUSION

The study has specifically examined the youth's perception of STIs causes, transmission preventive measures, lay referral and accessibility to health services.

- The findings indicate that generally, the proportion of youths who are aware of STI especially on the preventive aspect is very small.
- A small proportion of youths perceived those who indulge in sexual activities to be a factor in transmission of STIs.
- About a third of the youth seek treatment from a traditional healer and two-thirds from the formal health sector.

RECOMMENDATION

1. Establish and promote different educational media related to STI among the youth.

Suggestions for further research:

i. Research on factors affecting utilization of health services.

ii. Conduct ethnographic research on sexual behaviour in youths.

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