

## **Health-seeking behaviour of STD patients in an urban area of southwest Nigeria: an exploratory study \***

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### **Abstract**

Sexually transmitted disease patients of health institutions in Ado-Ekiti responded to questionnaires on the quality of STDs treatment; four-fifths of the institutions are privately owned. Gonorrhoea and syphilis are the major STDs reported by the respondents and treated by the health-care providers. Other types are candida, dysuria, lymphogranuloma venereum, chancroid, trichomoniasis and STD-related problems. The symptoms noticed by the respondents are pain, burning sensation, discharges, itching and open sores. Most sought treatment within seven days of noticing the symptoms. Most sought treatment from other health providers before coming to the health institutions where they were interviewed. Respondents were attended by modern doctors during their search for a cure, but in most cases, only by physical examination because laboratory facilities were non-existent or inadequate. Treatment was mainly chemotherapy, involving antibiotics and analgesics. In addition to chemotherapy, the health providers counselled the patients. Most respondents reported that they were satisfied with the quality of treatment. Results are discussed and recommendations are made.

Sexually transmitted diseases (STDs), especially gonorrhoea, are highly prevalent in both rural and urban areas of many African countries. In certain areas of Africa, it has been reported that 80 per cent of urologic practice involves the treatment of urethral strictures and management of reproductive failure that results from sexually transmitted diseases (Osoba 1990). Among females salpingitis and pelvic inflammatory diseases are the most commonly reported complications of gonorrhoea, often resulting in tubal occlusion and infertility. For instance, among 100 Zulu women with genital ulceration, syphilis was diagnosed in 40 per cent; genital herpes, 18 per cent; donovanosis, 16 per cent; chancroid, 14 per cent; lymphogranuloma venereum, 7 per cent and scabies, 2 per cent (O'Farrel et al. 1991).

STDs have long been identified in the Southwest African region and there are many types with the most recognized being gonorrhoea with its various types especially the 'blood type' and the 'milk type' (Akinnawo 1994). Osoba (1981) reported a prevalence of

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10 per cent for gonorrhoea and 5 per cent for syphilis in the general population. The STD prevalence among Nigerian prostitutes was found to be 14 per cent in 1990 and 20 per cent in 1992 (Mann, Tarantola and Netter 1992).

In the developing countries, a past history of sexually transmitted diseases has been found in many AIDS patients: 50 per cent of those in Kinshasha, 35 per cent in Tanzania, 67 per cent in Rwanda, 71 per cent in males in Zimbabwe and 51 per cent in females (Peplin et al. 1989). In both the United States of America and Africa, there is a high correlation between HIV-seropositivity and a past history of genital ulcer disease (GUD), mainly chancroid. There is also some reported evidence associating HIV-seropositivity with chlamydia, trichomoniasis and gonorrhoea. The strongest evidence indicates that genital ulcer disease (chancroid, syphilis, herpes) facilitates the sexual transmission of HIV.

In both Haiti and Africa, Bazell (1988) noticed that AIDS spreads easily because of the high incidence of sexually transmitted diseases such as herpes and chancroid, which leave open sores on the genitals. In Uganda, the number of episodes of gonorrhoea, chancroid and syphilis are reported to be significant risk factors for HIV (Berkley et al. 1989). It is therefore of paramount importance to combat other types of STDs in order to prevent the spread of the HIV infection.

A significant incidence of STDs, especially gonorrhoea, has been indicated for Southwest Nigeria (Orubuloye 1993; Akinnawo 1996); it had also been established that high-risk behaviour is commonly practised (Orubuloye, Caldwell and Caldwell 1993; Owuamanam, 1996). The implications of this high-risk behaviour for the transmission of STDs, particularly HIV/AIDS, have also been pointed out by Orubuloye, Caldwell and Caldwell (Orubuloye 1993; Orubuloye, Caldwell and Caldwell 1993, 1994). It is however difficult to curb the high-risk behaviour because of the psycho-social, economic and cultural practices precipitating and maintaining it (Orubuloye et al. 1994; Akinnawo 1995; Akindutire 1995). Intervention programs aiming at attitude change and behaviour modification may be useful.

While we recognize the importance of intervention programs providing preventive measures, we also realize that a certain percentage of the population is already infected. Obviously, for a meaningful intervention aiming at prevention and control of STDs, the already infected population needs some sort of psychological, social and medical attention, which necessitates the planning and implementation of relevant intervention programs. In this regard, answers to the following questions become relevant.

Are there adequate facilities and human resources to meet the psychological, social and medical needs of STD patients in this part of the world?

Are the patients ready to make full use of the available resources? What is the nature of their health-seeking behaviour?

Information on the health-seeking behaviour of STD patients in Southwest Nigeria, and on the interaction between the patients and their health providers, is yet to appear in the literature in this era of AIDS. To bridge this gap in knowledge, this study was an attempt to investigate the health-seeking behaviour of STD patients in an urban area of southwestern Nigeria. Specifically, the study was focused on health seeking behaviour of STD patients, the services received from the health providers and the patients' assessment of the quality of services.

Information contained in this study not only will assist health policy makers in developing adequate intervention programs for STD patients in Nigeria and other socio-culturally similar African countries, but also may help STD treatment staff to improve their professional skills.

## **Method**

### ***Instrument***

An in-depth interview supplemented with a structured questionnaire was employed in the study. The interview investigated the patients' knowledge of STDs (particularly symptoms recognition), their health-care seeking behaviour and the type and quality of health care services received from their health care providers.

#### ***Subjects and setting of the health institutions***

Forty-one STD patients fully participated in the study. Their ages ranged from 16 to 65 years (mean = 29.8 years); 54 per cent were aged 20-30 years. Thirty (73%) of them are male, 18 (44%) were currently married. Among the married patients, 13 had married only once and six had married two or more times. All of the patients had formal education, the majority of them being secondary school leavers.

All of the patients were selected from urban health institutions. Twenty of them were from private hospitals or clinics; 13 from pharmaceutical shops; two from chemist or patent medicine stores; one from a traditional treatment home and five from mission hospitals. Most of the health institutions (85%) were owned by private individuals. Others were owned either by Christian missions or groups of individuals. Only 11 (27%) of the patients reported that there was an STDs clinic in the health institution they visited. An attempt to include a sample from the only government hospital or clinic in the area was not successful.

#### ***Data collection technique***

The STD patients were interviewed in the various health institutions where they were currently receiving treatment. This arrangement, though it had some difficulties, was possible because of the co-operation of the staff of the health institutions. After the interview and subsequent counselling, the patients were educated on the need to report for treatment as soon as STD symptoms were recognized.

### **Results**

#### ***Symptom recognition***

Gonorrhoea and syphilis are the major types of STDs contracted and reported by the patients. Twenty-four (59%) of them reported gonorrhoea and eight (19%) syphilis. Other types of reported STDs are candida, dysuria, lymphogranuloma venereum, chancroid, trichomoniasis, and AIDS-related STDs. The first symptoms noticed by the patients are pain on urinating, urethra burning sensation, bloody discharge, itching, milky discharge, abdominal pain, open sores and vaginal discharge. All the respondents except four realized that STD was dangerous to their health: infertility and destruction of sexual organs are the dangerous effects recognized by a majority of the respondents. Others reported dangerous health effects include urinating problems, pain and discomfort and fear of symptoms leading to more serious problems like AIDS, loss of weight and even death.

#### ***Health-care seeking behaviour and services received***

Most of the patients (33 or 81%) sought treatment within seven days of discovery of symptoms and a few of them (8 or 20%) did not seek treatment until 15-30 days after symptom recognition. Some of the respondents (31 or 76%) had sought treatment from other health institutions before the decision to seek treatment from the health institutions where they were interviewed. Treatments were formerly sought from patent medicine stores, government hospitals, chemists and traditional treatment homes. Most of the patients were attended by

modern doctors during their first search for a cure. In most cases, however, no laboratory test was carried out though physical examination was involved. The cost of first treatment ranged from 45 to 5,000 Naira (mean 569 Naira). These patients took the decision to consult the health institutions where they were interviewed because they were not satisfied with the quality of the services received at the health institutions initially visited, in which few of the health providers provided laboratory tests, some provided physical examinations, while many of them did not carry out any examination before treatment. This was because the necessary facilities were either not available, or not functional.

Treatments were mainly chemotherapy. Prescriptions given to the respondents include procaine, penicillin, streptomycin, Septrin injection or capsule, canesten pessary, gentamicin injection, Flagyl, piriton and Panadol. In addition to chemotherapy, the health providers engaged in counselling as a preventive measure. Patients were educated on the use of condoms, and advised to bring partners for treatment, to refrain from sexual activities until treatment was completed, and to avoid sharing toiletries. The cost of treatment ranged from 50 to 5000 Naira (US\$0.65 to US\$65.00)<sup>1</sup>.

#### ***Respondent's assessment of the quality of health service***

Most of the respondents reported that they were satisfied with the services provided by the health care providers. Indeed, the responses ranged mostly between improved condition and full recovery. A few of them, however, reported that they were dissatisfied. Most of the respondents reported that the treatment received was effective and 95 per cent of them believed that the privacy of patients was maintained by the health providers. A good number of the respondents (78%) believed that the cost of treatment was reasonable, though the remainder (22%) felt that the treatment was very expensive.

A majority of the respondents (70%) believed that STDs can best be treated in modern hospitals. In terms of the quality of service, 51 per cent, 17 per cent, and 12 per cent of the patients reported modern hospitals, pharmacy and chemists as the best respectively. Spiritual healers were ranked as the worst in terms of the quality of service provided and efficacy of treatment because there was no basic treatment, no drug supply and the treatment given was not realistic. Traditional healers were ranked next to spiritual healers because there was no laboratory test before treatment, so treatment was not effective. However, it was also reported that in the case of the chemists, there was neither a test nor an examination before a prescription was given.

#### **Discussion and conclusion**

The demographic characteristics of the sample revealed that the majority of the STD patients are young and particularly students between 20 and 30 years of age. This is consistent with findings from other parts of the world (Mann 1988; Mariasy and Radlett 1989; Isiugo-Abanihe 1994) It also draws our attention to the likely socio-economic effect of STDs, especially AIDS, on Nigeria in particular and Africa as a whole.

The sex ratio of three males to one female does not indicate the sex distribution of STD patients in the study area but shows that more male than female patients reported for treatment. This should be expected since women can harbour STDs for weeks or months without experiencing the symptoms, whereas for men, symptoms are experienced as early as within 24 - 48 hours in many of the common types of STD.

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<sup>1</sup>Exchange rate based on US\$1.00 = 80 Naira

The fact that the sample included educated civil servants, students and the unemployed shows that people from various occupational groups suffer from STDs. The notion that STDs are common only among the already identified high-risk groups (Orubuloye et al. 1994; Akinnawo 1996) should therefore be treated with caution. One of the implications of this finding is that any meaningful intervention program aiming at STDs, particularly HIV/AIDS, prevention and control should be carried beyond the high-risk groups and extended to all professional groups. Secondly by implication, emphasis should be shifted from low-risk groups to high-risk behaviour. Intervention programs should therefore be concentrated on modifying high-risk behaviour through attitude change and behaviour modification programs. High-risk behaviour includes multiple sexual partnership, casual sex, commercial sex (Orubuloye et al. 1994), homosexuality (Owuamanam 1994) and other sexually and non-sexually related cultural practices such as circumcision and scarification (Akintuire 1995; Okoro 1995).

The patients knew about STDs, particularly their symptoms, and realized that STDs were injurious to their lives, so they were anxious to get rid of the disease. Their pattern of health-seeking behaviour is such that patients consult health providers for professional help within seven days of symptom recognition. But unfortunately they usually consult the wrong providers such as chemists, patent medicine sellers and traditional doctors in their first search for cure. However, they often turned to private hospitals and clinics, where better services were being provided, when their condition worsened.

The primary reason for consulting incompetent providers at the initial stage could be economic. Treatment is far cheaper at the chemists', patent medicine stores or herbal homes than in good private hospitals or clinics, but private hospitals and clinics have more facilities and more qualified health providers than chemists or patent medicine stores. Patients attending private hospitals consequently have to pay more for the high quality of the services received. With this knowledge most patients, especially during this period of economic instability, experiment first with the chemist, patent medicine stores and herbal homes where in most cases temporary relief may be given. Occasionally, some patients may be lucky enough to be cured by this set of unqualified health providers. They are considered lucky since a majority of the health providers in chemists' and patent medicine stores are not only quacks in handling STDs but have no facilities for laboratory tests. This is part of the reason why neither test nor physical examination was carried out in most of the cases before or after treatment. The health providers are guided by patients' self-diagnosis and personal experience which may be grossly inadequate to handle sensitive cases of STDs.

The reason we had no sample from a government hospital was not unconnected with the economy. At present in Nigeria, virtually all the government hospitals are no more than 'prescription clinics'. The 'brain drain' has sent many of the country's experienced and qualified health professionals out of the country in search of greener pastures. Some of them have chosen private practice. The shortage of qualified health professionals coupled with the absence of functional essential facilities and grossly inadequate supply of drugs in government hospitals makes the hospitals unattractive to average citizens, especially patients with sensitive problems like STDs, in the era of AIDS.

It is interesting to consider the implications of the finding that about 88 per cent of the patients in this study were attended in health institutions where there were no STD clinics; this gives a rough picture of the situation in Southwestern Nigeria. STD clinics are too expensive for individual private hospitals to run. This responsibility should be shouldered by either government or non-governmental organizations but unfortunately this is more of a dream than reality owing to the current economic problems. This however means that more of the STDs patients will continue to be treated not only by quacks but without laboratory tests. What then is our hope in this situation? This condition has serious implications for accurate

diagnosis, effective management and assessment of therapeutic efficacy as well as the transmission of STDs, particularly HIV.

Though the patients reported that they were satisfied with the quality of services received from the health providers and considered the cost of treatment reasonable, their subjective assessment may not be reliable (especially in the absence of any laboratory test) since absence of symptoms or relief from pain does not mean cure, particularly in cases of STDs. Exploratory as it is, the following conclusions can be drawn from the study:

STDs patients in this study had adequate knowledge of the implications of their ill health. Their pattern of health seeking behaviour was conditioned by the present economic conditions in Nigeria. STD clinics were either not available or not functional in most of the health institutions in the study area. The health providers adopted chemotherapy and counselling in the management of the STD patients.

For a meaningful intervention program aimed at controlling and preventing the spread of HIV/AIDS, the following recommendations are made.

Intervention programs should include attitude change and behaviour modification strategies. Attention should be concentrated on 'high-risk behaviour'.

There should be mass education on the dangers of consulting unqualified health providers and seeking help in health institutions where essential facilities are inadequate. For instance, patients could be encouraged to request laboratory tests before and after treatment.

STD clinics should be made available in both urban and rural areas. While foreign financial assistance should be sought to establish STD clinics, all levels of government (federal, state and local), NGOs, religious organizations and individual donors should be encouraged to contribute to the running of STD clinics.

STD treatment should be heavily subsidized.

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