

Health seeking and sexual behaviour among patients with sexually transmitted infections - the importance of traditional healers.

R Zachariah, W Nkhoma, AD Harries, V Arendt, A Chantulo, MP Spielmann, MP Mbereko, L Buhendwa

Abstract

We aimed to describe health seeking and sexual behaviour including condom use among patients presenting with sexually transmitted infections (STI) and, to identify socio-demographic and behavioural risk factors associated with “no condom use” during the symptomatic period. A cross-sectional study of consecutive new STI cases presenting at the district STI clinic in Thyolo were interviewed by STI counsellors after obtaining informed consent. All patients were treated according to National guidelines. Of 498 new STI clients, 53% had taken some form of medication before coming to the STI clinic, the most frequent alternative source being the traditional healer (37%). 46% of all clients reported sex during the symptomatic period (median=14 days), the majority (74%) not using condoms. 90% of all those who had not used condoms resided in villages and had seen only the traditional healer. Significant risk factors associated with “no condom use” included: visiting a traditional healer; being female; having less than 8 years of school education; and being resident in villages. Genital ulcer disease (GUD) was the most common STI in males (49%) while in females this comprised 27% of STIs. These findings, especially the extremely high GUD prevalence is of particular concern, considering the high national HIV prevalence in Malawi (9%) and the implications for STI and HIV transmission. There is an urgent need to integrate traditional healers in control activities, encourage their role in promoting safer sexual behaviour, and to reorient or even change existing strategies on condom promotion and STI control.

Introduction

Sexually transmitted infections (STIs) are known to facilitate the sexual transmission of HIV[1][2] and effective STI case management is known to reduce the incidence of HIV.[3] Malawi has both high HIV and STI rates. The National HIV prevalence in Malawi is 9%, while among antenatal women the syphilis seroprevalence is estimated at 2-10%.[4] In 1990, 42% of antenatal clinic attendees were diagnosed with at least one STI and HIV infection rates among patients with STI's range from 53-83%.[5] STI control in Malawi is therefore of major public health importance.

An important determinant of effective STI control is the health seeking behaviour of people with STI's who may seek care from alternative sources (outside an official STI clinic) such as traditional healers, private clinics, pharmacists and market vendors. Traditional healers in particular are well reputed in African rural communities and are often considered to be the most appropriate initial point of contact for help when symptoms of STIs are thought to be linked to traditional beliefs and related perceptions.[6] Knowledge about the relative importance of these alternative providers in STI control could encourage better collaboration with some of these groups, encourage early referral for effective antibiotic treatment and help remove or reduce

potential barriers to STI control. Control of STIs involves not only providing effective and early treatment, but also promoting safe sexual practices by those that are infected. Information on such practices, would be useful for assessing and improving existing control activities

The objectives of this study were a) To describe health seeking and sexual behaviour, including condom use during the symptomatic period among patients presenting with STIs; and b) To identify socio-demographic and behavioural risk factors associated with “no condom use” during the STI symptomatic period.

Methods

The study was conducted in the main rural public hospital STI facility in Thyolo district, southern Malawi. Consecutive new STI cases presenting during a 4-month period were interviewed after obtaining informed consent. A semi-structured questionnaire, which was pre-tested, was used to gather basic socio-demographic data, as well as information on health seeking and sexual behaviour. Confidentiality was ensured and all patients were diagnosed and managed using National STI guidelines adapted from the syndrome-based approach (clinical assessment of signs and symptoms) as recommended by the WHO.[7] Reported “no condom use” during sexual encounters in STI symptomatic period was designated as the dependent variable for identifying potential risk associations.

Analysis was done using the Epiinfo software (Centers for Disease Control, Atlanta), and the LOGISTIC software.[8] The level of significance was set at $P=0.05$ and 95% confidence intervals (CI) were used through out. The measures of risk were determined by crude odds ratio (OR) and adjusted odds ratios (adjusted OR). Odds ratios were adjusted using multivariate logistic regression, and all related P-values were based on the likelihood ratio statistic.

Results

A total of 498 new STI clients who were diagnosed with an STI participated in the study (median age 25 years). The majority of patients (79%) came from villages, were married (62%) with a mean educational level of 6 years in school. Patients included farmers (38%), unskilled employees (36%), skilled employees (3%), business people (14%) and students (9 %).

In male patients genital ulcer disease (GUD) was the most common STI (49%) followed by urethral discharge (42%). In female patients, abnormal vaginal discharge with or without dysuria was the most common (50%), followed by genital ulcer disease (27%), and pelvic inflammatory disease (18%). The median reported time with STI symptoms before coming to the STI clinic was 14 days (range 2 days to 4 years), with 53% of all patients having taken some form of medication before coming to the clinic. The most frequent single source of medication was the traditional healer (37%) (Table 1).

(Table 1 on the next page).

The majority of STI clients (83%) who had seen a traditional healer resided in villages and 90% of these patients had an educational level of less than 8 years in school.

46% of patients with an STI had reported having sex during the symptomatic period, the majority (74%) had not used condoms 90% of all those who had not used condoms during sexual encounters resided in villages and had seen only the traditional healer. The main reasons for no condom use during sex in the symptomatic period are shown in table1.

Table 1: Health seeking and sexual behaviour of patients presenting with sexually transmitted infections

Variable	Males (%)	Females	Total (%)
Total	248	250	498
Previous medication			
Modern (ampicillin, cotrimoxazole etc)	132 (53)	130 (52)	262 (53)
Traditional (herbs, roots etc)	50 (38)	43 (33)	93 (35)
Both	48 (36)	49 (38)	97 (37)
Both	34 (26)	38 (29)	72 (28)
Source of previous medication (n=262)			
Private health facilities	26 (20)	29 (22)	55 (21)
Drug vendors/pharmacy	24 (18)	38 (11)	62 (24)
Traditional healers	48 (36)	49 (38)	97 (37)
Several of the above	34 (26)	14 (11)	48 (18)
Median duration of STI symptoms (days)	14	11	14
Sex during symptomatic period =yes			
With same partner	97 (42)	134 (58)	231 (46)
With different partners	67 (69)	124 (93)	191 (83)
With different partners	30 (31)	10 (7)	40 (17)
Condom use during sex in symptomatic period (n=231)			
Always	3 (3)	2 (2)	5 (2)
Intermittent/sometimes	34 (35)	22 (16)	56 (24)
No condom use	60 (62)	110 (82)	170 (74)
Reasons for "no condom use" (n=170)			
Sex with steady partner or spouse	32(53)	84 (76)	116 (68)
Refusal by partner	2(3)	11(10)	13(8)
Condom not available	15(25)	8 (7)	23(14)
Reduces pleasure	4(7)	3(3)	7 (4)
Religious reasons/did not know	7 (12)	4 (4)	11(6)

Significant risk factors associated with "no condom use" while having sex in the symptomatic period include having visited a traditional healer, being female, having had less than 8 years of school education, and being resident in villages. (Table 2)

Table 2: Selected socio-demographic and behavioural risk factors associated with "no condom use" in STI patients reporting sex during the symptomatic period (n=231)

Variables	Condom=No (%)	OR	* Adjusted OR (0.95, CI)	p-value
Sex				
Male	60/97 (62)	1	1	
Female	110/134 (82)	2.8	2.5(1.1-6.2)	0.04
Age				
< 20 yrs	146/198 (74)	0.9	0.9(0.3-2.4)	0.78
> 20 yrs	24/33 (73)	1	1	
Marital status				
Single/divorced/widowed	33/54 (61)	1	1	
Married	137/177 (77)	2.2	1.5 (0.6-3.3)	0.36
Education				
<8years	154/196 (79)	4.4	2.6 (1.1-6.2)	0.03
>8 years	16/35 (46)	1	1	
Residence				
Semi-urban towns	21/46 (46)	1	1	
Villages	149/185 (81)	4.9	4.0 (1.9-8.5)	<0.001
Occupation				
Farmers	90/105 (86)	3.5	1.3 (0.5-3.2)	0.63
Non farmers	80/126 (64)	1	1	
Partners				
Same partner	144/191 (75)	1.7	0.9 (0.4-2.2)	0.82
Different partner	26/40 (65)	1	1	
Previous medication				
Traditional medicine alone	41/45 (91)	4.5	4.1 (1.3-12.9)	0.01
Other sources	129/186 (69)	1	1	

* Adjusted for sex, age, marital status, education, residence, occupation, partners, and previous medication

Discussion

This study shows that 53% of all STI patients had first sought care at an alternative source, the majority with the traditional healer. GUD rates in STI clients is extremely high and 74% of

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clients engaged in unprotected sex while symptomatic. Having unprotected sex was significantly associated with visiting the traditional healer, being female, being resident in villages and having had less than 8 years of school education.

Since over half of all STI clients, had first received medication at a source outside the official STI clinic, these different sources could be targeted to improve STI management and reduce delays in effective treatment.[9]

The traditional healer was found to be the most important single source of alternative care. Visiting a traditional healer for care was also found to be a risk factor associated with "no condom use", indicating that condom promotion is not effectively encouraged by this group. In Malawi, traditional healers are generally reputed as being sympathetic, more confidential, and easily accessible. Considering their importance as an alternative care provider, and the potential role they could play in encouraging safer sexual behaviour, it would be important to integrate them in control activities and ensure condom availability (to clients) at their sites. The National Tuberculosis control program in Malawi conducts training sessions with traditional healers from around the country, and encourages early referral of tuberculosis suspects. Training on STIs and HIV infection could be linked with such an existing initiative, and might be one way of also encouraging earlier referral (by healers) for antibiotic treatment.

The extremely high GUD rates in our rural setting although alarming, is similar to a study in Lilongwe where 67% of all STI clients had GUD.[10] These figures also compare with other South African countries worst affected by HIV infection, where the proportion of men and women with STI who had genital ulcers lay in the ranges 45-68% and 13-68% respectively.[11] However, the implication of this particular finding on transmission of HIV, merits that the National AIDS control program develops a specific focus for decreasing the incidence and prevalence of GUD's. Mass awareness campaigns that are adapted for the less literate, [12] increased condom availability in rural areas and promoting the female condom that could facilitate independent and assertive behaviour on safer sex by women are all measures to be considered. The findings of this study will be useful for reorienting or even changing existing strategies in STI and HIV control in the district.

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Authors:

R Zachariah¹, W Nkhoma², AD Harries³, V Arendt⁴, A Chantulo⁵, MP Spielmann¹, MP Mbereko⁵, L Buhendwa¹

- 1 Medecins Sans Frontieres – Luxembourg, Thyolo district, Malawi.
- 2 National AIDS Control Program, Ministry of health and Population, Malawi.
- 3 National TB control program / DFID Technical advisor
- 4 Department of Tropical and Infectious diseases, Luxembourg.
- 5 STI services, Thyolo District, Ministry of Health and Population, Malawi

Address for correspondence:

Dr. R. Zachariah, Head of Mission (Mission Malawi), Medecins sans Frontieres-Luxembourg,
70 rue de Gasperich, L-1617, Luxembourg
Tel : (265) 644409 (Malawi)
Fax: (265) 641 468 (Malawi) (352) 335133
E-mail : msfblantyre@malawi.net

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