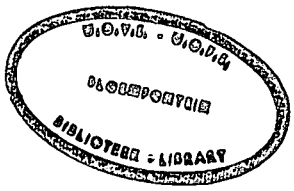

THE SOCIAL EPIDEMIOLOGY OF SEXUALLY TRANSMITTED DISEASES AMONG ADOLESCENTS AND YOUNG ADULTS IN TRANSKEI

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PREFACE

The study investigated the influence of the geographic, demographic,socio-cultural and socio-economic factors in the transmission, treatment and control of sexually transmitted diseases (STDs) in Transkei. The study was conducted in ten districts of Transkei. These are Butterworth, Bizana, Kentane, Tabankulu, Maluti, Lusikisiki, Elliotdale, Cofimvaba, Mqanduli and Umtata. These districts are highlighted on the map of Transkei which is Annexure II of this document.

The study was motivated by the dissatisfaction of the researcher with the available health strategies for treating STDs, which seem to prevail in their presence. Broadly the study attempts to contribute more to the knowledge of human and sexual behavioural dimensions of health problems. It also contributes to the social epidemology of STDs, since such a view is important, considering the dynamic social changes which in turn affect the transmission of STDs markedly. The social epidemiological approach to diseases has thus far been given little chance in the identification of many health problems, particularly in Transkei.

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THE RESEARCHER

L I S T O F C O N T E N T S

CHAPTER 1

TRANSKEI : SOME GEOGRAPHIC AND DEMOGRAPHIC FEATURES

1.1 Geographic Features.

Transkei is situated between latitude 30°S -33,5°E and 27°E-30°S in Southern Africa. It borders on the Indian Ocean in the east and south east, the province of Natal in the north east and Cape Province in the west and north west. It consists of two "islands" one in Natal and another in the Cape Province. Topographically, Transkei is a broken landscape consisting for the greater part of mountains and only 11% is flat. Mean summer temperatures vary around 22°C and drop to 18°C around Matatiele. Mean winter temperatures near the coast are usually above 15°C, but inland they drop to 7°C (Development Bank of Southern Africa 1987).

1.2 Demographic Features.

The 1991 census has shown that the population size (de jure) was 4 509 824 for Transkei for that year. The urban population size was 5% , while the rural population was 95%. It becomes clear that most people in Transkei live in rural areas. This implies a great degree of inaccessibility that may be experienced by most people in getting institutionalised health services. The supposed target population size of this study was 1 460 738; that is those who are between the age range of 15 years and 30 years.

1.3 Health Care Facilities.

There are 308 health centres in Transkei. This figure includes both hospitals and health clinics or health centres. (It is important to highlight that the terms health clinic and health centre are used interchangeably for this study, both meaning a small governmental health service run by nurses alone). Considering the population size of Transkei and the number of health care centres, it appears that each centre serves more than 10 000 population, while the World Health Organisation's norm is one clinic for every 10 000 population.

These health centres are erected at a distance of approximately 13 kilometres from each other. This distance is not consistent for certain areas, because of the already discussed topography.It is possible to walk over 40 kilometres or more before reaching a health centre. There are set stipulations before a clinic is built for any community in Transkei. Each community has to contribute R5000.00 as a prerequisite for health clinic construction and as a measure of commitment in their felt need and as a form of community participation in the rendering of a health service . Sometimes it becomes very difficult to build a health clinic even for the communities that have already contributed the amount of money because of financial constraints. For instance in 1992 the quotations for health clinic constructions ranged between R200 000.00 to R300 000.00 for a simple small health centre. Because of these high building costs it becomes difficult to

provide all the people of Transkei with easily accessible health services. Hence it appears that community based STDs clinics would be ideal to relieve Transkei from this situation of financial constraints and bring health services to the doorstep of many rural people of Transkei.

2. RESEARCH PROBLEM AND RATIONALE OF THE STUDY

2.1 Statement of Problem

In 1990 health statistics for Transkei revealed a high prevalence of sexually transmitted diseases (STDs); in this country in 1990 alone, 23 137 patients with STDs were seen at health centres, while in the region of 10 000 patients with STDs were treated at five of the 30 hospitals in Transkei (Transkei Health Statistics, 1990:10). It should be borne in mind that these figures only represent those who visit the health centres, omitting those who do not visit such institutions.Also considering the poor reporting system for diseases in Transkei, one tends to suspect that what reaches the statistical office is only the tip of an iceberg. Statistics also reveal considerable interregional variation in the incidence and prevalence of STDs, as shown in Table A which follows .

Table A. INTERREGIONAL DISTRIBUTION OF STDs IN TRANSKEI 1990.

REGIONS	PREVALENCE
Eastern Pondoland	5000
Maluti	4000
Dalindyebo	4000
Fingoland	4000
Umzimkulu	3000
Gcaleka	2500
Nyanda	900
Emboland	800
Western Tembuland	400
TOTAL	22380

These variations raise questions regarding the role of ecological, demographic, socio-cultural and socio-economic factors in the transmission, treatment and control of STDs. Many studies have shown that STDs are problems of many countries (Moran et al.1989;Aral & Holmes 1991) thus undermining the present curative aspects. However, the dominance of the clinical, biomedical view of diseases has caused the official approach towards the problem of STDs in Transkei to be largely focused on curative interventions relating to the physical or somatical manifestation of symptoms of these diseases. The result is that resources are predominantly allocated and channelled into curative programmes which reach and benefit only the few individual sufferers of STDs who visit health centres. There are very little resources that are allocated both financially and in

human material that contribute towards the prevention and identification of these rapidly spreading diseases. The social epidemiology of STDs, i.e. the role that the geographic, demographic, socio-cultural and socio- economic factors play in the etiology, course and transmission of STDs, is largely disregarded, neglected and or ignored.

Against this background the rationale of this study lies in the contention that the available resources can be more efficiently and effectively utilised (to greater social benefit at least) if channelled into more appropriate intervention programmes which will be acceptable for those communities at risk of contracting STDs. However, such appropriate intervention programmes cannot be achieved successfully without an appropriate and applicable social epidemiological study. Hence the study asks the following questions:

1. To what extent do demographic, socio-cultural and socio-economic factors influence the incidence, treatment, occurrence and control of STDs? (Income, cultural behaviours, cultural beliefs, knowledge and practices about sexuality, etc.).
2. To what extent do geographic factors delay treatment and control of STDs?.(Urban and rural differentials in accessibility of health centres by patients, distance walked by patients before reaching clinics or health points, condition of roads and transport).
3. What are the demographic characteristics of patients

who choose to attend health centres? (Age, sex, marital status, educational status, etc.)

4. Which educational methods most effectively reach patients who attend health centres when they have contracted STDs ? (TV, radio, pamphlet, etc)

5. Are patients who have contracted STDs ready to accept new technological preventive measures? (Condoms, etc.)

6. Are these patients ready to change their sexual behaviour? (One sexual partner, regular use of condoms, choice of partners etc.).

2.2 General Objectives of the Study

The general objective of this study is twofold:

Firstly, the aim was to gather as much information as possible on geographic, demographic, socio-cultural and socio-economic factors which have a bearing on the transmission, treatment and control of STDs in the Transkei. For this purpose, various aspects regarding the perceptions,attitudes, knowledge beliefs and practices that adolescents and young adults who suffer from STDs have or display, relating to STDs' transmission, treatment and control, as well as their illness behaviour (especially in so far as the seeking of treatment and sexual behaviour during illness were concerned) were investigated. Because this information was obtained from the target population, the information gathered can be regarded as indicative of the real demand for the change in the provision of health care in so far as STDs are concerned. In effect, this means that the information thus obtained can be used to

identify and describe the prerequisites that intervention will have to comply with in order to ensure their maximum impact on the problems of STDs.

A second aim of the study was to use the collected information to argue why reconsidering change in the allocation, present management and prevention of STDs' nature is necessary and to motivate a reorientation in the approach towards the endeavour to avert spread of STDs to be prioritised by public health programme managers. It was hoped that this study would yield an optimum strategy for the more efficient and effective utilisation of scarce resources which are currently consumed by curative, institutionalised health measures, which seem not to be effective enough. The aim was to scientifically substantiate with this study the strong argument in support of community-based, target-oriented approaches and strategies in the prevention, treatment and control of STDs in Transkei.

2.3 Specific Objectives

The study sought to identify and describe those geographic, demographic, socio-cultural and socio-economic influences in the prevention,transmission, treatment and control of STDs. The specific objectives of the study are as follows:

1. To identify geographic, demographic, socio-cultural and socio-economic factors that aggravate the occurrence STDs, delay treatment and slow down control.
2. To provide information concerning the existing sexual

behaviour, knowledge, attitudes, beliefs and practices of those who contracted STDs and visit health centres in order to approximate the information to unknown and potential cases and to use it to prevent the spread of STDs.

3. To determine popular means of communication that reach patients who attend health centres in order to identify and approximate means of communication for unknown cases and those at risk, as this will help in strategic health planning and intervention programmes.

4. To identify the characteristics of patients to a profile of those who are willing to change their sexual behaviour and ready to accept new technological preventive measures in order to use such persons in influencing the larger community-based preventive health measures.

3. METHODOLOGY: RESEARCH METHODS AND SAMPLING PROCEDURE

The study was conducted in ten districts of Transkei. These districts are shown on the map of Transkei which is provided in this document (Annexure II). The investigation was conducted within a sample of Transkeians between the ages of 15 and 30 years (both females and males) who were diagnosed by nurses as having STDs and who were seeking medical treatment at health centres.

This cut-off point was based on literature reviewed that

indicated a high incidence of STDs within this age range as compared to adults (Smith et al. 1988:291). Structured interview schedules were used to gather information from 15 respondents at each of ten selected health centres. Nurses trained in the technique and skills of interviewing, conducted the interviews.

3.1 Sampling Procedure

In the first phase of sampling, ten clinics were randomly selected from a sample framework consisting of all clinics in Transkei. The sampling frame was stratified according to urban and rural differentials. Geographically, Transkei is divided into 28 districts, only two of which can be regarded as urban according to the Department of Commerce of Transkei. Since there was evidence that the prevalence of STDs varied remarkably between the urban and rural areas of Transkei, the stratification of the sampling was deemed necessary.

With simple random sampling from a single framework, chances were that no clinic from either of the two urban districts would have been selected, resulting in the under-representation of urban STD-suffers in the final sample and a distorted reflection of the phenomenon under investigation. The sample framework for the first phase of sampling consisted of the districts of Umtata and Butterworth on the one hand, and of the 26 remaining districts on the other hand. Though Butterworth and Umtata are districts consisting also of rural

areas, sampling was done in the municipal areas only.

In Butterworth there are three health clinics in the municipal area,one of these were randomly selected. The names of the three clinics were written on three small pieces of similar papers, folded, placed in a tin and shaken.
Thereafter one piece of paper was randomly selected and Msobomvu clinic represented the urban clinics of Butterworth. There are three clinics in the Umtata urban area. A similar procedure of random sampling was adopted for Umtata urban area and Stanford terrace clinic was selected. Butterworth and Umtata formed the first (urban) stratum.

The second (rural) stratum was made up of eight districts and was randomly selected according to the population size to ensure that small, less densely populated districts stood an equal chance of being selected as larger, more densely populated districts. The sample framework for the second phase of sampling consisted of the names of clinics in the eight districts that were selected from the rural stratum during the first phase of sampling. Eight clinics were selected from the following districts:

	DISTRICT		CLINIC
1.	Lusikisiki		St. Elizabeth
2.	Elliotdale	-	Elliotdale clinic
3.	Kentane	-	Tafalofefe clinic
4.	Maluti	-	Maluti health centre

5. Cofimvaba - Ncora
6. Tabankulu - Zulu
7. Bizana - St Patrick clinic
8. Mqanduli - Zitulele clinic

The combinations consisting of five digits each in the table of random sampling numbers (Byrkit 1987: Appendix D-2/Tables) were used to select the districts. Combinations consisting of two digits each in the table of random numbers by Byrkit were used to randomly select health clinics.

The third phase of sampling concerns the selection of suitable respondents at the various health clinics. For practical, financial and time considerations the interviews were conducted with the first 15 visitors who were

1. brought to the attention of the interviewer at the selected health clinics and, in addition, who were
2. between the ages of 15 and 30 years old,
3. clinically or positively diagnosed by a doctor or professional nurse as suffering from STDs, and
4. were willing to give their consent to take part in the study.

Information was gathered from the 30 STD sufferers attending clinics in urban areas and the 120 STD sufferers attending clinics in rural areas of Transkei. This would give a valid and reliable wide range of geographic, demographic, socio-cultural and socio-economic factors and the perceptions,

knowledge, attitudes and practices regarding STDs among the population, which was defined as adolescents and young adults in this study and who are at risk of contracting STDs.

3.2 THE INTERVIEW SCHEDULE

A structured interview schedule was used for the data collection. Variables were operationalised on the highest possible level of measurement with a view to the explanatory and analytical purpose for which it was intended.The instrument consisted of closed and open-ended questions. The variables and their values were precoded for all questions except for the responses to open-ended questions which were grouped together according to differences and similarities and post-coded. The interview schedule gave an account of:-

1. biographic details of the respondents;
2. respondents' sense of morality and moral values,
3. relevant aspects of respondents' sexual behaviour,
4. respondents' socio-cultural beliefs, perceptions, general knowledge, attitudes and practices regarding STDs,
5. the illness behaviour and care-seeking behaviour of respondents, especially patterns, preferences as regards the treatment of STDs,
6. the geographical factors,
7. provision of health services,

The interview schedule was preferred to other methods of collecting data for this study for various reasons. The interview schedule is precise and direct; it is not time

consuming like the in-depth interview for instance; it is controlled , inclusive and exhaustive. Because of its structure it yields answers that are easily quantifiable and easily coded with less errors. Questions are asked without rephrasing when one is interviewing the next respondents as is the case with unstructured interviews. The interview schedule has more chances of full participation than some methods such as the mail questionnaire.

Questions for the interview schedule were derived from the literature reviewed. The literature was reviewed on the following areas:-

1. Geography and health.
2. Demographical influence on STDs.
3. Sexually transmitted diseases.
4. Sexual behaviour.
5. Socio-cultural , knowledge , practices and beliefs about diseases and STDs.

Other questions were extracted from the questionnaire on AIDS by Mathews et al.(1990:160). Questions on health beliefs were derived from a health belief questionnaire by Mkumatela (1986)which is a 16 item test designed by Dressler to determine if respondents were aware of health belief statements.

Since the mother tongue of all respondents is Xhosa, the interview schedule was translated into Xhosa. It was crucial that the information obtained from various respondents was

standardised and comparable. Several misinterpretations and misunderstandings could have resulted from the free translation of questions by interviewers. To avoid this it was considered methodologically necessary to formally translate the interview schedule into Xhosa. The translated interview schedule was sent to the Professor of African Languages at Vista University in Bloemfontein for test of relevance in cross-cultural African aspect. It was also pretested and evaluated by the provincial health educators and professional nurses in Bloemfontein for suitability of the interview schedule in the collection of data, after which certain questions were restructured.

3.3 TRAINING OF INTERVIEWERS

Nurses were trained in the techniques and skills of interviewing individuals at their health clinics by the researcher during the delivery of the interview schedules to the selected clinics. The interviewing process in the health clinics took ten days. The training of interviewers took one day in each health clinic. The training placed emphasis on objectivity as against subjectivity in asking questions that the interviewer could judge as sensitive. It was emphasised that the interviewer should ask questions as written on the interviews schedule.It was emphasised to the interviewer that if they changed the wording of the question,it would distort the response and render the study invalid.Interviewers were asked to write the responses verbatim without alterations.

In the process of training,the interview schedule was read in the presence of the interviewer.In the health centres where there were patients with STDs practical demonstration was done by the researcher. The researcher interviewed patients in the presence of the interviewer where there were patients with STDs. Interviewers were told not to be judgemental about the respondents' answers. Interviewers were also warned about the non-verbal behaviour of both themselves and the interviewees as these may cause the respondents to distort the truth. The interviewers were urged to create a friendly situation that would make respondents comfortable even when asked sensitive questions. Nurses, because of the type of the work they do every day which also involves interviewing, did not find training difficult to understand. Moreover, nurses are used in interviewing patients about their medical history which makes them the best people to ask sensitive questions without distorting the appropriate response. Nurses could be trusted to do good work during their interviews. The guidelines in the training of interviewers were found in Ross & McNamara(1981).

In addition to the training they were given a guideline to the diagnosis of various types of sexually transmitted diseases to refresh their knowledge about the signs and symptoms of STDs. The guideline was formulated by the researcher using her nursing professional background as well as the guideline used by Dangor et al.(1989)in their study done in Carletonville Clinic in the Transvaal.The name of the guideline was "THE

DIAGNOSTIC SET", and this was the name given by the researcher to render it authentic.It was written in the following way

1. The inguinal lymph nodes that are discreet, bilateral, rubbery and non-tender are taken as relatively one feature in establishing diagnosis of chancre.
2. Multiple, deep, painful lesions with sloughy, distinct red margin and the incubation period of less than seven days are a sensitive indicator of chancroid infection.
3. Urethritis, mostly amongst men, is diagnosed by burning micturition (urination) after incubation period of one to two days. Burning micturition is also a diagnostic measure for women.
4. Discharge from genital organs served as another indicator associated with sexual contact within a known period preceding appearance of signs and symptoms. Pussy discharge from the penis (commonly known amongst patients as drop) is diagnosed as a gonococcal infection. While in women lower abdominal pains and yellowish purulent discharge are associated with gonorrhoea.

Nurses who were interviewers were not restricted to these guide-lines, they also used their own knowledge in diagnosing STDs. However, diagnosing other STDs was not easy, since they needed sophisticated laboratory techniques and skills which were not available for this study.

3.4 DATA COLLECTION

Data was collected between the 20th of June 1993 and 25th of

July 1993. The data collection process took a long time, because patients in some areas were not coming in large numbers to the health centres. In the clinic in Umtata municipal area, where the researcher herself conducted interviews, patients were coming to the clinic at the average of five per day. The collection of data took strictly three days. The delay in collecting data in other clinics might have been caused by various reasons, amongst others the fact that patients were deciding themselves to visit the clinic was an important one. In areas where patients tried somewhere else before they visited clinics, data collection was markedly delayed. These were the areas characterised by low incidence. Not all the interview schedules were completed, four interview schedules were not fully completed and were taken as spoilt and discarded. This occurred in two different clinics in Maluti and Elliotdale.

The researcher managed to supervise the interviews once a week by visiting one health centre. Nurses in all the clinics complained that the questionnaire was too long. In some cases nurses had to beg patients who got bored half way through the interview schedule to complete it. This emphasises that the problem of administering long interview schedules by un paid interviewers is problematic and may lead to errors.

The researcher also observed that the interview together with treatment of patients took 20 to 30 minutes. This delayed the nurses, the patients interviewed and other patients who were

waiting to be attended to, since the professional staff are few in these health clinics and they attend to various other general health problems.

3.5 DATA ANALYSIS

Computer services of the University of Transkei was used to process the data. First, all data was used to describe the sample in terms of biographic characteristics and to judge what the sample represented . The statistical package used for the data analysis was the Statistical Analysis Systems programme. The methodological and the sociological requirement of this study were checked and controlled by experts in the Department of Sociology at the University of Orange Free Sate. The data processing and statistical analysis were controlled by the statistical analysts of the computer centre of the University of Transkei.

To give clarity on the statistical method used, the following, are mentioned: Under correlation analysis, Pearson'S correlation co-efficient was used, as this method would give better relationship in case of attitudes and behaviour variables in accessibility of health services. On measures of central tendency,means of certain variables and variability in distributions were processed. Cross-tabulation and frequencies were done.

3.6 LIMITATIONS OF THE STUDY

This study had its own limitations. It was targeted at young adults in Transkei within the age range of 15 to 30 years. This age range left out other sexually active adults beyond this age group. This limitation was guided by literature reviewed, which indicated that STDs are prevalent mostly amongst adolescents and young adults (Kim et al. 1988; Smith et al. 1988). A small sample was decided on because of lack of funds.

The study could not do serological investigations, which could have confirmed diagnoses, because of lack of facilities for such procedures. There was no chance of clinics in rural areas doing laboratory tests. Even if they could have been done for in urban areas, it meant that more arrangements for blood tests, discharge swabs and culture of these were needed. This would have involved hospital laboratories and use of laboratory material and staff. This would have involved a lot of money for transportation, payment of the staff, which was not available for this study.

The study was fitted within theoretical and conceptual frame works such as:

1. the social constructionist approach;
2. the reasoned action theory;
3. sexually transmitted diseases'review;
4. sexual behaviour;
5. geographic influence on health and accessibility to health centres;
6. demographical influence on STDs and health;
7. the socio-cultural factors , knowledge , beliefs and practices.

The theoretical perspective of this study is found in the next three chapters, i.e chapters 2,3 and 4

CHAPTER 2

1. DISEASE AND ILLNESS AS SOCIAL CONSTRUCTS

The biomedical model, although forming the cornerstone of modern medicine, is subject to increasing criticism. Such criticism regards the prevailing medical model as too limited in its approach to health and disease. Through critical, pragmatic approach, the specific etiology or monocausal model of diseases which was associated with the germ theory for a long time has now been replaced by the multicausal model (Morgan et al. 1985:20). Recognition of the pervasive effects of social and psychological factors on disease and health has not only influenced the epidemiological study of the causes of diseases, but also resulted in broadening of definitions of health to encompass social, behavioural, cultural, emotional, and similar non-organic elements (Morgan et al. 1985:21).

The social constructionist approach as one of the critical theories directed to the monocausal model of diseases focuses on the way sufferers make sense of their bodies as opposed to the germ theory. The emphasis is placed on examining the lay interpretative process within the context of lay knowledge and beliefs. This approach, rather than treating health beliefs as idiosyncrasies, emphasizes their logic and integrity in the understanding of disease etiology. Social constructionism takes the view that disease labels are social

constructs. This conceptualisation is based on the view that for most people concepts and ideas about the diseases are not only those of scientific medicine. Such ideas and concepts about diseases, although they may be borrowed accurately or inaccurately from those formal systems of knowledge belong to the logic of ordinary people. The lay people's experience, socialisation and immediate social networks shape and continually develop people's notions of health and illness which differ to that of the scientific medical knowledge (Morgan et al. 1985:28).

Social structure is the relatively stable ongoing pattern of social interaction. In most societies there are recognisable patterns of interaction that are appropriate to different social structures and social relationships. Behaviour in these relationships is regulated through a number of mechanisms, including social control and shared cultural values. Failure to understand health and illness within their cultural and social relationships may lead to total disarray, because both scientific and non-scientific ideas about them are the results of social construction (Freund & McGuire 1991:5).

Therefore, social and medical discriptions, are social constructions in that they include some information and exclude other information. Social constructionism makes clear that ideas of the body, illness, diseases and health are socially constructed realities that are subject to social bias and some forms of limitations. Some forms of limitations are

noticed in the biomedical assumption of mind-body dualism. The medical model assumes a clear dichotomy between the mind and the body. This view locates physical diseases solely within the body (Freund & McGuire 1991:6). Because of this dualism biomedicine tries to understand, and treats the body in isolation from other aspects of the person suffering. The physical reductionism of the biomedical model excludes social, psychic and behavioural dimensions of illness and health. This approach ignores social conditions contributing to illness or promoting healing.

Social constructionism accuses reification of diseases of having delayed the development of the multicausal model of diseases. Reification of diseases means conveniently forgetting the social process by which the concept of disease is produced. It means denying the social meanings embodied in symptoms, diagnosis and therapy. Reification of the body results in an even greater dehumanisation because of the closed connection between the body and identity. The clear picture of reification of diseases is seen when a practitioner fails to acknowledge that a diagnosis or medical disposition is a human creation. The diagnostician constructs a disease identification from an assortment of ambiguous signs and symptoms. Furthermore these signs and symptoms are explained and seen by human beings and their processes and interpreted in the context of human evaluation of the patient's social, psychological and physical conditions (Freund & McGuire 1991:5). For instance, diagnosis of an AIDS victim is sorted

from ambiguous signs and symptoms which are explained by human processes and interpreted in the context of social, psychological as well as physical conditions. (This really means that disease is a social construct.)

Diagnoses are products of social interaction. They must be seen to be liable to bias and misconception of both health practitioners and community. It would be an error if the reification of diseases assumed primacy, more especially if it conflicts with the patient's subjective illness experience. But in most practical medical situations reified, disease is often treated as more real than the sick person's feelings. In some cases patients internalise these images of their bodies and diseases. This image in turn shapes even their self perception, experience and perception by both significant and generalized others in the community (Morgan et al. 1985:64-74).

The ideological function of reification of disease and the body is a result of an emphasis on individualistic rather than social or political responses to diseases. The emphasis that is placed upon disease as an object that occurs within an individual produces a tendency to locate responsibility for illness in the sufferer only. This is one form of blaming the victim. In some cases of illness the person is assumed to be responsible for having taken health risks. For example, in many publications AIDS victims have been associated with some kind of promiscuous behaviour. AIDS sufferers are indirectly

held accountable for unhealthy life styles (Morgan et al. 1985:36).

Blaming- the- victim approach to diseases as the condition of the sick often depoliticises illness causation in that political influences are never considered in disease causation. It further obscures awareness of the social context of the sick person's needs to be taken into cognisance by diagnosticians. Victim blaming and other social constructs result in stigmatisation of other diseases. Some diseases carry negative connotations or stigma; these negative attitudes towards certain illnesses could be worse than the condition itself (Morgan et al. 1985:64-74). This means that what is socially constructed about a condition could bring outright discrimination. For example, a person suffering from epilepsy may entirely avoid being socially identified as having the disease, because of the stigma epilepsy has. This reaction to epilepsy could also delay medical help and proper control. It appears that the source of the stigma is not the disease, but rather the social imputation of negative connotations. This shows that disease and illness are social constructions and how they can be treated largely depends on the social networks of their constructions. They could be properly controlled, treated and prevented only if their social fabrics are known and clearly defined for loosening in order to weaken the social network of their constructions.

2. THE THEORY OF REASONED ACTION

The theory of reasoned action offers one approach for explaining an individual's behaviour and intention to engage in certain behaviour. This approach also supports the view that the medical, monocausal model alone cannot succeed without considering other aspects surrounding the disease. This theory further explains people's ways of changing their behaviour towards health oriented behaviour. For example, omission of such explanation in understanding of disease causation, treatment and control is like continually pouring water in a bucket with multiple small holes which will attract the actor's attention after a long time of effort to try to fill the bucket. Among other aspects surrounding the disease, attitudes, knowledge and beliefs have been acknowledged or observed through various studies as most influential in disease control (Ajzen & Fishbein 1980:65).

Ajzen & Fishbein (1980 :65) define an attitude as "a disposition to respond positively or negatively to an object, person, institution or event". Attitude, by definition refers to something identifiable. To have an attitude therefore requires some degree of conscious awareness or knowledge of the object . An attitude also implies some kind of feeling of like or dislike towards an object. For instance these feelings may under certain circumstances give rise to behavioural response - approach or avoidance towards the object.
The main reason , attitude is closed together with beliefs is

the possibility of utilising them as the more conveniently available substitute for behavioural phenomena (Ajzen & Fishbein 1980:62).

Attitudes are spoken of as hypothetical constructs that can be inferred from observable responses that show or reflect positive or negative evaluation of the attitude object. These observable responses may be of three kinds, mainly cognitive responses or beliefs, affective responses or feelings, and behavioural intentions and its tendencies (Ajzen & Fishbein 1980).

For instance, an individual's attitude towards sexually transmitted diseases (STDs) may be inferred from feelings towards STDs one expresses while discussing them, and this marks one's affective component. If one in one's statements makes seriousness of STDs as a health problem, this marks a cognitive component. If one for instance does not want to use the condom or visit a clinic, this marks one's behavioural reaction or conative response. Like many other instances of social discourse one's verbal reports regarding one's feelings, beliefs, plans or intended behaviour are used as common basis for one's attitudes. The theory explains that beliefs representing people's subjective knowledge about themselves and their world are determinants of attitudes.

Each belief links the attitude object to a positively or negatively valued attribute. Generally speaking the greater

the number of beliefs associating an object with positive attributes, the more favourable will be the resultant attitude towards that object. According to reasoned action theory, individuals are more likely to engage in health behaviour if such actions are seen as instrumental in achieving desired consequences and are considered worthwhile by persons or groups the individual wishes to please. Therefore, it means that some variables that influence health behaviours are mediated through attitudinal and normative components of individuals. Hence it is worthwhile taking these into consideration in the treatment and control of STDs.

3. SEXUAL BEHAVIOUR

Sociologists regard sexual behaviour as part of social action, because it does not only influence, but in turn is influenced by the factors. Often it interferes with other social behaviour and supplies a motive for action (Jones 1991:65). Jones explains that sociologists have talked of an eroticised role by which they mean that people possess social roles such as lover, wife, prostitute, etc, which have a heavily sexual element embedded in them together with economic or effective exchange. He further explicates that the work of many researchers has provided strong evidence that although sexual behaviour may be biogenic in origin, the particular aspect adopted by persons in order to achieve sexual gratification is socially learned. Socio-economic inequalities influence sexual behaviour amongst certain groups in society.

This is a point noted by Aral & Holmes (1991:18) that the swiftness of demographic, economic and political changes in populations result in a social situation in which the level of transience and marginality is high. Conditions of marginality reinforce exchange based on socio-economic inequality such as prostitution, which changes sexual behaviour. Prostitution has always been most common in settings characterised by poverty, social disintegration and double standards of sexual behaviour. Prostitution emerges as an adaptive response that helps people acquire money, power or pleasure that would otherwise be unattainable, yet an activity that can enhance spread of STDs (Aral & Holmes 1991:18).

Sexual behaviour is closely associated or connected with physical and biological developmental characteristics of individuals. This is a point also noted by Grant & Demetriou (1988:1276) that early pubertal development is associated with early initiation of sexual activity. Hormonal influences may be responsible for early sexual motivation and behaviour for both girls and boys. Early pubertal development in girls is associated with greater heterosexual interests and behaviour, more concern with personal, physical appearance and lower self-esteem. The connection between sexual behaviour and an individual's physical and biological development emphasizes the great need of clear understanding of the interrelationship of physical changes, sexual activity and social influences. It also brings forward and marks the earliest opportune timing for implementation of sexually related health education for

the youth. Therefore understanding sexual behaviour of adolescents can yield to the understanding of issues surrounding their sexual and physical development and their knowledge of their sexual practices in the process of controlling STDs. It means also that sexual behaviours that are risky can be assessed by watching pubertal changes and their impact on individuals.

From puberty individuals grow towards identity and independence which involve the separation from the family. Yet it is the family that usually provides the necessary moral and ethical foundation on which to build one's acceptable sexual behavioural codes (Grant & Demetriou 1988:1277). The suggestion here is that if individuals have been missed at puberty there is another chance to get them at the stage of seeking identity which seems to be a critical stage, as is the stage of coming out of parents' control, joining peer groups and their pressures. However, it appears that there may be a problem in the timing of seeking self-identity since Grant & Demetriou did not come up with markers or time of self-identity. Nevertheless, their work helps to identify the most important time of starting sex education. This means that sex education should start just before puberty and at puberty sexual behaviour must be modified towards maintenance of sexual behaviours that have lower risks of both STDs and teenage pregnancy. It would appear that STDs' control measures should be intensified from puberty stage so as to capture the stage of self-identity and independence of adolescents.

According to Grant & Demetriou (1988:1277), families in which there is mutual closeness, consistency of values between parent and children, and an intact family structure are more likely to have adolescents who delay sexual activity. The relationship of family communication to sexual behaviour seems to vary with the gender of parent and child. Grant & Demetriou (1988) explain that it has been found through various studies conducted that mothers appear to be effective in delaying sexual activity if they counsel their sons, while fathers appear to promote it. On the other hand, sexual discussion with daughters by either parent do not seem to delay sexual activity. This means that understanding of both parents' values about sexual issues is important as these would later influence the adolescents' sexual behaviour and their sexual behaviour through-out life and their sexual behavioural values. Parents therefore should have similar sexual behavioural values so that they instil the same values to avoid confusion around sexual issues for adolescents who are also subjected to peer groups' sexual behavioural norms.

Some studies done in North America by Grant & Demetriou (1988) and Friedman (1989) found a positive correlation between having sexually permissive friends and being sexually active. Peer influence varied with gender, race and age. Whites, according to these studies, tended to be more influenced by peers than blacks, females more than males, and adolescents more than older ones. Boys sought peer support for decision, while girls were influenced by what they perceived as their

female peers' sexual activity. However, it was their male partners that they relied on for sexual decisions. Young, sexually active girls were more likely to engage in sexual behaviour to please their boyfriends without actual enjoyment of sex. This may mean that screws for acceptable and health related sexual behaviour should be tightened more amongst boys, since girls' sexual decisions seem to be more influenced by them.

Human sexual behaviour is also on the other hand heavily determined by culture. Widdus et al. (1990:177) observed that it is the society in which people live rather than people themselves that determine who may have sex with whom, where, when and how. Widdus et al. (1990:172) explain that cross-cultural studies of human mating systems around the world show that of the 849 societies studied, 84% were polygamous. In the same studies it was discovered that each man and woman in Western countries will probably have more than one sexual partner in a life time. It was discovered that the average man is likely to have more than one woman sexual contact. Although at any one time a man is likely to have one woman, such relationships most often break, leading to many successive sexual relationships being formed.

Viewing culture and its relationship to sexual behaviour Grant & Demetriou (1988:1281) clarify that expectations related to males' and females' sexual behaviour are present even before one is born. The awareness about these allows for later

dialogue or expression of individuality. For Grant & Demetriou use of appropriate or real names for penis, clitoris, vagina, etc. during the upbringing of children makes it easier to facilitate discussions as the child grows older. However, sexual activities vary with different cultures. For example, in other cultures use of appropriate names for penis, clitoris and vagina is prohibited or a taboo. From experience amongst my own ethnic group and many other ethnic groups in Transkei, real names for penis and vagina are prohibited. As a child one is punished whenever one is heard calling real names for these reproductive organs. This may mean that since the use of such names is prohibited, presumably, sexual behaviour is not developed well, but develops under clandestine, stringent distorted circumstances. It is no wonder then that today teenage pregnancy and STDs' prevalence have reached alarming levels according to health statistics of this country (Transkei Health Statistics 1990).

Sexual partners tend to choose partners with similar sexual behaviours. Women tend to choose sexual partners having a similar rate of partner change as themselves. Women with a low rate seem to choose men who also have a low rate. While women with a high rate of partner change, to a larger extent seem to prefer high rate partners. When women choose steady partners, they tend to do so from the same sexual activity group and social class as themselves. The classification of a relationship as a steady or casual one is the individual's definition (Campbell & Baldwin 1991:1137-1140; Herrero et al.

1990:384; Stone 1990:791-792). This means that choice of partners and rate of changing partners may influence the risk of contracting sexually transmitted diseases.

Behaviour patterns could potentially contribute to the differences in STDs' rates among sexually active groups. In a study done by Stone (1990) in the USA it was found that differences in sexual behaviour could cause differences in frequency of sexual contact, sexual practices or numbers of partners. It was also discovered that care-seeking behaviour could influence STDs' rates because of those who are not treated promptly and are likely to infect others. Knowledge about sexual behaviours within populations is critical for both monitoring of disease transmission and targeting specific health education messages. But the concept sexual behaviour becomes complicated because it involves many variables. These variables encompass current and life-time number of sex partners, age at first intercourse, frequency of intercourse, inconsistency of sexual activity, mode of recruitment of partners, and duration of sexual unions. However, the distribution of these in the population determine aggregate exposure to the risk of contracting sexually transmitted diseases (Moran et al. 1989:560-564).

There could be significant differences between the sexes in terms of sexual behaviour and related attitudes. Residences could also influence sexual behaviour. Grant & Demetriou (1988:1281) explain that adolescents exposed to socio-economic

disadvantaged areas present with different patterns of behaviour and sexual attitudes from suburban adolescents. The sexual issues that both groups are handling are the same. It is only their response to them that varies. This means that one responds to sex in accordance with one's background, beliefs, norms and attitudes . This further means that perhaps prescription of standard sexual behaviour based on positive health related attitudes would play a major role in the control of teenage pregnancy and STDs world wide, rather than depend on various attitudinal and cultural stipulations. However, since this may not be practical because of various political and social factors, it seems important that for communities' health intervention strategies, values and attitudes of a community in which they are implemented be integrated to maximize effectiveness.

It is clear that there is a relationship between the social network, the culture and the sexual behaviour of any individual. This suggests that there is a link between sexual behaviour and the risk of contracting STDs.

4. SEXUALLY TRANSMITTED DISEASE: A REVIEW

Communicable diseases are due to specific infectious agents or their toxic products. Such diseases develop after transmission of these agents or their toxic products from infected persons or the reservoir to the susceptible host either directly or indirectly. Communicable diseases may occur as sporadic cases,

outbreaks, epidemics or endemic. The control of these diseases depends on the effective intervention in the relationship between agent and host (Farmer & Miller 1983:129-140). Useful preventive action does not necessarily require knowledge of etiology (Farmer & Miller 1983). Full understanding of the causes of diseases and factors that determine causal relationship need to be identified in order to construct appropriate preventive and control programmes. Epidemiological studies are used to identify the agents and those elements in the environment, in peoples' behaviour and personal characteristics which are the key determinants of the natural history of diseases (Farmer & Miller 1983). Prevention of communicable diseases depends on a complex combination of interventions many of which demand the personal initiative of potential sufferers (Cates 1989). Understanding people's social and geographic environment could play a major role in the control and prevention of diseases.

At least 25 distinct diseases can be transmitted by sexual contact. The most important are gonorrhoea, chlamydia, chancroid and clinical syphilis. These used to be the most important ones before the appearance of AIDS, because of their prolonged course, widespread incidence and their serious effects on human systems and social stigma. The spirochaete treponema pallidum that causes syphilis is a delicate organism that is sensitive to antibiotics. Syphilis has for the most part been successfully controlled. However, it continues to be seen among promiscuous, homosexuals and heterosexuals (Brandt

1988:375-380). Gonorrhoea is highly infectious and control is difficult for several reasons. Gonorrhoea is more common and widespread in homosexual promiscuity, especially among young people. The use of the contraceptive pill is said to be increasing the risk of transmission because there is no mechanical barrier to the gonococcus as would be the case with condom use. Moreover, the vaginal mucosa may be more hospitable to gonococcus when it is influenced by the hormonal changes due to the pill (Nathanson et al. 1984:1-24).

Gonorrhoea is most commonly transmitted by some form of sexual contact. This acute disease is manifested by purulent urethritis in the male and may not be associated with symptoms of urethritis or vaginal discharge in the female. Thirty percent of females with positive cultures and physical findings who have gonorrhoea are asymptomatic (Nathanson et al.1984:1-24).

The spread of gonorrhoea has been favoured not only by behavioural and cultural practices, but also by changes in Neisseria gonorrhoea. The most significant adaptation of the organism has been its evolving resistance to antimicrobial agents, resulting in an unacceptable clinical failure rate with conventional therapy in many areas of the world (Nathanson et al. 1984:7). Many epidemiological studies were done in 1976 when strains of gonorrhoea with plasmid-mediated resistance to penicillin were observed. These strains produce a beta-lactum hydrolysing enzyme and have been named

penicillinase-producing Neisseria-gonorrhoea. These are the strains that are responsible for non-controllable gonorrhoeal infection amongst many sufferers of this disease (Nathanson et al. 1984).

The epidemiology of gonorrhoea can be fully understood only by appreciating the diverse clinical presentations of gonococcal infection. The variety of clinical syndromes complicates diagnosis, their therapy and reporting of disease. For example in the United States gonococcal infections are reportable while complications often due to gonorrhoea such as pelvic inflammatory disease are not reportable (Nathanson et al. 1984:14). Symptomatic uncomplicated gonorrhoea typically presents as purulent urethritis in males. Gonococcal urethritis in males usually causes urethral discharge with dysuria and sometimes urinary frequency. The vast majority of infected men become symptomatic within two weeks of exposure, but a small proportion of men will not notice symptoms. In women the usual sites of infection by Neisseria gonorrhoea include the cervix, urethra, rectum and pharynx in decreasing frequency. The clinical manifestations of genital gonococcal infection in women are surprisingly poorly defined. Gonococcal infection has been correlated with certain symptoms and signs for example dysuria and cervical discharge. However, in some females, sexually transmitted diseases, with mucopurulent cervical discharge was found to be correlated with cervical infection by C. trachomatis but not by Neisseria-gonorrhoea (Nathanson et al. 1984:1-24).

Another STD of growing importance is chancroid (Aral & Holmes 1991:20). In Africa this infection is the most common cause of genital sores (Nathanson et al. 1984:1-24). It has always been strongly linked to prostitution and to sex with prostitutes. Studies showed that genital ulcers in prostitutes and in male STD patients were associated with a greatly increased risk of sexually acquired HIV infection. In the USA chancroid had been rare during World War II. In 1984 a series of outbreaks began to appear in the innercity and migrant labour populations of Los Angeles, etc. This increase could have profound public health consequences because chancroid may facilitate HIV transmission. Worse still, the bacterium that causes chancroid has developed resistance to many antimicrobial drugs. In persons who have been exposed to HIV, chancroid often fails to respond to some therapies that are otherwise highly effective. Thus, HIV infection may help the spread of a bacterial STD that in turn helps to spread HIV (Aral & Holmes 1991:20). In a study done by Dangor et al.(1989) in Carletonville(South Africa) amongst 240 migrant workers attending STD clinic it was found that chanchroid was the most common cause of genital diseases; of the 240 mine workers 68% had penile sore. Out of the 68% of penile sore found , 3% in the sample were from Transkei.

Chlamydia trachomatis has become far more common than gonorrhoea, syphilis or chancroid. It is also a much more important cause of reproductive health problems in women. Like gonococcus, chlamydia usually causes infection of the urethra

in men and of the cervix in women. If the infection ascends into the uterus and Fallopian tubes, it can cause abnormal bleeding, vaginal discharge or lower abdominal pain. Even in the absence of symptoms, scarring of the Fallopian tubes can cause blockages and sterility (Aral & Holmes 1991:20).

Unlike gonorrhoea, chlamydia infection commonly occurs in all racial and ethnic groups, and in all socio-economic classes. Young and older women using oral contraceptives seem to be more susceptible than others to acquiring chlamydial infection of the cervix if they are exposed. It has been noted clearly that asymptomatic chlamydial infection is much more common in men and women than asymptomatic gonorrhoea. It is common to find silent chlamydial infection of the cervix in up to 5% of middle class pregnant women and female college students (Aral & Holmes 1991:20). In two military studies silent chlamydial infections of the urethra were found in about 10% of healthy young men (Aral & Holmes 1991:20).

There are various factors which are related to the perseverance of sexually transmitted diseases (STDs) in communities of various countries. Amongst these factors the perception that sexually transmitted diseases, amongst other diseases, is strictly a medical problem is taken as the one that delayed the extinction of these diseases amongst many communities (Freund & Mcguire 1991). The problem of STDs could have been thought of as a social problem with very significant medical risk. The preconceived view that STDs is a strictly

medical problem has directed forms of treatment and control of these diseases to individuals affected, isolating them from various related factors; Such an approach delayed research of empirical knowledge about the extent to which other people perceive themselves to be at high risk for contracting STDs and are changing their behaviour to reduce their risk (Cates 1989).

Before the appearance of AIDS the primary strategy used to control the spread of STDs among young adults relied on secondary prevention; primary prevention efforts have been to lesser extent. Treatment and contact tracing have been the most widely used containment strategies reflective of secondary prevention. The inadequacy of these strategies is reflected by the increasing rise in the prevalence rate of STDs in many countries. This inadequacy also has been observed by other medical authorities in the prevalence rate of STDs in many countries (McGregor et al. 1988:110).

The changing nature of STDs infection has invited focus on primary prevention of these diseases. This means that the focus now is directed on preventive measures rather than concentration on curative measures. This emphasis on primary prevention strategies has important implications for providing health care to young sexually active adults. It also stresses increased attention to existing health intervention.

Development of these interventions could be aided through

knowledge about how countries are responding to the broader issues of STDs and the current AIDS epidemic.

Mechanical and chemical barriers protect against most STDs. Barrier methods of contraception include condoms, diaphragms and vaginal spermicides. Any mechanical barrier that remains intact and prevents genital contact with infectious agents should reduce risk of STDs. Vaginal spermicides provide chemical barriers that protect the cervix and vagina, provided that adequate volumes are properly dispersed. Some barriers that contain or are used concurrently with spermicide provide both mechanical and chemical protection (Stone 1990:772).

Sexually transmitted diseases have been of major concern in the public health field for many years. Nevertheless, the incidence of these diseases has seldom been evaluated prospectively from population-based data. Although the surveillance systems adopted by different states or countries report incidence rates for syphilis and gonorrhoea, numerous surveys have shown that these official reports underestimate the true incidence of STDs (Alary et al. 1989:547). Treatment and prevention of STDs are problems of contact tracing. Steingrimsson et al. (1990) also observed that treatment regimens currently recommended for STDs have major shortcomings and drawbacks. These drawbacks are caused by patients' non-compliance with multiple-day regimens and increased resistance of Neisseria gonorrhoea to penicillin and other drugs.

McGregor et al. (1988:110) on the other hand explain that recent studies done in the USA, as well as of the infectious diseases have revalidated Smith's original conception of the determinants of infection and the means of preventing it, which is as follows: Infection = inoculum x virulence.

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host defenses

McGregor et al .(1988) further suggests that if one employs these relationships, the prevention of STDs becomes ultimately a function of (1) eliminating or reducing exposure to infectious agents; (2) reducing inoculum; (3) encumbering virulence factors; (4) bolstering host defences or (5) a combination of any of the above. He emphasises that research imperatives that follow along these lines and include new behavioural, microbiological, immunological and even marketing approaches to STDs prevention could do much in the promotive and preventive strategies. Some examples of putting Smith's principle to work in prevention of STDs include: (1) careful consideration of the number and nature of one's sexual contacts; (2) use of barrier methods of contraception such as condoms with spermicides; (3) use of antigonococcal and antichlamydial preparations in order to prevent ophthalmia neonatorum, etc.

Abstinence is the only preventive method that is 100% effective for preventing STDs. The definition of the term abstinence may vary among persons using it with reference to

sexual activity. Often the term is used to connote avoidance of any sexual activity rather than specific avoidance of penetrative genital, anogenital or oral-anogenital contact. Although oral-genital contact may result in transmission of several STDs, other sexual activities that do not include direct genital and anogenital contact generally should not result in disease transmission (Stone 1990:791). Although prevention of STDs by way of selection of sexual partners and restriction of sexual activities is the better attitude towards behaviour change, it has its own problems. Stone (1990) explains that limiting the number of sexual partners is likely to reduce infection, is a simplistic conception. Limiting sexual activity to one partner will ensure freedom from STDs transmission only if both partners are uninfected and the sexual relationship remains mutually faithful. Because STD risk may be determined more by the behaviour of the man than women's behaviour, it is not surprising that many women who report monogamy are infected with STDs.

5. AIDS

During the 1980s the Acquired Immuno-Deficiency Syndrome (AIDS) emerged as one of the most serious STDs and threat to health all over the world.Africa is one of the severely affected continents. Many African countries have an extremely high prevalence of Human Immuno-Deficiency Virus (HIV) infection in their general population (Mathews et al.1990).

The connection between AIDS and one's sexual behaviour was not properly introduced if one considers the notion of the reification of diseases and stigmatisation by Freund & Mcguire (1991). In handling the AIDS issue, it was stigmatised, as it was associated with prostitutes on TV screens, on health promotion by dancing dolls, which created an impression that it is associated with people with low morals. This is an unfortunate case like many others such as Tuberculosis (TB) which from my own childhood experience was associated with poor people with unhygienic behaviours. Tuberculosis was mishandled and was stigmatised; many people from hospital experience did not like to be diagnosed as having TB. This perhaps could be one of the reasons that explains why TB is still a problem in this country. The same thing can also happen with AIDS, if the tendency to stigmatise it is not stopped.

The stigmatisation of a disease like AIDS could perhaps arise from the fact that a disease is diagnosed by specialists in the medical field who are not specialists in handling social issues and therefore introduce or publicise it to the society in an unskilled manner. In doing so, it disturbs the societies'moral network. Society by its very nature reacts to anything that tries to interfere with its cultural aspects. It becomes highly sensitive more especially to elements that disturb moral codes of behaviour. Such reaction is not unique to society alone; it is common to all other systematic organisations or structures.

It is important perhaps to highlight here for medical specialists that according to Comte's view " society is a system of interrelated parts, it is something more than the mere sum of individuals within it"(Cuff & Payne 1984:26).
For Durkheim " other individuals develop common ways of perceiving, evaluating, feeling and acting. These new patterns of values, perceptions and actions then give rise to expectations and constraints on how persons should or ought to behave" (Cuff & Payne 1984:31). It is important to know and understand the organismic view as this would help to diminish an extensive reaction to a minimal reaction from the society. Society reacts to foreign social elements just as the human body does to foreign chemicals. Referring to personal experience in medical situations, medical practitioners, whenever they introduce a drug and are not sure about the patients' physiological reaction to that particular drug, desensitise the patient. Desensitisation means introduction of a drug in small amounts so as to familiarise the human body with the drug to avoid an extensive reaction that may lead to total collapse and death.

Similar steps are also important and needed for the systematic nature of society. The society also must be desensitised, the process of desensitisation here could take the same medical pattern by slowly encouraging institutionalisation and deinstitutionalisation so as to familiarise the society slowly with new social aspects. The society has its own social networks such as values, beliefs, morals and other

institutions, which analogically are like blood systems, nervous systems, lymphatic systems, etc, of the human body. Medical specialists know which systems are very sensitive to what drug, because of their specialised knowledge about the human body, hence they handle and manage this area well. So it is the case with specialists in social sciences because of their knowledge they know very well which aspects of the society are likely to erupt extensive and strong reactions if foreign social elements are introduced. Hence it is important that they must be given opportunities to handle social issues in collaboration with other fields when need arises to avoid social distortions and non-compliance.

In view of this literature reviewed on sexually transmitted diseases, it becomes clear that in this era of incurable sexually transmitted infections, primary prevention is increasingly becoming important. Primary prevention focuses on avoiding infection, while secondary prevention is prompt identification and effective treatment of infected persons.
Also identification of risk sexual behaviours and risk markers such as biographic, socio-economic, cultural and geographic factors are important in prevention and control of STDs.

CHAPTER 3

DISEASE, HEALTH AND GEOGRAPHY

The topography of a country plays a major part in the transmission, treatment, prevention and control of diseases. This is also a point noted by Ayeni et al. (1987:1083) in a study done in Nigeria, where it was discovered that proximal and distal determinants interact with individuals to produce a variety of health related outcomes. The topography of any country could influence diseases through difficulty in making transportation networks that could make easy access to available health centres. A country that is mountainous gives problems of meeting or extending outreach projects to those in need. Ayeni et al, also observed that accessibility incorporates physical, social and organisational dimensions as barriers to care.

Rosenberg (1988:179) explains that linking of facilities to the spatial distribution of the population at risk is a rational response to designing health care delivery systems in developed capitalist countries. Public health systems in developed capitalist countries have mainly been created in response to the environmental factors related to the spread of disease. With respect to some activities in the community, medical geographers play an important role in linking environmental factors, the pattern and spread of disease and

how a public health system is organised to respond to the linkages identified. Lack of such information in a country may cause problems in the correct pattern of delivering services. Hence the work of geographers need to be consulted by public health planners to improve accessibility and identification of risk populations (Gesler & Meade 1988:443-461).

The inequalities in the distribution of health facilities and services between rural and certain urban areas arise partly because health care facilities are inadequate and partly because the geographical coverage is unbalanced. Governments try to improve the geographical coverage of services because they believe all sections of the populations will benefit from the service if people are closer to it. One common measure of the adequacy of coverage is the extent to which a population is disadvantaged by poor accessibility to health services (Ayeni et al. 1987:1083-1994).

Long distances walked by patients before they reach a health centre and expensive travelling fees can also influence the trend of a disease in any country. The study done by Ayeni et al. (1987:1086) revealed that long distances to services could cause problemsof accessibility. It was also determined that the perception of the quality of service changes the coverage of distances. If people's willingness to patronise health clinics in urban areas that are related to their perception of the quality of the services provided, they visit it despite the distance or travelling fee. By increasing the quality of

service, people travel more for the service. This shows that though topography of a country can influence the trend of diseases through perhaps inaccessibility to health centres, this can be counteracted by improving the quality of service in accordance with people's expectations. Availability of public or private transport affects the health of a community. In the same study it was found that differences in physical terrain, availability of public or private transport and patients' access to alternate forms of transport, such as motor vehicle, bicycle and foot, affected functional distance. This is also a point noted by Gesler & Meade (1989:445).

The concept of neighbourhood cannot be left out in considerations of factors that influence diseases, since it forms a geographical basis for organisation. Kivell & Dawson (1990:701-711) explain that definitions of neighbourhood rely on a broad measure of agreement over the inclusion of area, common ties and social interaction. In any neighbourhood there is a unifying theme in the notion of a cohesive group of people held together by different terms which they share for example territory, work and ideas. Neighbourhood is a little social organisation of a population residing in a geographically proximate locality. This definition includes not only social bonds between members of the designated population but all of the groups' link to neighbourhood as well (Kivell & Dawson 1990:701-711).

Another variable feature of neighbourhood is its areal extent.

With the social sphere the majority of an individual's friends and contacts may be confined to a few immediately adjacent streets. Weaker and less frequent contacts can be spread over a wider area. For understandable reasons analysis of health data, such as social and environmental data should be taken into cognisance by health care policy makers, as these play a major role in influencing disease and illness in certain groups (Kivell & Dawson 1990). This means that reliance upon practising administrative boundaries or statistical units in health care provision without considering meanings of social units cannot solve health and illness problems that are posed by geographical boundaries together with their social network.

Concentration of health services in one area, for example in urban areas, influences the health and illness of people in these areas differently from those living in rural areas, where there are poor to no health services. In a study done in the West Indies it was found that people who stay in urban areas tend to have a different disease picture trend as a result of numerous health services and easy access to these centres, because of availability of private transport, public transport and short distances they walked to health centres, than was the case with those staying in rural areas (Kivell & Dawson 1990).

Resettlement of people in the slums of urban areas influences the spread of communicable diseases. This is a point noted by Kloos (1990:643) in his study in Ethiopian resettlement. Kloos

explains that infectious diseases are commonly introduced and spread in new settlements in different ways: (1) Disease causing organisms and their vectors may be introduced by settlers from their home areas; (2) development activities in the settlements may create favourable conditions for the spread of vectors and disease agents; (3) increases in population density in settlements facilitate the transmission of density-dependent diseases; (4) the physical and psychological stress of the resettlement process, including adaptation to the new environment, tend to predispose migrants to ill health; and (5) deficiency of health services which usually characterizes resettlement areas is a noted factor.

Geographical allocation of medical doctors and their entrepreneuring of medical services influence the treatment and control of diseases (Eyles 1990:157-162). Many private medical practitioners open their services only where there is the highest potential for their business, regardless of the need of their services in other geographical areas. It was noted by Eyles that in poor modestly organised societies or systems there are few trained personnel. The most of these trained personnel are concentrated in national capital cities in primarily private practice. Eyles observed that in most developing countries much investment goes to the construction of sophisticated hospitals in the largest cities, while the majority of the population is treated by traditional healers in rural areas.

In poor, moderately organised systems health care development is given more priority, but there is still concentration of doctors and hospital beds in urban areas. Attempts have been made to establish staff centres in rural areas and some villages also have auxiliary health workers. In poor, highly organised systems, health care is seen as a public responsibility to be assumed by government at all levels. Emphasis is placed on health authorities to improve the delivery of primary health care. In such situations traditional healers are important and attempts are made to integrate them into the formal system of health service (Eyles 1990:158).

The geography of provision and its spatial configuration enable some development to proceed easily, while placing great constraints on others. For example primary health care in such capitalist societies as the USA and Canada is provided by isolated profit-making practitioners whose offices are often located according to the effective demand principle. Such a provision will act as a constraint on attempts to initiate the health for all strategy based on need and use of primary health care teams. It may be an easier task to introduce such strategy in parts of China which have a well developed system and work-based health facilities. In these two cases it appears that the nature of environment and existing spatial patterning of care relations of profit accumulation and geography is an important principle in shaping health system management (Eyles 1990). It must be remembered that there is

no coincidence between level of economic development or type of political structure or method of allocation of services but it is carefully organised planning. It is possible to identify poor countries that use limited principles of central planning and rich ones with a high level of central planning. In practice certain fundamental differences may be found between health care provision in capitalist societies and those with collective provision.

Geography must be viewed as being of significance, because it literally locates the structure of provision and shapes the nature of availability and accessibility of health services, while in turn it influences disease, according to Eyles (1990). He further suggests that geography becomes a significant element in assessing probabilities of systems change and the rationale for theoretically derived systems. Without it, it is like suggesting that service delivery is universally and instantaneously available. Space organisation is necessary to overcome problems imposed by space. It may confound the effects of the economic, political factors and allocational parameters (Rosenberg 1988:179-186).

Political-geographical allocation of people within a country affects disease occurrence, treatment and control. A similar observation has been MADE by Rip & Hunter (1990). In their study done in Cape Town, it was observed that the Group Areas Act has resulted in unequally distributed health services amongst the residents of Cape Town. It was also found that in

the overview, the situation for black mothers in Cape Town was very poor in terms of venereal disease and illiteracy. In addressing the same issue of linking politics and geography in influencing diseases and health care delivery, it was also noticed that there was a health problem imposed by inaccessibility because of faraway health centres.

Rosenberg (1988:182) presents a Marxist view in this regard. He argues that the social and spatial aspects are seen as separate but interconnected theoretical categories. This argument leads to an analytical focus on socio-spatial structures and the key players in the system. The actualisation of this position is through a historical analysis of the system itself, concentrating on the strategies of the key players in the system and how they use space to achieve their goals. Rosenberg's organisational framework , though he uses the term key players, is implicitly class-based. Key players, for instance, if they are professionals, would argue that a health centre be next to the main road for them to reach their homes easily as opposed to the site allocation by the community in the area. Rosenberg explains that specific health outcomes are more determined by the way in which key actors (health planners) impinge upon the technical problem of health service provision than service consumers.

Climate and geography of a country could impose a strong influence on the treatment, control and prevention of

diseases. It was observed by Kloos (1990) in Ethiopia in villages and cities, where man has done much to modify the natural environment it is easy to overlook the importance of geographical factors in the development of community health services. For example, during heavy summer rains in areas where health services are far away and people have to walk long distances people may tend to ignore symptoms. Again, when there are no bridges to cross rivers, people may become reluctant to visit health centres. Patients may not go to health centres on very cold days where they have to walk long distances. Linking location of facilities to the spatial distribution of the population at risk is a rational response to designing health care delivery systems in developed capitalist countries. It assumes that health care delivery systems are designed or should be designed to respond primarily to the spatial distribution of disease. Many public health systems in developed capitalist countries have mainly been created in response to the environmental factors related to the spread of disease. The main activities in public health systems have been to ensure the cleanliness of the water and the development of infrastructure such as sewage and sanitation systems. With respect to these activities medical geographers have an important role to play in linking environmental factors to the pattern and spread of diseases, and how a public health system is organised to respond to the linkages identified (Rosenberg 1988:179).

Relevant literature reviewed on geography shows implicitly

that there is a link between geography and diseases. This link need to be considered in the understanding of diseases, the failure of their treatment , ineffectiveness of control measures and in planning of health services.

CHAPTER 4

DISEASE, HEALTH AND DEMOGRAPHIC/BIOGRAPHIC , SOCIO-CULTURAL AND SOCIO-ECONOMIC INFLUENCES

Social epidemiology is defined as the study of social factors in the etiology of disease,their incidence, distribution thereof and the way these relate to populations and subgroups in specific societies (Van Rensburg 1975:177). This discipline attempts to determine the relationship between life style and living conditions of a population and the health risks to which groups are subjected. The emphasis in this field is on the distribution of diseases among people in their environment and the effect of social variables such as race, sex, age, socio-economic class, residential area and occupation. The focus in social epidemiology is not on the individual and his/her biophysical aspect but on the health problems of large groups of people (Van Rensburg 1975). The study of social variables, also in the causation of STDs, is important since such diseases have become threatening health problems for many people throughout the world.

1. DEMOGRAPHY/BIOGRAPHY AND SOCIO-CULTURAL BELIEFS

Demographic factors have been generally regarded as most accurate risk- markers in the investigation and understanding of diseases. The issue of demographic factors and their influence on the transmission, treatment and prevention of STDs and other diseases were concerns for Moran et al.

(1989:560). Amongst other demographic factors age, more especially young age, is seen as a strong demographic factor in the transmission of STDs. The high prevalence of STDs is most often associated with adolescence. However, sexuality is not unique to the adolescent period but a phenomenon that spans the entire life cycle (Grant & Demetriou 1988).

1.1 AGE

What is remarkable about adolescence is the complex physical cognitive and psychosocial changes that affect the way in which sexuality is expressed. Physical maturity and the ability to engage in sexual activity, do not necessarily imply sufficient cognitive maturity to understand and anticipate undesirable consequences such as STDs. Because STDs are concentrated among adolescents and young adults, these infectious diseases can be expected to rise in incidence if the population is bulging within the age ranges of the teens and the young adult years. This may also be influenced by the fact that, when the number of young people is disproportionately large, it tends to be less influenced by the social norms of the older generation. Consequently more of them may engage in behaviours that raise STDs (Grant & Demetriou 1988:1271-1281). Many teenagers contract STDs, with the highest incidence of reportable STDs occuring in the ages 20 to 24 years (Widdus et al. 1990:179). This age group is closely followed by the 15 to 19 years old group . This is attributed largely to ecological and behavioural factors of adolescence. Teenagers also less frequently use barrier

contraceptives which prevent transmission of many STDs, and prefer the use of oral contraceptives which appear to render women susceptible to chlamydial infection (Aral & Holmes 1991:20). The consequences of STDs are particularly significant since adolescents are just entering their reproductive years (Campbell & Baldwin 1991; Grant &Demetriou 1988; Ramstedt 1991).

Biological characteristics make sexually active teenagers more vulnerable to pregnancy and STDs than sexually active adults. This is caused among other factors by the point that changes in the epithelium of the uterine cervix during adolescence increases the risk for developing STDs. In early adolescence the columnar epithelium extends from the endocervical canal onto the exocervix. If therefore sexual intercourse occurs before the exocervix is protected by cervical mucus membrane it becomes susceptible to potential pathogens introduced during sexual intercourse. Adolescents also have a relatively low immune system because they have had little prior exposure to most STDs agents. With age and sexual experience their local and systemic immune systems mature and may provide some degree of protection from these agents (Grant & Demetriou 1988:1279).

The sexual behaviour of the adolescent is an enormous burden both for adolescents themselves and to society. The problem is that adolescents are sexually active and have little preparation and guidance in developing responsible sexual

behaviour. In a study done by Grant & Demetriou (1988) in the USA it was discovered that teenagers' primary source of information regarding sexuality is their peer group. The peer group is experiencing and reinforcing the same behaviour. In the same study it was found that though the family is a major socializer of other behaviours it is not a powerful force in moulding responsible sexual behaviour, because of parental discomfort with sex education and sexual discussions.

Knowledge of adolescent sexual behaviour, drug use and sexually transmitted diseases suggests that many adolescents are in jeopardy of acquiring Human Immune Deficiency Viral infections (Friedman 1989:312). This is noted also by Widdus et al. (1990:179). On the other hand it is explained that sex education has to go beyond simple handing out information. Young people are becoming sexually active at an earlier age than ever before (Kim et al. 1988:70).

The literature reviewed above shows that age is an important risk-marker that should be taken into consideration when looking for risk factors that precede transmission of STDs. Age therefore is an important indicator to detect which group is at high risk of contracting sexually transmitted diseases.

1.2 GENDER

Gender is another demographic factor that has been widely used as a risk indicator in many medical and epidemiological studies. This is a point supported by a study done by Alary et

al. (1989:549) on STDs. It was found that gender played a major role in detecting groups which were at high risk of contracting STDs among females and males. Gender also seemed to play an important role in health education programmes. It was observed that female patients found it more difficult to communicate freely with male physicians when they had gynaecological problems than with female physicians. Males also agreed that they became very uncomfortable discuss ing their STD problems with female physicians. This suggests that gender can have a significant influence on a patient's perception regarding health care and the physician's own feelings and response are important in determining the quality of the doctor-patient relationship (Fortenberry et al. 1988; Kim et al. 1988).

There is a difference between males and females with regard to free communication about STDs. Studies done in Sweden by Anderson-Ellstrom & Forssman (1991:73) between 1986 and 1988 revealed that girls were free in their communication about STDs. Girls in these studies agreed that they had discussed STD with some other person more often than boys, and they also knew more about STDs concerning treatment sources. In the case of boys it was found that they often gave nonspecific answers such as doctor or hospital in reference to their consultation. On the other hand, almost all girls have more specific answers such as a gynaecologist, midwife, contraceptive service or a teenager's clinic. Both in 1986 and 1988 4 to 5% of the boys and 8% of the girls who had sexual intercourse had been

treated for STDs. The fear of contracting STDs increased between the two periods particularly among boys in 1986 and in 1988 respectively (Anderson-Ellstrom & Forssman 1991:73).

Gender and nationality are demographic variables that are sometimes paired in comparative studies. In a study done by Moran et al. (1989) in the USA it was discovered that black females have higher levels of sexual experience than do white females. The disparity was greatest in 1977 when 23% of never married 15 to 19 year whites and 52% of blacks were sexually experienced. It was discovered that black girls 15 years initiated intercourse about one year earlier than white girls in the USA.

It was estimated that the number of cases of gonorrhoea in the United States in 1984 was in the order of 1,7 million. Since 1984 the race difference in reported cases has been growing. In 1988 there were 20 times more cases in blacks than in whites. This finding might have been due to bias in reporting practices. A more detailed analysis of incidence trends over the last 15 years shows that gonorrhoea has increased much more among women than among men. The recent downward trend in rectal gonorrhoea in men has been associated with a behaviour change in the homosexual community (Widdus et al. 1990:180).

Homosexual men are at high risk of contracting a variety of sexually transmitted diseases (Coutinho 1988). As observed, the risk depends primarily on the sexual techniques used

and the number of partners. A study done in Amsterdam by Coutinho (1988) reveals that male prostitution does occur. Partners were mostly chosen on the basis of a voluntary,unpaid relationship. The mean age of the men studied was 22,7 years, were intravenous drug users and 10 used cocaine regularly. Twenty- five men had been prostitutes for more than one year. The average number of clients a month was 24,5 and the average total number of partners and clients in the year was 147,1. However, results of this study showed that the prevalence of infection in male prostitutes was no higher than in other groups of homosexual males with multiple partners, but could be seen as having high STD markers (Coutinho 1988:207).

Unlike many other diseases the symptoms, complications and psychosocial factors of STDs have significantly different implications for women than for men. STDs have more serious consequences for women than for men. This is caused by the fact that anatomical differences allow many STDs to be transmitted more readily to women, yet diagnosed less easily than in men. Certain STDs such as gonorrhoea and chlamydial infection are usually asymptomatic in women and mostly symptomatic in men. Because societal values and attitudes towards sexuality have not kept pace with changes in women's work roles and sexual behaviour, women with STDs often bear a greater social and psychological burden than men (Stone 1990:790).

Mapelli(1993:1002) observed that women on the average demand 20% more health service than men. Again women have been observed to follow-up treatment more often than men. They are also more keen in using barriers as compared to men. In a study done by Campbell & Baldwin (1991) it was found that women partners used condoms for prophylaxis and three quarters of them explained that they began that practice after hearing of AIDS. Women whose partners used condoms for contraception or prophylaxis is much higher, at 62%. The proportion of women who measure to prevent infection was highly correlated with their perception of their own risk of infection. The few women who thought they had a very strong chance of getting AIDS reported the highest proportion of changing sexual behaviour (54%) and the highest proportion whose partners used condoms. The proportions exercising various degrees of caution differed greatly for different segments of the population.

The number of life time partners showed a strong relationship to the prevention of infection. The relationship was much stronger for behaviour change than for condom use. The proportion of women reporting any contrary actions rose from 25% among those with one partner to 84% for those with three or more partners. The safe-sex message appeared to be getting through to a majority of young sexually active women in a study done in the USA: 56% of the sexually active 15-19 year olds reported some degree of caution. Most of this involved behaviour change, but the young also reported the highest proportion of condom use (35%) for

any group (Campbell & Baldwin 1991:1136-37).

1.3 MARITAL STATUS

Marital status has a significant influence on the transmission of sexually transmitted diseases. Lee et al. (1988:1-6) in a study done in the USA observed that married or coha-biting women were more likely to have a mutually monogamous sexual relationship than previously or never-married women. This is a finding that could explain the difference between married and unmarried women in the risk of contracting STDs. Campbell & Baldwin (1991) on the other hand constituted a proxy for exposure to the risk of contracting by combining marital status with the number of lifetime partners. Nearly two-thirds of whom reported behaviour change or condom use to prevent infection. The frequency of STDs is higher among single, divorced and separated persons than among married couples. Other risk groups include prostitutes and international travellers, whose numbers have grown steadily during the past two decades and who have played a particularly important role in the rapid spread of penicillinase-producing strains of gonorrhoea throughout the world (Widdus et al. 1990:183).

1.4 RESIDENCE

Residence is another important risk factor of sexually transmitted diseases, though it overlaps with other variables such as educational status, income and occupation, and is more often than not determined by the three variables mentioned.The stratification of residential areas in urban areas as high,

middle and lower class areas is determined mostly by the three variables mentioned. These variables also play a major role in influencing the transmission, treatment and control of STDs. Aral & Holmes (1991) observed that those three sexually transmitted diseases had actually been increasing at epidemic rates among urban minority populations in the US. Urban poverty and social disintegration along with prostitution and the relatively new phenomenon of sex in exchange for drugs seemed to underlie this epidemic.

Furthermore, Aral & Holmes noticed that STD problems in the USA are located in the rise of drug resistant strains of STD bacterial infections and rapid spread of incurable viral STDs. This deteriorating STD situation of the US urban underclass increasingly resembles one that is seen in the slums of the less developed countries where the Acquired Immune Deficiency Syndrome has been spreading at epidemic rates among heterosexuals. Unlike gonorrhoea, chlamydia infection of the cervix is much more common in up to 5% of middle class pregnant women and female college students. Chlamydia infection amongst this group seemed to be prevalent because the programme recommended for controlling the spread of chlamydia had never been implemented. Where-as such programmes were very effective in lower class areas where they have been implemented (Aral & Holmes 1991:20).

The point of residential influence in the transmission of STDs is supported by Van de Perre (1986) in his study in Ruanda. He

found that many people in that country had HIV positive blood tests and other STDs. This was caused by the fact that Ruanda is a country that has a central traffic network between east and central Africa. Therefore Ruanda, because of its geographical situation to other countries, tends to be at high risk of getting infected people passing through and at the same time spreading STDs. Thus, Van de Perre observed that people living in towns and metropolitan areas tended to contract more STDs infection than those staying in rural areas. This point was also noted by Van der Stuyt (1985) regarding migrant labourers in a study done amongst Turkish and Irish migrant groups. Migrant groups from rural areas in the big cities separated from their families, engaged in sexual behaviour that exposed them to sexually transmitted diseases. The study indicates that the migrant groups tended to have problems with many diseases, including genito-urinary diseases.

As to socio-economic variables Moran et al. (1989) found that there was correlation of the incidence of poverty in the spread of STDs. It was recognised that STDs are more common among the poor and the unemployed than amongst the wealthy and the employed. The study revealed that patients with gonorrhoea who visited STD clinics were males and single, from a lower socio-economic level and a lower educational standard.

1.5 Religion

Religion, like other biographic factors, is a risk-marker. According to Becker & Maiman (1975) people have faith in their beliefs whether they are true or not. Many religious beliefs condemn promiscuity and encourage good moral conduct. In both the United States and Canada studies by Becker & Maiman (1975) have shown that Catholic girls started to involve themselves in sexual activities later than non-catholic girls regardless of socio-economic status. Religion appears to be an important factor that distinguishes early from later initiator of sexual activity. Those who view religion as important to them and who attend services regularly appeared to be more likely to abstain from sexual activity. Individual denomination does not seem to be as powerful as the perceived importance of religion. Thus, literature review on demographic factors reveals that there is a relationship between biological, economical, social status and bacterial invasion in producing diseases and particularly in this case of STDs.

1.6 Beliefs and Culture

Health beliefs are social constructions; therefore, one's ideas of the body and one's health are influenced by both one's culture and one's social position, such as class or gender. Both cultural and socio-structural factors are important in understanding people's behaviour and health. People act as they do, not only because of their beliefs about health, but also of structural aspects such as how power is

distributed and relationships are organized (Jones 1991; Morgan et al. 1985). Since the definition of culture includes elements such as values, belief, actions, material objects, the nature of good and evil, ideals like justice, freedom, language, etc; all these play a major role in influencing disease trends in any community.

The influence of culture on STDs' infections, treatment and prevention was observed in a study done in the USA by Darrow (1974:18). It was found that belief played the most important part in personal disease susceptibility. The study revealed that people who believed that they were susceptible to infections, and that STDs were serious and condoms could prevent them, were more likely to use condoms than those whose beliefs were different. On the other hand Ajzen & Fishbein (1980) refers to values as things people consider to be relatively desirable and these values are used to help people choose between alternative courses of action. For example, some people choose a sexual relationship where there is a risk of contracting diseases rather than abstaining or choosing sex without any risk.

Darrow (1976) have shown that some policy-makers support child-maternal health care programmes but do not value control of STDs. STDs programmes which would prevent the squaelae of pelvic inflammatory diseases, pregnancy wastage, neonatal deaths and congenital disabilities were not supported because of prevailing values. Freidson (1970) on the issue of cultural

influence on disease, treatment and control explains that a culture which is markedly different from that of the professionals in which there is a well developed cohesive lay referral structure, e.g. where deviations are not regarded as symptoms of illness and the problem resolved by referring the deviant to an indigenous practitioner, has a high degree of resistance to utilise professional services. He explains that in a culture that differs from a professional culture but where there is only limited lay referral systems such that individuals are exposed to influence outside the local community there is a greater degree of utilisation of services.

1.7 Symptoms and Help-seeking Behaviour

The assumptions underlying the health belief model (Freund & Mcguire 1991:4) explains that people who exhibit the appropriate combination of motives and beliefs will accept and undertake recommended behaviour designed to prevent illness in the absence of symptoms or restore good health after the actual diagnosis of illness. In studies done in the USA (Morgan et al. 1985:59-80), it was found that cultural beliefs and psychological factors played an important role in influencing individuals' and social groups' response to signs and symptoms. It is suggested that the question of why some people seek medical help and others do not, has to be understood within a framework in which they take place (Morgan et al. 1985).

The more a symptom is visible or recognisable and the more readily it can be defined within a known and familiar theoretical framework of beliefs, the more response it receives from the individual. For example, the more the STDs' signs and symptoms get an explanation in one's beliefs the more people will respond and conform to treatment and prevention of STDs. It was found in the same study done by Morgan et al. (1985:59-80) in the USA that if sufferers and significant others believed that symptoms and signs of a disease present future probabilities of dangers, they tended to respond to them. It was found that besides cultural influence, response to symptoms of diseases is also determined by the extent to which the symptoms disrupt family work and social activities. This means that if symptoms of a disease do not interrupt daily activities they could be neglected by the sufferers and significant others.

In the study done by Morgan et al. (1985:59-80) in the US it was discovered that conditions accompanied by pain and irritation were more likely to be responded to than those without pain and irritation. Frequency of the appearance of symptoms, their persistence or frequency of occurrence had an important impact in help-seeking behaviour. It was observed that some people responded more often to long persisted symptoms than symptoms of short duration. People's willingness to tolerate symptoms seemed to depend on their values about independence and stoicism. Available information, knowledge and cultural assumptions and understanding of medical

knowledge are associated with differential responses (Morgan et al. 1985).

The relationship between anxiety and fear about symptoms and patterns of help-seeking behaviour is not straight-forward. For example, in studies of patients with possible signs and symptoms of cancer by Moran et al.(1989), it was found that there was a delay in seeking medical care, because cancer is associated with high levels of fear, for some symptoms were associated with embarrassment stigma or humiliation from a cultural point of view. Two studies of medical care-seeking behaviour among STD clinic patients have yielded contradictory results. In a 1971 study of STD clinic patients in Sacramento by Moran et al. black men were found to delay significantly longer than non-blacks before seeking treatment. Whereas in 1977 a study of STD clinic patients in Columbus black men and women with discharge or dysuria tended to go to the clinic sooner after onset of symptoms than Whites (Moran et al. 1989:564).

1.8 Religion; Traditional Ceremonies and Treatment of Diseases

Widdus et al. (1990) explain that throughout the Western world, but especially in the United States, improved communications and growing urbanization have loosened the grip of the strict religious and cultural constraints on sexuality and given sexual behaviour free reign, enhancing the opportunity for STDs transmission. In many traditional

societies in sub-Saharan Africa the pubertal initiation ceremonies allowing sexual activity to commence are more important than the act of marriage itself. But the Western world, with its prohibition of premarital sex, has been caught completely unprepared by the combination of an earlier age for onset of sexual activities with a relation of cultural restraints on adolescent sexual behaviour.

Otite (1987), on the issue of cultural influence on treatment and control of disease, explains that the perception of health problems, where, how, when and from whom patients seek medical care, as well as their treatment are all aspects of the cultural expectations. He had observed that health and illness behaviour of many populations extended even to the realm of astrology. This astrological perception of physical and mental well-being and fortunes is also found in other parts of the world. He gives an example that in Nigeria and in many African societies where cosmic forces and planetary movement, such as the appearance of new moon, are believed to cause mental disorders and illness. On the other hand, Christians who oppose this astrologic explanation, were members of healing churches where it was believed that prayers without medicine can cure any patient. This may well be the belief part of what has gained cultural respect through the analysis of health in the African context. According to Otite, Nigerians have greater confidence in their traditional cultural skills than in those of modern doctors and nurses.

Some Nigerians had suggested that reliance on traditional medicine at the onset of illness was derived from the fact that healers were seen in bigger numbers and were more accessible than formally trained modern health workers. Nigerians believed that ill health was caused to a large extent by the evil manipulations through witchcraft or sorcery. Consequently many Nigerian patients believed that traditional healers are far more competent than modern health workers to treat many health problems. Healers could counter the evil forces which were also believed to be the cause of ill health. Otite (1987:603) explains that the phenomenon of health is both a medical and a socio-behavioural concept, just as medicine itself is a natural, as well as a socio-behavioural science. But there have been more advances in and seriousness with medical discipline than is the case with the socio-behavioural science component. The socio-behavioural science component related to disease causation needs further serious advancement if diseases are to be controlled successfully.

1.9 Pain

Pain and its psycho-social dimensions play a significant role in seeking medical help amongst many people (Freund &Mcguire 1991). Freund suggests that socio-cultural and psychological dimensions of pain need to be considered in understanding treatment compliance. Studies have shown that these aspects of individuals have great impact on dimensions of pain. Pain is a

form of bio-feedback essential to an individual's survival. Although pain is an essential warning system for the body it can also be a scourge and a terrible reality, a source of fear and anxiety that in some cases becomes all-consuming and overwhelming. Pain is the symptom that makes people seek help and comply with doctors' instructions. This could mean that people who suffer from diseases with less pain or no pain could only depend on their socio-cultural explanation as to whether it is necessary to seek medical help or not.

1.10 Adherence to Therapeutic Recommendations

Adherence to therapeutic recommendations of doctors may not be the only course of action which a sick person would follow.. The advice of a lay consultant, herbalist, massage therapist or spiritual healer might also be considered. Some sick persons deliberately seek several opinions, medical or otherwise, and therefore obtain several therapeutic recommendations.

Adherence thus implies actively choosing which advice to follow (Freund & Mcguire 1991). Mkumatela (1986), in her study done in Transkei found that many people believed in the colour of the medicine, form and size of the container and taste, for more adherence to therapeutic treatment. She discovered that the less and non-educated believed more in big sized bottles for their medicine, blackish or brown in colour and of bitter taste, while those with more education believed in tablets and

injections. This could also mean that adherence to treatment is largely determined by the individuals' lay cultural conceptualisation of illness and treatment.

Literature review on socio-cultural beliefs and values show that without understanding these aspects of individuals, endeavours to control diseases will continue to be weak and sometimes totally ineffective. Sexually transmitted diseases also could be affected by these very influences, since, like all other diseases they, occur in the socio-cultural context of the sufferers.

1.11 Prevention

In prevention of sexually transmitted diseases many studies reveal that the characteristics of the population at risk for these diseases and the measure for their treatment are both known, but what is not known is the base-line data for specific areas. Thus, public health programmes for primary and secondary prevention of these diseases urgently need to be organised in order to reduce their frequency and their effects. However, the evaluation of such public health programmes before a true prevention policy can be instituted at the national level is difficult. The difficulty is caused by rapid changes in the incidence of the various STDs. A feasibility study done near Paris in 1984-1985 in a prevention programme had the following main messages (Meyer et al. 1991:152-158):

1. Inform people about the risks associated with multiple sexual partners.

2. Decrease the delay between infection and consultation. Treat all the STD infected partners.

3. Educate health professionals particularly regarding organisms such as chlamydia trachomatis.

Various educational media were chosen in accordance with the most important target, the young. Measures facilitating access to care such as treatment and screening for minors, systematic refunds for chlamydia trachomatis tests were done. Diffusion of condoms by means of installations of automatic vending machines, free distribution by health centres, universities and youth clubs were done. Public information messages were disseminated using a variety of media actions adapted to different social groups. The media used were the following: advertisements on local radio and in local newspapers, debates, free-phone hotlines using recorded messages, posters in medical offices and public areas, a thirteen-minute videotape used to introduce the debates, a two-minute cartoon shown during advertisements in the major cinemas, pamphlets, and many others. This campaign resulted in a significant decrease of STDs (Meyer et al. 1991:153).

Prevention, also according to the literature review, needs to be organised in a manner that will be acceptable to different

social groups, failure to do so may result into a lot of bias and negative connotation about the method of prevention.

RESULTS

The empirical results of this study are presented according to the sections that appear on the interview schedule. The first part of the results is found in chapter 5. The results in this chapter are on the biographic and socio-economic characteristics of the interviewees. Also presented in chapter 5 are the variations of the distribution of diseases which fall under the categories of STDs as identified in this study.

The second portion of the results are in chapter 6. The results in that chapter are on the sexual behaviour, patterns preferences regarding treatment and referral systems.

The third section, which encompasses chapter 7, deals with the results on the accessibility and availability of health care centres. Also presented in chapter 7 are the results on the general knowledge, perception, attitudes and beliefs of the respondents about STDs. Results on sexual behaviour are also found in chapter 7. Chapter 8 is the last section that includes a discussion , conclusions and recommendations.

The results are presented in percentages and arranged in tables that are accompanied by interpretation and discussion. Where tables have not been constructed results are explained

and percentages, rates, means and correlation symbols are shown.

Of the 150 interview schedules administered, 146 were completed infull, while four were spoiled by partial completeness, these were discarded. The overall full completion which is regarded as full participation was 97.3%.

CHAPTER 5

THE BIOGRAPHIC AND SOCIO-ECONOMIC CHARACTERISTICS OF THE RESPONDENTS

1.1 Biograhic characteristics

The study examined biographic and socio-economic characteristics of the respondents; these include age, gender marital status, level of education, occupation, income and employment. Another variable which was examined is the number of dependants of the respondents.

Age is one of the important risk-markers in the transmission of sexually transmitted diseases (Widdus et al. 1990). The age distribution of the respondents is presented in table 1.

TABLE 1. THE AGE DISTRIBUTION OF RESPONDENTS

AGE GROUP	N	%
15 - 19 yrs	52	35.6
20 - 25 yrs	47	32.2
26 - 30 yrs	47	32.2
TOTAL	146	100.0

Age distribution, according to the statistics in table 1, shows that there was a fair distribution of respondents in the

sample. Most respondents (35.6%) were in the age range 15-19 years . The second highest(32.2%) was in the age group 20-25 years and was the same for 26-30 years. The mean age of the sample was 22.5 years.

TABLE 2. THE GENDER DISTRIBUTION OF THE RESPONDENTS

GENDER	N	%
Male	114	78.3
Female	32	21.7
TOTAL	146	100.0

Results on gender distribution of the respondents are shown in Table 2. The table on gender distribution shows that MORE males were represented (78.3%), than females (21.7%). The results in table 2 could be interpreted in two different ways. Firstly, results suggests that males visit health centres more than females, refuting the general view that women visit health centres more than men, or the view that women on the average demand 20% more health service than men (Mapelli 1993:1002). However, at the same time it is in line with Mapelli's finding that such statements should be expressed categorically in relation to the type of disease. Secondly, the results are in congruence with the theory that the anatomical differences allow many STDs to be transmitted more readily to women , yet diagnosed less easily than in men (Nathanson et al.1984). This could mean that women did not present themselves to clinics because some STDs such as gonorrhoea and chlamydial infection are usually asymptomatic

in women . Therefore it would mean that the gender distribution of the sample shown in Table 2 is not related to the use of health centres by men and women, but is more likely related to the behaviour of STDs' infection between the gender.

Marital status is another variable that has been examined. The marital status of the respondents is summed up in Table 3.

TABLE 3. MARITAL STATUS OF RESPONDENTS

MARITAL STATUS	N	%
Single never married	101	69.2
Married	45	31.1
Separated/Divorced	0	00.0
Widowed	0	00.0
TOTAL	146	100.0

The results show that there were more (68.9%) single respondents in the sample than any other marital status category. This reflected that most single people are at high risk of contracting STDs. The results are in congruence with the results found by Widdus et al. (1990: 183) that single never married have a high risk of contracting STDs. The highest percentage of single, never married might have been raised by the distribution of respondents in age range 15 - 19 years in Table 1, most of whom were not married. Married patients on the other hand were represented 30.8%. While separated, divorced and widowed were not represented at all in the sample.

Marital status categories were not well represented. The picture that is depicted by the last two marital categories should be checked against misrepresentation or non-representation and be treated as showing no significance in relation to the phenomenon under investigation. If the results in table 3 on separated, divorced and widowed could be taken as meaningful that would be misleading.

Educational status of the respondents is another important variable examined and sample results appear in Table 4.

TABLE 4. THE EDUCATIONAL STATUS OF THE RESPONDENTS

LEVEL OF EDUCATION	N	%
Never been to school		00.0%
Sub A - Std 1	46	31.5
Std 2 - Std 5	73	50.0
Std 6 - Std 9	17	11.6
Matric	8	05.6
Diploma	2	01.3
Degree	0	00.0
Other	0	00.0
TOTAL	146	100.0

According to the data in Table 4 most respondents(50.0) managed to reach standard 5 . On the average this outstandingly illuminates that the standard of education in the sample was relatively low with,67.8% of the sample being

sub A -Std 5. Eleven percent was found in range 6 - Std 9. The results reflect that the sample consisted of people with a low standard of education. As in the instances of marital and gender distributions, the distribution of educational status reveals that there was no fair representation in the sample. There are two explanations that could be given for the picture drawn by the distribution of the educational status of the respondents. Firstly, it could happen that highly educated people are more careful about their sexual behaviours. Secondly, it may happen that highly educated people do not attend general government health clinics in which the study was conducted, but consult private doctors who may also be their friends and therefore are treated privately. The 1991 census results showed that there were 49205 people in Transkei who were matriculated and post matriculated (Statistical Bulletin 1992:15).

Occupational status of the respondents was another variable examined. The results, as shown in table 5, reveal that of those employed, most (31.1%) respondents in the sample were labourers. This table together with table 4 confirm that the sample represented people with low socio-economic status. This was supported by the results in table 5 on occupational status. Of the 146 respondents 31.1% were labourers, while 21.0% were still students and 40% were not employed. Professionals and skilled workers constituted 8.0% only.

TABLE 5.THE DISTRIBUTION OF RESPONDENTS BY OCCUPATION

OCCUPATION	N	%
Unemployed	58	40.0
Labourers	46	31.0
Students	30	21.0
Skilled	6	4.0
Professional	6	4.0
TOTAL	146	100.0

Income was another variable examined which also confirmed low socio-economic status of the sample. Results are presented in Table 6.

TABLE 6. THE INCOME DISTRIBUTION OF RESPONDENTS

INCOME	N	%
R100 - R299	46	32. 0
R300 - R499	89	60. 7
R500 - R699	4	2. 4
R700 - R899	5	3. 6
R900 -R1999	2	1. 3
R2000-R4000		0. 0
TOTAL	146	100.0

The statistics in Table 6 show that 60.7% of the respondents in the sample were earning between range R300 -R499 per month. There was only one respondent who earned more than a thousand rand per month.

The residence of the respondents was another variable examined in the definition of characteristics of the sample. Results on residence are in Table 7.

TABLE 7. DISTRIBUTION OF RESPONDENTS BY RESIDENCE

RESIDENCE	N	%
Rural	126	86.3
Urban	20	13.7
TOTAL	146	100.0

The majority(86.3%) of respondents lived in the rural areas. Thirteen point seven percent of respondents came from urban areas. However, it was difficult to get strictly urban dwellers in urban clinics. The reason was that there are no real boundaries that strictly divide rural from urban in Transkei. For both Butterworth and Umtata there were respondents from adjacent rural areas around these two urban areas who were treated in urban health clinics. The urban and rural residence classification does not seem to work well for Transkei in other respects. For this particular instance it could be explained in various ways. Firstly, for most rural areas that are adjacent to urban areas there are no health services at all. That means those people living in these areas have to use health centres in urban areas. Secondly, because of housing problems in urban areas many people who work in urban areas reside in these rural settings around the urban areas.

Most tables have shown that the sample did not represent all the groups in Transkei in so far as biographic and economic description is concerned. The biographic and economic characteristics were examined further, relating them to the distribution of the diseases amongst the respondents. The results on distribution of diseases are presented in the subsequent tables. Now that the results that are to be described are on the disease distribution, the term respondents changes to patients. The term patients will be used throughout the following chapters. Gonorrhoea and gonococcal urethritis will be used interchangeably or at the same time for this study. Again for other distributions of frequencies for gonorrhoea, gonococcal urethritis and burning of micturiction will be summed up to form one figure . This is done, because the two diagnoses, gonorrhoea and gonococcal urethritis are very similar since the causative organism is the same (Easmon & Ison 1987) and burning micturition is the symptom of both of them (Nathanson et al.1984).

2 THE BIOGRAPHIC CHARACTERISTICS AND THE DISTRIBUTION OF DISEASES (STDS)

The discussion of the distribution of STDs amongst patients has been arranged according to socio-biographic characteristics. The first distribution is the frequency of diseases which appears in Table 8.

TABLE 8. STDs(N & %) IN THE SAMPLE ACCORDING TO TYPE OF DISEASE

TYPE OF STD	N	%
Gonococcal urethritis	50	34.2
Gonorrhoea	37	25.3
Penile sore	21	14.3
Burning of micturition (BOM)	17	11.6
Syphilis	9	6.1
Penile warts	7	5.1
Vulval warts	5	3.4
TOTAL	146	100.0

Gonococcal urethritis had the highest(34.2%) incidence in the sample. Gonorrhoea was the second highest 25.3%. The third highest (14.3%) incidence in the sample was penile sore. Burning of micturition comprised 11.6% and syphilis 6.1%. Both Penile and vulval warts constituted 8.5% of the sample.The last two, penile warts and vulval warts were lower as compared to other STDs in the sample. The table shows that the most common diseases were gonorrhoeal urethritis, followed closely by gonorrhoea and then penile sore in the third place . The results were in congruence with other studies that found gonorrhoea to be the most problematic (Widdus et al.1990:180; Moran et al. 1989 :561). The table shows both symptoms and types of STDs, this combination being guided by the questionnaires in which symptoms were made diagnosis.

displayed in Table 9.

TABLE 9. INCIDENCE (N & %) OF STDS IN THE SAMPLE BY AGE

	GONOCOCCAL URETHRITIS		GONORR-HOEA		PENILE SORE		SYPHILIS		PENILE WARTS		VULVAL WARTS	
AGE GROUP	N	%	N	%	N	%	N	%	N	%	N	%
15 - 19 YRS	23	37.7	27	63.0	2	9.5	0	0.0	0	0.0	0	0.0
20 - 25 YRS	20	32.8	12	28.0	10	47.6	2	22.3	5	71.4	3	60.0
25 - 30 YRS	18	29.5	4	9.0	9	42.9	7	77.7	2	28.6	2	40.0
TOTAL	61	100.0	43	100.0	21	100.0	9	100.0	7	100.0	5	100.0

Gonococcal urethritis and gonorrhoea had the highest(37.7% and 63.0%) incidence respectively among the age group 15-19yrs. Gonococcal urethritis in the age group 20-25 years had second highest(32.8%) incidence . The third highest(29.5%) gonococcal urethritis incidence was found in the age range 26-30 years. Generally, gonorrhoea appeared to be fairly distributed in all age groups. The picture drawn in Table 9 about gonorrhoea and its incidence according to age-group was also observed by Smith et al. (1988).

Penile sore followed immediately after gonorrhoea and gonococcal urethritis by an incidence of 47.6% being highest in the age range 20-25 years and 42.9% in the age group 26-30 years. Syphillis was 77.7% and found mostly in the age range

26-30 years. The significantly high incidence (47.6%)of penile sore is in congruence with what Dangor et al.(1989: 339-341) found amongst mine workers which revealed an incidence of 68% penile sore.Out of the 68% of penile sore found by Dangor,3% in the sample were from Transkei. The results on cross-tabulation between age and disease in Table 9 showed that age is a risk-marker of STDs. Gonorrhoea was a problem of all age groups.

Marital status was also examined so as to identify the difference in disease distribution amongst marital status categories. Results are in Table 10.

TABLE 10. INCIDENCE (N & %) OF STDS IN THE SAMPLE BY MARITEL STATUS

MARITAL STATUS	TYPE OF STDs									
	GONOCOCCAL URETHRITIS		PENILE SORE		SYPHILIS		PENILE WART		VULVAL WART	
SINGLE	N	%	N	%	N	%	N	%	N	%
	56	53.8	12	57.1	4	44.4	4	57.1	2	40.0
MARRIED	48	46.2	9	42.9	5	55.6	3	42.9	3	60.0
TOTAL	104	100.0	21	100.0	9	100.0	7	100.0	5	100.0

The results showed that there was higher incidence of gonococcal urethritis (53.8%) amongst single never married as compared to the married(46.2%). This shows that there was little difference in the spread of infection amongst married

and single. The spread of infection was relatively similar in all other diseases. Of the single patients 57.1% had penile sores while 42.9% patients who were married had penile sores. Syphillis was contracted by (44.4%) of the single patients while 55.6% married patients had syphillis. Penile warts was contracted by(57.1%) single patients and 40.0% single had vulval warts.Of married patients 42.9% had penile warts while 60.0% had vulval warts. As was explained previously that considering the non-representation of separated/divorced and widowed as the true picture could be misleading is again highligted that it could be dangerous to conclude that these marital status categories have a low risk of contracting STDS.The data in table 10 show low differences in the spread of STDs between the married and the single.

Residence was examined in relation to the incidence or prevalence of STDs. The results are in Table 11.

TABLE 11. THE INCIDENCE (N & %) OF STDs BY RESIDENCE

	GONOCOCCAL URETHRITIS		PENILE SORE		SYPHILIS		PENILE WART		VULVAL WART	
	N	%	N	%	N	%	N	%	N	%
Rural	90	86.6	14	66.7	6	66.7	5	71.5	5	100.0
Urban	14	13.4	7	33.3	3	33.3	2	28.5	0	0.0
TOTAL	104	100.0	21	100.0	9	100.0	7	100.0	5	100.0

The results of residential influence on STDs' incidence reflected that 86.6% of all patients with gonococcal urethritis were from rural areas, while 13.4% were from urban areas. Of those who were diagnosed to have penile sore 66.7% were from rural areas and 33.3% were from urban areas.
Of those with syphilis 66.7% were from rural areas, while 33.3% were from urban areas. The results showed that people who resided in rural areas contracted STDs more than those who lived in urban areas. However, as mentioned earlier, the residential differentials in the spread of STDs bear little significance in the case of Transkei, because of high commutation between these two areas.Moreover, the sample had more respondents(82.1%) who were from rural areas.

The two variables, employment and disease were cross tabulated; the results are shown in Table 12.

TABLE 12. THE INCIDENCE (N & %) OF STDS IN THE SAMPLE BY EMPLOYMENT STATUS

EMPLOYMENT	TYPE OF STDS									
	GONOCOCCAL URETHRITIS		PENILE SORE		SYPHILIS		PENILE WART		VULVAL WART	
	N	%	N	%	N	%	N	%	N	%
YES	35	34.0	9	43.1	1	11.1	2	29.0	0	0.0
NO	41	39.0	10	47.4	8	88.9	4	57.0	5	100.0
STUDENT	28	27.0	2	9.5	0	0.0	1	14.0	0	0.0
TOTAL	104	100.0	21	100.0	9	100.0	7	100.0	5	100.0

Gonococcal urethritis was contracted by 34% of those employed, 39% unemployed and 27% students. Penile sore was contracted by 43.1% of those who were employed and contracted by 47.4% of those unemployed respectively.Of those who had syphilis 88.9% were not employed. The results showed that all those who were not employed had a high risk of contracting STDs as compared to those employed and students. The results could be linked to results on the question of how days were spent by those who were unemployed and not at school, all(100%) of whom were spending their time doing absolutely nothing. The results supported those found by Dangor et al. (1989:339-341) which proved that

prostitution which was promoted by unemployment was run at as low as R4.00 to R11.00 or 3 to 6 bottles of beer in Carletonville . The study revealed that when people are unemployed they could indulge in sexual activities due to idleness.The unemployed and those who have nothing to keep them busy have a higher risk of contracting STDs than those who are working and attending school or are busy.

Gender was not cross-tabulated with disease, not that it was a less important risk-marker, but because for this study it would be very insignificant because women were far less (21.7%) represented than men(78.3%) in the sample.

The distribution of STDs according to biographic and other socio-economic factors thus described, showed that there is a link between STDs and socio-economic factors. But the study

at this descriptive level would not have meant anything more than telling us that there were STDs distributed in the pattern already given. The distribution of STDs would not give us details related to other factors that might be influencing the picture of STDs in the presence of available health institutions and drugs in Transkei. Biographic factors are risk-markers rather than being risk factors. For argument's sake, age, i.e by being young or old on its own, cannot be directly linked to contracting of STDs per se. It therefore appears that there could be risk factors that confound with biographic and socio-economic factors in the spread of STDs. Hence the study examined the patients' illness behaviour in the risk of spreading STDs. In examining illness behaviour, behaviour tendency such as patterns and preferences regarding treatment, responses to signs and symptoms, and their influence in taking action or adoption of a sick role, were examined. The results on illness behaviour are on tables 13 to 17 of chapter 6. Results on availability and accessibility of health care which were examined formed another portion of chapter 6.

CHAPTER 6

HEALTH AND ILLNESS BEHAVIOUR: PATTERNS AND PREFERENCES REGARDING TREATMENT

Patients were examined for the signs and symptoms which urged them to seek help so as to identify signs and symptoms which were considered important by patients . It was hoped that the information gathered could be used in the health education programmes,in which more emphasis would be placed on the signs and symptoms patients considered to be less important while in infact there were also dangerous. This would help to measure patients' recognition of the seriousness of signs and symptoms. Results on signs and symptoms appear in Table 13.

TABLE 13. SIGNS AND SYMPTOMS THAT URGED PATIENTS TO VISIT HEALTH CLINICS

SIGNS AND SYMPTOMS	N	%
Burning of micturition (BOM)	66	45.0
Genital discharge	44	30.0
Genital sore	22	15.0
Genital warts	10	7.0
Pain	4	3.00
TOTAL	146	100.0

Burning of micturition(BOM) appeared to be the most common symptom which made most patients (45%) seek help in health

centres. There could be various explanations on why most patients had been compelled by BOM to seek for help. One explanation is that BOM is associated with painful urination; urgent need to urinate; urination at night and blood in urine (Foxman & Frerichs 1985: 1308). It would appear that signs and symptoms of BOM could be embarrassing to the patient, more especially if it involves urgent and frequent toilet visit and pain. Embarrassment caused by the disease might yield prompt reaction and high frequency on health consultation.

Genital discharge on the other hand was the second most common sign that drew 30% of patients to seek for medical help. Genital discharge might be embarrassing just like BOM, more so that it could soil the garments. Only 15% of patients reported that penile sore made them to decide to seek medical help. Penile sore could be embarrassing to sexual partners. One patient reported that the sore was embarrassing and painful during sexual intercourse. Pain appeared to be the lowest symptom instigating help seeking (3%).

The results suggested that many patients would report more to health centres if they had burning of micturition, genital sores and genital discharge than those with warts and pain. The study revealed that people would take action if the illness disturbs their normal behaviour and embarrass them to the significant others. There is congruity in this conclusion about people's behaviour in engaging in health behaviour with the reasoned action theory that people will engage in health

the reasoned action theory that people will engage in health behaviour if such actions are considered worthwhile by persons or groups the individuals wish to please(Ajzen & Fishbein 1980 :62-65) and also in line with the study done by Morgan et al.(1985:59-80) which found that response to symptoms is determined by the extent symptoms disrupt family work and social activities.

It was necessary to examine the time patients took between manifestation of signs and symptoms and their visit to health centres. This time span was important in measuring patients delay before visiting health centres.Furthermore this was assumed to be the most risky period in the spreading of STDs. The results on the period taken by patients between manifestation of signs and symptoms and consulting health centres are explicated in Table 14.

TABLE 14. THE TIME SPAN BETWEEN MANIFESTATION OF SIGNS AND SYMPTOMS AND VISIT TO HEALTH CENTRES

TIME SPAN	SIGNS AND SYMPTOMS									
	BOM		GENITAL DISCHARGES		PENILE SORE		GENITAL WART		PAIN	
	N	%	N	%	N	%	N	%	N	%
THIS MORNING	0	0.0	2	6.5	0	0.0	0	0.0	0	0.0
LAST NIGHT	17	25.0	9	25.0	1	5.0	0	0.0	0	0.0
TWO DAYS AGO	50	75.0	18	50.0	7	35.0	0	0.0	2	20.0
LAST WEEK	0	0.0	7	18.5	11	50.0	3	25.0	5	50.0
CANT' REMEMBER	0	0.0	0	0.0	2	10.0	9	75.0	3	30.0
TOTAL	67	100.0	36	100.0	21	100.0	12	100.0	10	100.0

Most patients(75.0%) with burning of micturition reported to health centres two days after the manifestation of the disease.Of patients with genital discharge 50.0% reported two days after symptom manifestation. Fifty percent of the patients with genital sore reported within a week , while those with genital warts(75.0%) could not remember when the signs and symptoms started.Of the patients who reported that they were brought by pain to the health centre 50% within a week , while 30% could not remember. It could be deduced that patients with genital sores and genital warts might be spreading the disease more than other patients with other symptoms or signs, because of the length of time they spent between manifestation of the disease and commencement of treatment. This suggests that patients with genital warts and genital sores should be strongly encouraged to bring their sexual contacts to the health centres.

The results revealed that there could be a high risk of spreading STDs between the appearance of signs and symptoms and commencement of treatment. This suggests that it must be emphasized to patients and the community that commencement of treatment anytime during the course of the disease is not as important as taking the treatment at the earliest time of symptom manifestation. It should also be clarified to patients that there is increasing high cost a result of delay in beginning treatment. The delay in taking treatment is a high risk factor in the spread of STDs, as many infected

people could spread the disease.

The variable in time taken before visiting health centres were further cross-tabulated with signs and symptoms, while controlled for other variables such as income and occupation that could confound delay in commencement of treatment. The results showed no substantial difference in the cycling cross-tabulation of these variables, 2.3% and 0.78% for the cycles respectively.

On the question of whether patients had the disease before or not, they were asked to identify the most recurrent STDs among patients to infer the results to the community. The results on recurrence of STDs are shown in Table 15.

TABLE 15. THE RECURRENCE OF STDS IN THE SAMPLE

RESPONSE CATEGORY	TYPES OF STDS							
	GONOCOCCAL URETHRITIS		PENILE SORE		SYPHILIS		GENITAL	
	N	%	N	%	N	%	N	%
YES	42	40.7	2	10.0	2	22.0	0	0.0
NO	34	32.2	8	38.0	5	56.0	11	91.7
DON'T KNOW	28	27.1	11	52.0	2	22.0	1	8.3
TOTAL	104	100.0	21	100.0	9	100.0	12	100.0

Gonococcal urethritis appeared to have a high recurrence rate

(40.7%) as compared to the other STDs. However, 27.1% of patients with gonorrhoea were not sure whether they had it before or not. The evasive answer that some patients did not know whether they had gonorrhoea or not, could be attributed to the stigma associated with recurrence of STDs to sexual misbehaviour in particular and stigmatisation of STDs in general (Mathews et al. 1990 :14).

This suggests that emphasis should be placed during health education that evasiveness on giving the history of STDs is very dangerous to patients themselves . Since if it occurred before and was only partially treated some resistance to the drug might have occurred.Hence, Nathanson et al. (1984: 7) explained that the spread of gonorrhoea has been favoured by changes in gonorrhoea and the adaptation of the organism to resist the drugs. The history of STDs is important and should not be hidden as this could distort the picture of STDs in the community and result in failure in the control thereof. As shown in table 15 many patients did not have STDs before. Patients with gonococcal urethritis,(32.2%) syphilis (56.0%), penile sore (38.0%) and penile warts (91.1%) also reported that they had not suffered from STDs before.The fact that many patients stated that they had not contracted STDs before, should be identified as a risk marker in drug resistance, which may lead to failure of treatment, defeat control measures and fuel the spread of sexually transmitted diseases, and suggests that patients should be encouraged not to hide their previous incidence of STDs.

On the question directed to those who had the disease before and to where they had gone for help, or what they had used for treatment, results are explicated in table 16.

TABLE 16. THE RESPONSE (N & %) OF PATIENTS WHO HAD STDS BEFORE AND PLACES VISITED FOR HELP

PLACES VISITED	N	%
Health centre/Doctor	32	42.7
Herbalist	25	33.3
Chemist	9	12.0
Used medicine available at home	9	12.0
TOTAL	146	100.0

Fourty two point seven percent reported that they had visited health centres or seen a doctor,while 33.3% said they had consulted herbalists . This showed that patients with STDs frequenlty sought the help of traditional healers. Eighty percent of all those who relied on traditional healers, reported that traditional healers helped them several times while health centres and western doctors had failed to help them. The remaining 20% of those who believed in traditional healers stated that in some cases STDs were caused by jealous males. They explained that many jealous males take a certain medicine which one patient defined as a mixture of Indian tonic and some traditional herbs. The male who has taken this Indian tonic-herbal mixture on sexual contact with the female

partner would be transmitting the mixture also. This mixture will cause forms of STDs which would not be treated by westernised forms of drugs. Thus according to this belief, this mixture serves as a preventive measure to further sexual intercourse by the female with other males. It was explained that if another male who is not the one who took the Indian tonic-herbal mixture, on sexual contact with the female to which the mixture was transmitted during sexual intercourse with the sperms will develop STDs and will not advance to that particular woman again. The male who transmitted the Indian tonic-herbal mixture to the female on sexual contact with the female, will not develop STDs and he will be the only steady male partner of the female involved. All this is done without the knowledge of the woman concerned.

The traditional frame of reference just explained, suggests that there are other explanations of the preference of treatment and transmission of STDs could be perpetuating the spread of STDs in the country. Such explanations should not be taken as insignificant as they might lead to either disastrous outcome or the better solution to the problem of STDs. The lay interpretation of the etiology of STDs thus given, should be seen within the social constructionist approach by which emphasis is placed on examining the lay interpretive process within the context of lay knowledge and beliefs, rather than treating such health beliefs as idiosyncrasies (Morgan et al. 1985:28).

Only 6.0% of patients reported to have bought medicine from a

chemist and 6.0% had used medicines that were available at home as attempts at self-treatment. However, 56% of patients who treated themselves before they visited health centres reported that they did not get relief but short lived relief of some symptoms such as pain. But relief of pain was of little significance to be associated with the spread of STDs since the results had shown no relationship between pain and search for treatment.

Regarding referral systems , several questions were asked to the respondents and results are presented in Table 17.

TABLE 17.RESPONSES(N & %)ON THE SOURCES WHICH ADVISED PATIENTS TO ATTEND HEALTH CENTRES

SOURCES (REFERRAL SYSTEM)	N	%
FRIEND	82	56.0
SELF	57	39.0
PARENT	3	2.0
SPOUSE	4	3.0
TOTAL	146	100.0

On the question of who advised patients to visit health centres 56% reported that they were advised by friends.Thirty nine percent were not advised by elsewhere.

On whether they told anyone about the disease the results reflected that 60.5% had told some about the disease, while

39.5% did not tell anyone. Those who informed friends were the ones who were advised by friends to attend health centres. This suggested that friend played a major role in referral systems. This further indicated that friendship referrals should be encouraged. The study also revealed that few(2.0%) were advised by parents . It could be deduced that spouses who got the infection from sexual contacts outside marriage do not tell their spouses about the STDs they contracted, because only 3.0%reported to have been advised by them to visit health centres.

Patients' views on choice of health consultants by gender were examined. It was assumed that the gender of the health consultant could be influential in the preference of treatment. The results on the question of who would the patient prefer for consultation when visiting health centres in as far as gender of consultants was concerned , appear in table 18 and are arranged in frequencies of responses.

TABLE 18. PREFERENCE OF HEALTH CONSULTANCY BY GENDER OF HEALTH CONSULTANTS

GENDER OF RESPONDENT	GENDER OF HEALTH CONSULTANT PREFERENCE OF RESPONDENTS							
	FEMALE		MALE		EITHER		TOTAL	
	N	%	N	%	N	%	N	%
FEMALE	11	34.5	0	0.0	21	65.5	32	100.0
MALE	27	23.7	88	33.3	49	43.0	114	100.0
TOTAL	38		88		70		146	

Most female patients (65.5%) in the sample did not mind about the gender of their consultants; 34.5% females preferred to be seen by other females. None of the female patients preferred to be seen by men specifically. Males on the other hand varied remarkedly in their choices of consultants. However, like females most male patients(42.0%) had no choice based on the gender of their consultants. Of the males 33.3% preferred to be seen by other males, while the other portion of male patients(23.7%) preferred to be seen by females. On the whole, most patients did not bother much about the gender of their consultants.

However, for males it appeared that there should be a variety of health personnel, and patients should be allowed to make their choices to encourage free communication, and better understanding for better treatment compliance and control of STDs.

which patients would like to have and be satisfied with. The examination was done to check if patients' expectations on treatment were met as it was assumed that this would lead to prompt response to disease and treatment compliance. The results on treatment preferences are classified in Table 19 .

TABLE 19. PREFERENCE OF TREATMENT BY RESPONDENTS IN CASES OF STDS

TYPES OF TREATMENT	CHOICE OF TREATMENT BY RECURRENCE OF STDS					
	YES		NO		DON'T KNOW	
	N	%	N	%	N	%
Injection	17	23.1	20	52.6	4	12.5
Medicine and injection	23	30.6	8	21.0	11	34.0
Medicine	1	1.3	2	5.4	0	0.0
Pills	8	10.6	0	0.0	0	0.0
Pills &Injection	23	30.6	0	0.0	12	38.0
Ointment	3	0.9	0	0.0	0	0.0
Any	0	0.0	8	21.0	6	15.0
TOTAL	75	100.0	38	100.0	33	100.0

Patients who had STDs before preferred medicine and injections(30.6%) as well as pills and injections(30.6%) respectively. Of those who had the complaint before 23.1% preferred injections. Though the results showed variability in choice of treatment, some preferences other than medicine, pills and injection were low . This means that patients visited health centres with their expectations about the

treatment they were to get. This could mean that if their expectations are not met they might not come back again to the same health centre.

However, it could be difficult to meet unreasonable expectations of patients to encourage their consultation at the expense of proper treatment. But at the same time it could be deduced that if the patients' choice is respected patients may come to health centres and that could help to monitor drug resistance. The patients could be educated better to change their choice treatment.If they know that their preferences are respected, they could yield to options and treatment compliance could improve. For health centres that are rigid as to have standardised regimen for STDs patients might loose confidence in the same treatment they get whenever they come with their complaints. This could encourage patients to look for other places for treatment. On the other hand it could be deduced that submitting to patients' choices of treatment could be an indicator for completion of treatment and compliance. This deduction was linked to the results on the question of what would be the patient's next action if patients did not get relief from treatment, 60.0% reported that they would go somewhere else for treatment .

The point on treatment preferences was previously examined by Mkumatela (1986) in Transkei, where she found that patients preferred bitter medicine to sweet medicine.Those

patients(51%) who did not have STDs before chose injection. Injection appeared to be the drug route of choice amongst most patients as shown in Table 19.Even of those who did not know whether or not they had STDs before or not 12.5% preferred ijection. This poses a problem as to whether all forms of drugs for STDs should be in an injection form to meet patients expectations, which would lead to more confidence in treatment. The results have shown that preferences of treatment and choice on gender
of health consultants could influence the spread, treatment and control of STDs.

2 THE ACCESSIBILITY AND AVAILABILITY OF HEALTH CENTRES

Although this study has revealed a link between preferences and use of health centres, it has not revealed whether there were health centres adjacent to patients . The study examined the availability and accessibility of the health care system and the problems encountered by patients even before they could make choices. Mode of transport to health centres, distance walked or travelled by patients to the health centres, the transport fare, and conditions of roads travelled by patients were investigated. It was assumed that these variables could influence the spread, treatment, control and prevention of STDs. The results on availability and accessibility of health centres are shown in Table 20.

TABLE 20. MODE OF TRANSPORT (N & %) USED BY PATIENTS TO HEALTH CENTRES

MODE OF TRANSPORT	N	%
Walked	15	10.1
Bicycle	0	0.0
Private car	0	0.0
Bus	60	41.0
Taxi	71	48.9
Other	0	00.0
TOTAL	146	100.0

Most patients(48.9%) used taxis to visit health centres. Slightly less patients (41.0%) used buses, while 10.1% walked to health centres. The use of buses and taxis in transportation indicated that most patients came from areas distant from health centres.

But the distance travelled by the patients could be clearly defined more when linked with the results on actual distances travelled in kilometres. Table 21 shows the relative estimate of the kilometres travelled and walked by patients.

TABLE 21. ESTIMATED KILOMETRES WALKED OR TRAVELLED BY PATIENTS TO HEALTH CENTRES

KILOMETRES	N	%
Less than a kilometre	0	0.0
Within two kilometres	33	22.6
Within 5 kilometres	29	19.8
Between 5 to 10km	58	39.7
Over 10 kilometres	27	17.9
TOTAL	146	100.0

Most patients (39.7%) travelled between 5 and 10 kilometres. This was the second longest distance travelled to health centres. The longest distance travelled was the one over 10 kilometres and 17.9% of the patients had travelled this distance to reach the health centres.Of the patients 19.8% travelled distances within 5 kilometres. Twenty two point six percent travelled up two kilometres.

There were no patients who walked or travelled less than a kilometre to the health centres. The kilometres travelled by patients reflected that most patients lived far away from health centres. The distance travelled by patients could be attributed to the fact explained in chapter 1 that health centres are built at a distance of approximately 13 or more kilometres apart. It is expected therefore that patients could even travel more than 20 kilometres before they reach a health centre.

It may be deduced that many patients would think twice before they travel such long distances at exorbitant fares (shown in table 22),and considering the fact that most patients (58.0%)were unemployed and31.1% were labourers.It could be deduced that many people who might have had STDs did not visit health centres because of the long distance they could have travelled. The distance confounded with other variables, such as employment and transport fare. These variables on cross-tabulation between distance and visit to the health centres were controlled. It was deduced that distance could delay commencement of treatment and was a risk- marker in the spread of STDS. While distance was identified as a risk-marker, unavailability of adjacent health centres and accessibility to health centres was identified as a risk factor to the spread of STDs.

It would appear that people living far away from health centres have more chances to spread STDs while they are contemplating the journey, the transport fees, and charges at the health centres. The results of this study on distance travelled by patients to health centres are in congruence with a finding by Poland et al. (1990:17) in the West Indies. Poland found that proximal and distal determinants interact with individuals to produce a variety of health related outcomes.

The results on the amount of money paid by patients for transport when visiting health centres are explicated in Table 22.

TABLE 22. THE COSTS OF TRANSPORTATION OF PATIENTS TO HEALTH CENTRES.

COST ON TRANSPORT	RESPONSES	
	N	%
Less than R1.00	22	15.3
R1.00 - R3.00	39	26.3
R4.00 - R5.00	29	20.0
R6.00 - R10.00	27	18.5
R11.00 - R15	29	19.9
TOTAL	146	100.0

Of all patients 26.3% paid between R1.00 - R3.00 for transport to health centres,20.0% spent R3.00 - R5.00 and 19.9% paid R11.00 - R15.00.The total cost of the latter group 19.9% could have risen to R20.00 when considering the R6.00 that is paid in health centres as a fee for treatment. The cost involved could be taken as a risk marker in the spread of STDS, more especially considering that most patients were unemployed and some were students. It was deduced that patients might have run the risk of spreading the STDs while still searching for money. The results revealed that there were high costs involved in the seeking of treatment which was associated with difficult accessibility to health centres. It could be deduced that unavailability of health centres near patients was associated with the spread of STDs.

On the question on whether there were health centres near the

patients' residences, 65.5% from rural areas reported that there were none.The 34.2% who reported that there were health centres near their residences had other reasons for having decided to visit a particular health centre. Some patients reported that, though there were health centres nearer to them than the one they attended, there was no transport going to that health centre. The distance was too long to be walked. This could be linked further to the results on the question on conditions of roads. Most patients(58.2%) reported that roads to other health centres were bad.That could be another reason that contributed to unavailability of transport. Some patients reported that nurses were busy with other types of health services and they could not wait since they were told that they would be attended in the afternoon. It would appear that bad roads that lead to some of the health centres could be associated with the delay in visiting health centres, since patients could not walk the distance to these health centres. Lack of transport was observed as another factor that could lead to the delay of commencement of treatment.

The lack of transport could be associated also with the period for some patients, between the manifestation of symptoms and the visit to the health centres explained earlier, and more especially for those patients who had penile sores and vulval warts . The unavailability of roads or bad roads could be linked to the topography of Transkei as explained in Chapter 1. The topography of Transkei might lead to lack of transport. The point on the topography of a country as an influencing

of a country as an influencing factor in spread of diseases; because of difficulty in making transportation network that could make easy access to available health centres was also observed by Poland et al. (1990:17) in the West Indies.

Table 23 presents results on cross-tabulation of availability of health centre and the occurrence of STDs.

TABLE 23. CROSS TABULATION OF STDS INCIDENCE AND AVAILABILITY OF A NEARBY HEALTH CENTRE

AVAILABILITY OR NOT OF NEARBY HEALTH CENTRE	TYPE OF STD							
	GONOCOCCAL URETHRITIS		PENILE SORE		SYPHILIS		GENITAL WART	
	N	%	N	%	N	%	N	%
YES	50	48.1	7	33.3	4	44.4	2	16.7
NO	54	42.9	10	50.0	1	11.1	7	60.9
DONT' KNOW		0.0	4	16.7	4	44.4	3	22.4
TOTAL	104	100.	21	100.00	9	100.0	12	100.0

Of those who had gonococcal urethritis, the incidence did not differ significantly between those (48.1%) who reported there were health centres nearby, and those (42.9%) who reported that there were no health centres nearby. This could suggest that people suffer from gonorrhoea at the same rate whether there were health centres near their residences or not. Even on Pearsons correlation coefficiency, results showed that

there was no relation between nearby clinics and incidence of gonorrhoea (r=-0.16851). Incidence of syphilis occurred at a rate of 44.4% even in the availability of health centres in the nearby, at 11.1% amongst those who reported that there were no nearby health centres. Syphilis appeared to be also common amongst those (44.4%) who did not know whether there was aclinic in the nearby or not. It was deduced that the most risky groups of patients and the negligent were those who did not know whether there were health centres near their residing areas or not. This attitude is explained by the reasoned action theory, that the careless statements made about one's illness condition will mark one's tendency in engaging in health behaviour (Ajzen & Fishbein 1980:62-65).

Of those with penile sore,50.0% reported that there were no nearby health centres. In this case, it showed that there was a relationship between incidence of penile sore and availability of health centres, with high risk of spreading STDs.

CHAPTER 7

GENERAL KNOWLEDGE, PERCEPTIONS, PRACTICES AND BELIEFS REGARDING STDs

This study also investigated the general knowledge, perceptions, attitudes, beliefs and practices surrounding STDs. Firstly, questions on the etiology of STDs, knowledge about STDs, and sources of the information or knowledge were asked. The aim was to determine if patients knew anything about STDs. It is believed that people take preventive health actions if they have certain levels of health related knowledge (Widdus et al. 1990:185).

It was assumed that general knowledge, perceptions, attitudes and beliefs would influence the spread, control and treatment of STDs. The results are shown in table 24.

TABLE 24. PATIENTS PERCEPTION OF THE ETIOLOGY OF STDS

PATIENTS' PERCEPTION OF ETIOLGY OF STDS	N	%
Infected Partner	69	47.3
Witchcraft	44	30.2
Exposure to cold	18	12.4
Do not know	10	7.0
Just infection	5	3.1
TOTAL	146	100.0

Most patients (47.3%) associated their illness with the last sexual contact with an infected partner. It could be deduced on the basis of these results that most people know that STDs are infectious, and that one contracts them through sexual contact. In this case, it would appear that the knowledge determined by this study could be used in the encouragement of condom use.Thirty point two percent of patients ascibed etiology of STDs to witchcraft .This was considered a high percentage which reflected that there were many causal theories associated with STDs. This finding linked these results to the results discussed on why patients consulted traditional healers: patients consulted them because they associated STDs with witchcraft. Hence the beliefs about the Indian tonic mixture in chapter 6.

All women in the study reported that they associated their illness with exposure to cold. The 12.4% percent in Table 24 constituted women only. The results are linked to the poor representation of women in the sample discussed in Chapter 5. This could mean that most women took their STDs less seriously, because they associated them with exposure to cold. It was deduced that women presented a high risk of spreading STDs, more especially if these results are associated with the asymptomatic behaviour of their infection discussed in chapter 5. Three point one percent reported that STDs were associated with an unspecified type of infection, while 7% did not know the cause.

The results on the sources of information about STDs are

presented in Table 25.

TABLE 25. SOURCE (N & %)OF INFORMATION ABOUT STDS

SOURCE OF INFORMATION	N	%
Radio	100	68.0
Nurse	26	18.0
Friends	9	6.0
Parents	4	3.0
Spouse	0	0.0
School	0	0.0
T V	3	2.0
News Papers	0	0.0
Magazine	1	0.0
Pamphlet	3	2.0
Other	0	0.0
Total	146	100.0

On the question on what patients know about STDs the results showed that 47.3%, as shown in table 24, knew that STDs are infectious. It would appear that regardless of the cause, patients knew that STDs are infectious. This meant that emphasis on use of condoms could help in the control of STDS. A high percentage of 68.0% patients reported that they obtained their information from the radio. This indicated that the successful method of communication in this country that reaches many people was the Radio Transkei Broadcasting Corporation. This method, though it appears to be successful,

has a few problems, inter alia, in that it is scheduled on time frames. This means that there is a possibility of missing the programme on STDs. More has to be investigated about the programme for health education purposes.

Nurses(18%) were identified as the source of information. This indicated, however, that there was rather little impact by health workers in the campaign of prevention of STDs. There are various explanations that could be given deducing from the results, amongst which maldistribution of health resources could be the most important one. The results indicated that most of the available health resources available are assigned to institutionalised systems of health care. If it was not the case the impact of nurses as a source of health education on STDs would not be as low as 18%. This showed that very few resources are allocated for community-based preventive strategies to combat STDs.

Television and pamphlets as sources of information on STDs shared the remaining 4%. If it is considered that most patients maintained a low socio-economic status and came from rural areas, television could not have been the most common source of information. On the other hand,a poor response to pamphlets could not be associated with the literacy status of respondents, because most of patients had been to school, as shown in Chapter 5. There are two explanations made for the poor response to pamphlets, as a source of information. Firstly, pamphlets might be largely unavailable. The few that

are available are not widely dispersed and those that are available do not deal with STDs. Secondly, the study indicates that the culture of reading is not nurtured. This means that there should be strategies to cultivate a reading culture amongst teenagers and students, especially because they form the target group for community- based strategies on prevention of STDs.

Tables 26.1 and 26.2 below present the responses on general knowledge, perceptions, attitudes, beliefs and practices regarding STDs.

TABLE 26.1 DISTRIBUTION OF RESPONSES REGARDING KNOWLEDGE, PERCEPTIONS,ATTITUDES, BELIEFS AND PRACTICES.

QUESTIONS	RESPONSES (N & %)					
	YES		NO		DON'T KNOW	
	N	%	N	%	N	%
- Do you think that you may be suffering from STDs ?	82	56.0	44	30.0	20	14.0
Have you ever heard about disease called AIDS?	67	46.0	60	41.0	19	13.0
Do you think that having sex could have caused the symptoms you are experiencing at the						

moment?	58	40.0	60	41.0	28	19.0
Do you think you can transmit the symptoms you are experiencing to somebody else by having sex with him or her ?	69	45.7	34	24.8	43	29.5
Do you believe that men should prove their masculinity by having more than one sexual partner?	45	31.0	69	47.3	32	21.7
Do you think that your symptoms are an indication that your ancestors are angry with you?	57	39.5	61	41.9	28	18.6
Do you believe that a woman should have a baby before getting married to prove that she is fertile?	52	35.7	62	42.6	31	21.7
Would you have sex with somebody known to have STD ?	52	35.7	62	42.6	31	21.7
Do you think it acceptable for a married man to have sex with women other than his wife?	39	26.4	51	39.5	50	34.1
Do you think it is acceptable for a married woman to have sex with men other than her husband?	45	31.0	46	32.0	55	38.8
Do you believe that it is actually possible to die from the disease called AIDS?	51	34.9	43	29.5	52	35.6

TABLE 26.2 DISTRIBUTION OF RESPONSES REGARDING KNOWLEDGE, PERCEPTIONS; ATTITUDES AND BELIEFS

QUESTIONS	RESPONSES					
	YES		NO		DONT KNOW	
	N	%	N	%	N	%
-Do you think that it is actually possible to die from the diseases called STDs?	62	42.6	38	26.4	45	31.0
Would you you have sexual intercourse with some-one you know has had many sexual partners?	41	28.7	63	42.6	42	28.7
-Do you contract STDs if you have sexual contact with someone who suffers from STD ?	76	52.7	29	19.4	41	27.9
-Have nurses visited you and discussed STDs with you?	22	15.5	70	48.1	54	36.4
-Do you think that young people should be better informed about STDS ?	46	31.8	21	14.7	78	53.5

As shown in Table 26.1, most patients(56.0%) knew that they were suffering from STDs. This brings hope that if patients know that they suffer from STDs, with more health education

they can use condoms. The results are linked with those in table 24 in which most patients (47.3%) associated their illness with sexual contact with an infected partner. The results were again linked to those in Table 15 in which patients (40.0%) with gonococcal urethritis have had the disease.

If they have had STDs before, it could be deduced that patients who know what their problem is through previous experience are less likely to spread the STDs than those who do not know their problem. Those who do not know what their problem is, might look for help from other places that might be of no help at all, while running a high risk of spreading STDS.

Those 30.0 % of patients who did not think that they were suffering from STDs could also spread STDs through ignorance. The 30% is rather high and thus warrants attention.This suggests that the community needs more education on signs and symptoms so that they do not doubt their illness. A total of 46% of the patients reported that they had heard about AIDS, while 41% had never heard about AIDS. Most patients (45.7%) knew that if they had sexual intercourse while they were ill they could infect their sexual partners.

AIDS was seen as a killer disease by(34.9%) patients only; while 29.5% did not see AIDS as a killer disease and 35.6% of the patients did not know whether AIDS is a killer or not.

This suggested that more education on AIDS is needed still. On the contrary, a higher percentage(42.6%) higher than one scored (34.9%) for responses on whether AIDS was seen as killer or not as shown in table 26.2, scored for STDs as killer. These figures pose a paradox, because it would be expected that most people would see AIDS as the most dreadful killer among the STDs, due to the fact that it is regarded as such by most people from medical and health disciplines.

Two explanations are given for the paradoxical response of patients about AIDS and STDs as killer diseases. Firstly, some patients who were suffering from STDs did not take AIDS as more serious than their own STD problem at that point in time, due to their STD problem then. Secondly, this surpports the view that the extent of the seriousness of the disease should be regarded cognitively to be so by those who were affected or those who see themselves at high risk of contracting the diseases, (Ajzen and Fishbein 1980 : 62 - 65) but in this case it was not so, hence they did not see AIDS more as a killer disease than the STDs they suffered from .

It would appear that people who are already suffering fro STDs cannot make any difference between the present condition and the seriousness of the disease that is yet to come. This would suggest that, emphasis on AIDS alone while less emphasis is placed on other STDs, which are vehicles for AIDS would have no impact.It further appears that concentration on AIDS prevention in isolation of other STDs will not succeed in the

areas where STDs are most prevalent.To neglect STDs and concentrate on the prevention of AIDS alone, which is not seen by poeple as the problem that warrants immediate attention will be a futile effort.

On the question of extra-marital relationship, 47.3% condemned extra- marital relationship for both sexes. This showed that though people might be involving themselves in extra-marital relationships they also know the risks involved. If patients knew the risks involved, they could use the condom in pursuing such relationships. More especially 47.3% of the patients knew that STDs were associated with sexual contact with infected partners.This knowledge could be used in the emphasis of campaigns on condom use.

Of the patients, 31.8% agreed that young population of their areas need more knowledge about STDs. The need for more knowledge could be emanating from the fact that 31.8% patients saw the young population of their areas involving themselves in promiscuous behaviours. These results were linked to results on the question on whether girls should get pregnant before they get married. Most responses (42.6%) were for no. This meant that patients did not condone premarital pregnancy resulting from premarital sexual contacts. Of all patients 60% responded in the affirmative to need of more knowledge on STDs.

Though results showed that patients were concerned about STDS and wanted more knowledge, 95% reported that there was nothing

that was done in their areas about the prevention of STDs. This meant that the community itself was doing nothing about the prevention of STDs. The explanation that could be given to the apathy of the community towards organising their preventive strategy, is the effect of the appropriation of health preventive health measures by health workers.
This appropriation rendered the community apathetic and underestimated its capabilities in the organisation of their own community-based promotive and preventive strategies. This means that communities need some guidance on the actions they can take in the prevention of STDs and other diseases in their areas.

For instance, organisation of youth clubs in a community where some members can educate other members about the use of condoms, to teach people how to use condoms, need no professional skills of any health worker. The jealous appropriation of health skills by health workers has rendered communities helpless. As a result communities want health workers to come and do for them even things they could do more efficiently and effectively .

Most patients (95%) thought that more education on STDs was needed,while 96% suggested that campaigns on STDs should be held in every community on a weekly bases. Though they wanted campaigns on STDs, they did not know how and when these could be held. On contraception, 98.2% of the females used a pill as a contraceptive method. The remaining 1.8% females

were not using any contraception. With regard to males, questions on contraception were regarded as not applicable. Most men (99.8%) interviewed by researcher took the question on contraception as irrelevant and be directed to females only. Most males who were interviewed did not see the role they could play in family planning. When the researcher tried to show that condom use is another means of contraception men could not realize their relevance in family planning. This reflected that men needed more education on the role they can play in family planning and the use of condoms. Results on the estimation of the prevalence of STDs by patients appear in Table 27.

TABLE 27 (N & %) ON ESTIMATION OF STDS BY PATIENTS

	N	%
Over thousands	95	65.0
Over hundreds	51	35.0
TOTAL	146	100.0

On the estimation of STDs prevalence by patients, 65.0% estimated that there might be over thousands of people with STDs.On the other hand, 35.0% estimated that there might be over hundreds. This showed that patients were aware that STDs were prevalent in the country.

2 SEXUAL BEHAVIOUR OF PATIENTS

The study also examined the sexual behaviour of the respondents before, during the course of illness and beyond recovery.This was needed and could be used as an indicator or

an approximation of the figure of those who were unknown and willing to change their behaviour.

The study on sexual behaviour investigated the frequency of sexual contact, use of condoms, dating and age when sex began. The results appear in the following section on sexual behaviour.

The mean age at which most male patients(95.6%) began sex was 17.5years. For women the mean age was 16.5years. The correlation co-efficienct was rather weak, being r=0.03 between the age at which sex was begun and incidence of STDs. Results on frequency of sexual intercourse are presented in Table 28.

TABLE 28. FREQUENCY OF SEXUAL INTERCOURSE IN THE PAST SIX MONTHS

CATEGORIES	N	%
Never	6	4.4
Less than once a month	10	7.0
Once a month	9	5.4
Twice a month	24	16.3
Once a week	54	37.2
Twice a week	23	15.6
More than 3 times a week	12	8.0
Do not count	8	6.1
TOTAL	146	100.0

The frequency of sexual intercourse was distributed unevenly amongst respondents. Within the past six months most patients (37.2%) have had sex once a week. Sixteen point three percent twice a month was the second highest frequency and (15.6%) rate of two times a week was the third. Only 4% did not have sexual intercourse in the past six months.Responses on frequency of sexual intercourse within the past six months could not be associated with sexual behaviour that might have led to the present infection. Results on other questions on sexual behaviour are in table 29.

TABLE 29 PATIENTS' RESPONSES (N & %) ON FURTHER QUESTIONS ON SEXUAL BEHAVIUOR

QUESTIONS	RESPONSES (N & %)					
	YES		NO		DON'T KNOW	
	N	%	N	%	N	%
Are condoms readily available in your area?	43	30.0	84	58.0	19	12.0
In general, do you have objections against use of condoms	70	47.7	76	56.3	0	0.0
Are you going to ask all your partners you had unprotected sex with since your symptoms appeared to come to the clinic ?	0	0.0	143	98.2	3	1.8
Do you ask a person about his/her previous sexual experience before you decide to have sex with him/her?	70	47.7	76	52.3	0	0.0
Do you intend to stop having sex until you are cured?	109	75.0	30	20.0	7	5.0
Do you think it is right to have sex on the first date?	81	55.3	65	44.7	0	0.0

The patients' illness was very much related with the non-use

of condoms, r=1,0. On the question on why patients did not use condoms, 58% reported that condoms were not available, while 20% reported that they did not like condoms as they thought that they would be seen as awkward and suspect of being positive, since use of condoms was associated with prevention of AIDS or HIV.Twenty two percent of male patients reported that ladies did not want condoms, while 100% females reported that males do not want condoms. It was deduced that unavailability of condoms and negative attitudes of both females and males towards condom use were problematic and could jeopardize efforts on control of STDs. On unavailability of condoms, something could be done to provide people with condoms. Most patients(98.3%) knew that condoms were found in health centres only. This could be seen as a limited way in the supply of condoms.

On examining whether patients have had sexual intercourse during the course of illness, 68.5% of all those who had penile sores agreed to have had sexual contacts during the course of their illness. As was explained in chapter 6 that patients with penile sores delayed visit to health centres and again they reported to have had sexual intercourse during the course of their illness.

This further supported the deduction that patients or people with penile sores were associated with high risk of spreading STDs. Though 68.5% have had sexual contact during the course of their illness, 52.3% did not tell their partners about their illness. This meant that most people would engage in

sexual activities even if they knew that they had STDs. The reason for not telling their partners about the STD were linked with the results in chapter 6 where results showed that 39% do not tell anyone about their problem . One patient reported that once one tells the other sexual partner about the illness, the other partner decides to break the relationship. Hence they kept it a secret from sexual partners. However, 44.2% responded that they would tell some but not all. Most patients(52.3%) reported in the negative, on the question whether they asked their sexual partners about their previous sexual relationships, while 47.7% reported in the affirmative. This would imply that most patients do not bother about their sexual partners' previous sexual contacts.

Seventy five percent responded that they would not engage in sexual contact until they had been completely cured. This suggested that patients were prepared to wait until they were cured before they could engage in sexual contact. This was taken as a positive attitude and a sign of realisation of the seriousness of the disease. Of all patients, 80% promised that they would use the condom so that all their sexual partners were protected from STDs.

On whether they saw it important to have a sexual contact on the first date of a relationship, 55.3% said yes, while 44.7% said no. It would appear that most patients involved themselves in sexual contacts with people whose sexual history they did not know. It was deduced that sexual behaviours of

this nature were associated with a high risk of transmission of STDs.

Most patients (96.4%) did not know what further research could be done on the question of STDs. The remaining 3.6% thought that further research should be directed on causes and better methods and strategies of preventing STDs.

CHAPTER 8

DISCUSSION OF RESULTS, CONCLUSION AND RECOMMENDATIONS

1.1 Discussion of Results

The general purpose of the study was to gather as much information as possible on the geographic , demographic/biographic, socio-cultural and socio-economic factors which have a bearing on the transmission ,treatment and control of STDs in the Transkei.The information gathered would be used to the influence STDs' preventive health strategies in Transkei. In the preparations to gather data, certain questions were raised which the study sought to answer in relation to STDs. The study could be seen to have succeeded in answering some questions, but could not come up with clear answers to other questions.The results that are discussed give the picture of which questions were addressed successfully by the study.

The study had its own problems, some of which were related to funds. Pertaining to funds, the study could not manage to use laboratory examination that would help in the diagnosis. Diagnosis was based on clinical examination, hence it appeared in the distribution of diseases that there was no standard that was laboratory based in diagnosing. For instance the study diagnosed gonorrhoea, gonococcal urethritis and burning micturition, the latter being the symptom. The study might have diagnosed even non-gonococcal urethritis as gonorrhoea. However, Dangor et al. (1989)

specified this problem also and generalised it as a diagnostic problem of most clinicians working in Southern Africa, in clinics and in out-patients' departments where there is often a lack of laboratory facilities.

Another problem observed is the limited representation of the target group of this study. This could be associated with financial constraints which determined the size of the sample, which was 150 for the whole of Transkei. Lack of funds did not allow a bigger sample that might have been more representative of the target group in terms of class structures that might be available. However, though this is so, there are some epidemological studies that had even smaller sample sizes 113 and 103 respectively (Smith et al. 1988 ; Kim et al. 1988). The study represented the low socio-economic class. Description of the sample by occupation, showed that 31.1% were labourers, 4.0% were professionals and 4.1% skilled workers. Concerning employment, 40.0% of the respondents were unemployed,as against 39.1% employed. The distribution of respondents skewed towards low socio-economic status. This might have been caused by amongst other factors, the fact that Transkei is 95% rural and the big portion of the respondents were from rural areas with all the obvious characteristics of rural areas, such as unemployment and poor educational status . The study has revealed the close association between STDs and low socio-economic status and in this respect is in congruence with the study done by Moran et al. (1989 : 564) who found that there

is a link between STDs and low socio-economic status.

The sample did not constitute a fair representation of both sexes. Of all respondents 78.3% were males and 21.7% females.Screening is needed for most women who appear to be unaware of their STDs, because of the behaviour of STDs in women.There was also only partial representation of the different marital categories, there were no divorced or widowed in the sample. It would be misleading to conclude that these marital status categories have a low risk of contracting STDs. However, there are no known studies of STDs that have dealt with these two categories specifically. It would be necessary that future studies also concentrate on these two marital status categories.

The study showed that there is a definite link between age and STDs. It revealed that STDs by age were fairly distributed in all ages 15-19 years(55.6%), 20-25 years(32.2%) and 26-30 years (32.2%). The explanation that could be given for this fair distribution is the short range between the lower limit 15 years and 30 years, which has shown that the peak of sexual activity is almost the same. However, those between 15-19 years had little bit higher percentage(35.5%)than the rest. The findings are in line with those of Widdus et al. (1990:179) who also found that the 15- 19 years range had a higher prevalence rate than other age groups.

The study revealed that gonorrhoea was evenly distributed

among patients;it found that patients with penile sore, delay treatment and therefore have a high risk of spreading the disease. This study, like the one done by Dangor et al. (1989), proved that penile sore is a problem, more especially that the source of infection of penile sore diagnosed in Carletonville 3% could be traced to Transkei. Penile warts 5.1% and vulval warts 3.4% were found. There is no proof whether the genital warts were of microbacterial or viral origin. If it was known, it would throw light on the type of treatment or preventive procedure to be taken. This suggests that another epidemiological study that would provide laboratory examination is needed.

The study did not show any significant difference in the distribution of STDs according to rural and urban areas . The reason for this is the fact that it was not easy to differentiate between rural from urban population . Many people who were from rural areas were seen in urban clinics. However, it was observed that there were more patients(86.6%) from rural areas with gonorrhoea or gonococcal urethritis and only 13.4% were from urban areas. In 66.7% of the cases of penile sores ,the patients were from rural areas. The explanation that could be given for the picture drawn by the results regarding urban-rural distribution of STDs,is that there are no real boundaries between urban and rural areas in Transkei. The areas which are peri-urban are purely rural in most respects. Because of the shortage of housing in urban areas most people who work in town stay in these adjacent

rural areas. There are no health centres in these rural locations around the urban areas. People who stay in these areas attend health centres that are situated in urban areas. The study could not identify the link between high prevalence of STDs and these areas, perhaps due to a small sample drawn from urban areas.

Burning of micturition has been the decisive sign and symptom that made patients (45%) to visit health centres. This could have happened because burning of micturition is characterised by frequency of urination. This finding is in line with the study done by Morgan et al. (1985) in the USA the essence of which was that sufferers, besides cultural influence respond to signs and symptoms if they disrupt family work and social activities.It was found that gonorrhoea and gonococcal urethritis had a higher recurrence(59.5%) than most other diseases.

The study revealed that there is a relationship between the availability of health centres and STDs. It was found that unavailability of health centres within reach of STDs sufferers could pose a high risk of spreading the disease. The study is in agreement with the study done by Ayeni et al, (1987 :1083-1094) which concluded that the accessibility of health care facilities to the rural inhabitants should be improved. This study also discovered that roads were bad, and that has caused long distances to be walked or travelled by patients.

On patients' knowledge about STDs the study discovered that most patients(47.3%) associated their illness with the last sexual contact preceding manifestation of symptoms. This suggests that some patients do know the source of their diseases, therefore there is hope to convince them to be cautious about their sexual behaviour. Most patients (98.2%) reported not to have used condoms. Patients had reasons for not using condoms. Some reported that condoms are associated with people who have AIDS, and if they used condoms partners would think that they have AIDS, or they would think that the other partner would think that he or she was not faithful.

This suggests that though there may be condoms for people to use, there should be appropriate communication that would urge people to use condoms without negative feelings. This suggests that more education on the use of condoms is needed. It should be done in a manner that will not lead to psychological stumbling blocks, such as people regarding condoms as a method to prevent AIDS by those who have AIDS or are HIV positive. The study has not shown any clear indication on the use of condoms in future. This study is in congruence with the one done by Campbell & Baldwin (1991 :1135) who found that results on the use of condoms did not give an indication of a change in sexual behaviour. Perhaps, if condoms could be made available everywhere, together with better educational communication at community level by community members themselves, condom use might improve.

Though the study had observed that patients with penile sore (68.5%) had sexual contact during the course of illness however most patients(78.3%) promised that they would not involve themselves in further sexual contact until they were certain that they were properly cured. This indicates that there is a willingness to change sexual behaviour. The problem with complete cure is that patients are never called back for review. It appears that if there is no other way of determining complete cure other than disappearance of symptoms, which does not mean complete cure, patients are going to involve themselves still into sexual contacts even if they are not completely cured. It would be better if all STDs patients that are on treatment are to come back for review and further examination so as to check if they have been completely cured.

The occurrence of STDs in this study was in accordance with findings of other studies done mostly in the USA and few in South Africa. The prevalence of STDs was similar to those of the study done in the USA and South Africa. (Aral and Homles 1991:18-25; Brandt 1988 :375-380; Dangor et al. 1989 ; Moran et al. 1989 :560).

1.2 CONCLUSION

Transmission, occurrence, treatment, prevention and control of STDs is influenced by geographic, demographic/biography,socio-cultural and socio-economic

factors. The study could not show clearly the link between young age and prevalence of STDs, because of the age range which did not cover the older people of the community.Instead the study has shown that many young people are affected by STDs at an early age of 15years.The study indicated that young people from age 15years to 30 years have the same rate of involvement in sexual activities, the distribution of STDs within this age group was more or less the same .These age groups are a determinant factor also in the transmission control,prevention and treatment of STDs. STDs occur commonly amongst members of low socio-economic status. The study did not show variation between marital status categories, because they were not well represented .

Beliefs influence the treatment of STDs. Many patients who associated their illness with witchcraft sought treatment from traditional healers also; this had a potential delay ofseeking treatmeent in health centres . It is not clear whether such treatment are to be discouraged or encouraged. More is yet to be discovered around the area of STDs and traditional healing. Accessibility and availability of health centres also influence the spread, prevention, treatment and control of STDs. Patients who reported that there were no clinics adjacent to their residences encountered many stumbling blocks to reach health centres . These stumbling blocks were distance to be walked or travelled to health centres and transport fares. Many patients with penile sores reported that there were no health centres adjacent to their areas.However, with

patients who had gonorrhoea or gonococcal urethritis accessibility and availability did not show much influence in the incidence of the two STDs, because both conditions seemed to be prevalent amongst those who had nearby clinics as well as amongst those who reported that there were no adjacent clinics.

Geographical influences were also seen to be affecting STDs, because some patients decided to attend the clinics they attended though there were health centres adjacent, because there was no transport going towards the nearer clinic . The lack of transport was associated with bad roads which were further associated with the topography of this country which would need highly sophisticated technological ways to by-pass hills in the country.

Socio-economic conditions such as unemployment, low income and low level of education were seen to influence STDs, because many respondents in the sample were characterised by low socio-economic status. However, the association of STDs with socio-economic factors is doubtful since the study did not have data from private health centres which could be used by certain people from a high class.

Use of condoms is associated with a lot of psychological stumbling blocks and misconceptions by most patients. Gross unavailability of condoms in most areas could be associated with poor use of condoms found by the study.

Lack of reading amongst most patients or unavailability of pamphlets is a problem that needs attention if more people are to be educated about STDs and if the incidence is to be controlled.

On knowledge ,perceptions, attitudes,beliefs and practices , the study found that some patients knew that STDs are infectious, while others did not know and never heard anything about STDs. Some patients perceived STDs to be associated with shame and did not want to tell other people about their condition.Other patients associated STDs with witchcraft, hence they consulted traditional healers as well.
On popular means of communication , the study found that Radio Transkei Broadcasting Corporation is popular amongst people.Nurses were also found to play a limited role in educating people about STDs . Reading culture was discovered to be poor in the country

In conclusion, through the observations of this study it is concluded that geographic, biographic, socio-cultural and socio-economic factors influence the transmission, treatment prevention and control of sexually transmitted diseases. If attention is not paid to what the study has revealed, STDs are going to remain a problem in Transkei. It is emphasized to the policy-makers that if HIV infection is to be controlled properly, the policy should start by concentrating on STDs and thereby HIV or AIDS will be prevented. No one can prevent AIDS in separation from other STDs.

3 RECOMMENDATIONS

(1) This study suggests that studies on STDs amongst women need to be done amongst females who attend antenatal clinics, gynaecological clinics and family planning clinics in Transkei. Many studies on females have been conducted at these clinics in USA, it shows that it has been difficult to get women in other general clinics. For those who attend none of these clinics, screening of women randomly with their permission is needed in mobile points.

(2) It is suggested that to be able to control the spread of STDs related to long distances , transport and roads, towards health centres should be made available.To prevent problems of delay in commencement of treatment , STD clinics, STD mobile points, youth health clinics separated from adult health centres that are community based should be organised.

(3) Radio Transkei Broadcasting Corporation should be used for health education on STDs . More pamphlets should be made available for people to read . Measures or strategies that promote a reading culture in the community should be encouraged.

(4) Contact tracing should be very strict and patients should be encouraged to bring contacts,legal measures should assist in bringing this into action. A Health act that deals with contact tracing should be made.

(5) STDs' treatment regimens should be changed and reviewed all the time. There should be no treatment regimen be in use for two years without review, and the studies should investigate their effectiveness.

(6) STDs patients should be reviewed to make sure that they have been completely cured.A patient should be called again to ensure by means of tests that he or she is completely cured.

(9). HIV programmes should include STDs programmes that are community-based and should not be separated from other youth development projects. Also health education should be continuous, because this study has revealed that people still do not know much about STDs and have stumbling blocks in engaging in change in sexual behaviour and in health related-behaviours.

SUMMARY

Respondents (patients)between the ages 15years and 30years (N=146)from each selected health clinic of the ten selected districts in Transkei were interviewed using a structred interview schedule. The respondents interviewed were patients who visited health centres and who were diagnosed to be suffering from STDs.The interviews were conducted to obtain information on the influences of geographic, demographic/biographic,socio-cultural and socio-economic factors in the transmission,treatment, prevention and control of STDs.The study was undertaken to provide information for planning STD preventive strategies and to argue why there should be a change in the management of STDs to community-based control measures.Most patients suffered from gonorrhoea and gonoccal urethritis more than any of other STDs.Some patients reported that they had STDs before, while others did not know.Some patients knew that STDs were infectious and that one contracts them through sexual contacts with infected persons.The most popular source of information on STDs was Radio Transkei Broadcasting Corporation. Pamphlets and other sources of information seem not to be popular.Nurses played a limited role as source of information .

Most patients did not use condoms during their sexual activities and some of the patints reported to have had sexual intercourse during their illness without condoms.Fourty seven

percent of the patients did not like condoms and associated them with people who are HIV positive or had AIDS.Some patients reported that they have heard about condoms,however condoms were not available in their areas.

Some patients reported that there were no clinics near their residential areas.Patients reported that even where there were clinics nearer the one they had attended, there was no transport to such clinics .Distances to these clinics were long to be walked.

A significant number of patients reported that they consulted traditional healers for their STD problems, because they associated their STD with witchcraft while others did so and when they did not get help from westernised health institutions.

It was found that patients visit health centres with some expectations that are related to choice of treatment.Injection appeared to be preferred more than other forms of treatment. Patients did not see AIDS as a greater killer than STDs. Fifty percent of all patients reported that the youth of their areas have promiscuous behaviour and need more information on STDs . Some patients reported that they were ashamed of their STD problems and did not want to tell other people, even their sexual partners.Patients wanted preventive strategies such as campaigns on prevention of STDs, but did not know how these could be conducted .

On whether they found it important to have a sexual contact on the first date of a relationship a significant percentage said yes, while some said no. It would appear that most patients involved themselves in sexual contact with people whose sexual history they did not know. It was deduced thatsexual behaviours of this nature were associated with a high risk of transmission of STDs.Most patients did not know what further research could be done on the question of STDs. The few thought that further researsch should be directed on causes and better methods and strategies of preventing STDs.

The study revealed that there is a link between STDs and geographic ,demographic/ biographic, socio-cultural and socio -economic factors .

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ANNEXURE 1

QUESTIONNAIRE

THE SOCIAL EPIDEMIOLOGY OF SEXUALLY TRANSMITTED DISEASES IN TRANSKEI: AN OBSERVATIONAL STUDY AMONG ADOLESCENTS AND YOUNG ADULTS ATTENDING HEALTH CENTRES

QUESTIONNAIRE NUMBER

A 1-3			

IOGRAPHICAL INFORMATION

. Name of clinic .....

4-5		

. Official diagnosis: .....

.....

6-7		

. Gender:

1	Male
2	Female

8	

. How old are you? .....

9	

. What is your present marital status?

1	Never been married
2	Married/Living together
3	Divorced/Separated
4	Widowed

10	

. Where do you live? .....

11	

. Describe the composition of the household you are a member of: *Alternatively:* Of which members does the household you call "home" consist of?

1	Single person/Only me
2	Married couple or couple living together/Myself and spouse/partner
3	Couple with dependents/Myself, spouse/partner and dependents
4	Single mother with dependents
5	Single father with dependents
6	Other (specify) ....

12	

FOR OFFICE USE ONLY

. What is the highest academic qualification you have obtained?

1	Never attended school (none)
2	Sub-A - Std 1
3	Std 2 - Std 5
4	Std 6 - Std 9
5	Matric
6	Diploma
7	Degree
8	Other (Specify) ....

13 [ ]

. Are you presently working for money?

1	Yes
2	No

14 [ ]

IF **YES**, CONTINUE WITH QUESTION 9.1
IF **NO**, GO ON TO QUESTION 12

.1 Where is your place of work? ..... 15 [ ]

.2 What is your occupation? (Describe the kind of work you do.) .....

..... 16 [ ]

0. Approximately how much money do you earn in one month?

R..... 17 [ ]

1. How many people do you support with your money?

..... 18 [ ]

2. Are you still at school?

1	Yes
2	No

19 [ ]

2.1 If **yes**, where do you go to school? .....

..... 20 [ ]

FOR OFFICE USE ONLY

3. If you neither work nor go to school, describe briefly how you keep yourself occupied every day/how you keep busy/what you do every day:

.....

.....

21-22 | | |

LLNESS BEHAVIOUR: PATTERNS AND PREFERENCES REGARDING TREATMENT

4. Describe the symptoms you are experiencing that made you decide to come to the clinic today

.....

.....

.....

23 | |

5. How long ago did you **first** become aware of these symptoms?

.....

24 | |

5. Have you experienced symptoms like these before?

1	Yes
2	No
3	Can't remember/Don't know

25 | |

5.1 If **yes**, how many times before? .....

26 | |

5.2 If **yes**, what did you do to relieve the symptoms?

1	Nothing
2	Went to the clinic
3	Consulted a doctor
4	Consulted a traditional healer
5	Got medication from chemist
6	Bought medication at supermarket, cafe
7	Took medication that was in the house
8	Other (specify) ....

27 | |

FOR OFFICE USE ONLY

. After how long did the symptoms go away?

.....

28 ☐

. Since the symptoms you are presently experiencing appeared, have you been elsewhere for help before you came to the clinic today?

1	Yes
2	No

29 ☐

.1 If yes, where did you go for help?

1	Doctor
2	Chemist
3	Traditional healer
4	Other (specify) ....

30 ☐

. Have you told anybody else about the symptoms you are experiencing?

1	Yes
2	No

31 ☐

.1 If yes, whom did you tell?

1	Parents
2	Spouse
3	Friend/s
4	Brother or sister
5	Other (specify) ....

32 ☐

.2 If no, why didn't you tell anybody else that you are having these symptoms?

.....

.....

33-34 ☐☐

FOR OFFICE USE ONLY

. Have you taken any medication to relieve the symptoms you are experiencing at the moment?

1	Yes
2	No

35 [ ]

IF **YES**, CONTINUE WITH QUESTION 20.1
IF **NO**, GO ON TO QUESTION 21

.1 Where or whom did you get this medication from?

1	Doctor prescribed it
2	Bought it at chemist
3	Bought it at supermarket/cafe
4	Got it from traditional healer
5	Was in the medicine chest at home
6	Friend/relative gave it to me
7	Other (specify) ....

36 [ ]

2 What kind of medication did you take?

1	Pills/capsules/tablets
2	Ointment
3	Medicine
4	Potion
5	Other (specify/describe) ....

37 [ ]

2.1 As regards pills, ointments and medicines, please give the **brand name** of that which you took

.....

38 [ ]

FOR OFFICE USE ONLY

0.3 Did the medication relieve the symptoms?

1	Yes
2	No

39 ☐

1. Did somebody tell you/advise you to come to the clinic today?

1	Yes
2	No

40 ☐

1.1 If **yes**, who was it? ..... 41 ☐

2. Do you believe that a traditional healer will be able to cure the symptoms you are experiencing?

1	Yes
2	No
3	Can't say/Don't know

42 ☐

2.1 Please explain your answer to the previous question

.....

.....

..... 43-44 ☐☐

. Do you have faith in the medicine of traditional healers?

1	Yes
2	No
3	Can't say/Don't know

45 ☐

.1 Please explain your answer to the previous question

.....

.....

..... 46-47 ☐☐

FOR OFFICE USE ONLY

4. Are you aware of other people with symptoms like yours who have gone to traditional healers for help/treatment?

1	Yes
2	No

48 ☐

5. When visiting a clinic, whom would you prefer to discuss your problems with?

1	Female attendant
2	Male attendant
3	Either/It doesn't matter
4	Other (specify) .....

49 ☐

6. What kind of treatment do you think will bring the best relief for your symptoms?

.....

.....

50 ☐

7. If the treatment you will receive at the clinic today does not work well according to you, what are you going to do then?

.....

.....

.....

51 ☐

AILABILITY AND ACCESSIBILITY OF CARE

8. What means of transport did you use to get to the clinic today?

1	Walked
2	Bicycle
3	Own car
4	Taxi
5	Bus
6	Other (specify) ....

52 ☐

FOR OFFICE USE ONLY

. How far did you have to travel to get to the clinic today?

1	Less than one kilometer
2	Between one and two kilometers
3	Between two and five kilometers
4	Between five and ten kilometers
5	More than ten kilometers

53 [ ]

. Are there any clinics that are easier for you to reach than this one?

1	Yes
2	No
3	Don't know

54 [ ]

.1 If yes, why didn't you go to the clinic that was easier to reach?

.....

.....

55-56 [ ][ ]

. How much did you pay in transport fares to get here today?

1	Nothing
2	Less than R1,00
3	R1,00 - R3,00
4	R3,00 - R5,00
5	R5,00 - R10,00
6	R10,00 - R15,00
7	More than R15,00

57 [ ]

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2. Describe the condition of the roads you had to travel on the way here:

1	Non-existent
2	Impassible
3	Extremely poor
4	Poor
5	Fair
6	Good

58 |

3. In general, what are the main problems you experience if you want to come to the clinic?

.....

.....

..... 59-60 |

Ds GENERAL KNOWLEDGE, PERCEPTIONS, ATTITUDES AND BELIEFS

. What do you think caused the symptoms you are experiencing at the moment? Alternatively: Why do you think are you experiencing the symptoms you described to me earlier on?

.....

..... 61-62 |

. Describe what you understand sexually transmitted diseases to be

.....

..... 63 |

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5.1 Where/whom did you get this information from?

1	Respondent totally uninformed
2	Friends
3	Parents
4	Spouse
5	Health worker
6	School
7	Radio
8	Magazines
9	Newspapers
10	Television
11	Information, pamphlets
12	Other (specify) ....

64-65		

FOR OFFICE USE ONLY

	1	2	3	
	Yes	No	Don't know	
. Do you think that you may be suffering from a sexually transmitted disease at the moment?				B1
. Have you ever hear about a disease called AIDS?				2
. Do you think that having sex could have caused the symptoms you are experiencing at the moment?				3
. Do you think that you can transmit the symptoms you are experiencing to somebody else by having sex with him/her?				4
. Do you believe that men should prove their masculinity by having more than one sexual partner?				5
. Do you think that your symptoms are a punish= ment from the gods?				6

FOR OFFICE USE ONLY

	1 Yes	2 No	3 Don't know	
2. Do you believe that a woman should have a baby before getting married to prove that she is fertile?				7
3. Would you have sex with somebody known to have a STD?				8
4. Do you think it is acceptable for a married man to have sex with women other than his wife?				9
5. Do you think it is acceptable for a married woman to have sex with men other than her husband?				10
6. Do you think that your symptoms are an indication that your ancestors are angry with you?				11
7. Do you believe that it is actually possible to die from the disease called AIDS?				12
8. Would you have sex with somebody known to have had sex with many different partners in the past?				13
9. Do the young people in your area sleep around a lot?				14
10. Do you know what a condom is?				15
11. Do you think that you can STD by having sex only once with a person who has STD?				16
12. Have any health workers ever visited your school/ workplace to tell you about STDs?				17
13. Do you think that young people should be better informed about STDs?				18
14. Would you personally like to obtain more information about STDs?				19

FOR OFFICE USE ONLY

5. What kind of information regarding STDs do you want?

.....

.....

.....

20-21

5. What is being done in your area to inform people about STDs?

.....

.....

22-23

. What, in your opinion, can be done to make people more aware of STDs?

.....

.....

24-25

. What means of information can, in your opinion, be used to make people more aware of STDs?

.....

.....

26-27

. What preventative measures do you take against STDs? (What do you do to ensure that you do not contract STDs?)

.....

.....

28

. What form of birth control are you using at the moment? (What do you do to keep yourself/ your partner from falling pregnant?)

.....

.....

29

. How many people can you think of who may be suffering from STDs at the moment?

.....

.....

30-31

. Tell me everything you know about a disease called AIDS

.....

.....

32

.1 Where/whom did you get this information from?

.....

.....

FOR OFFICE USE ONLY

33 |

XUAL BEHAVIOUR

. How old were you when you had sex for the first time?

..... years

34 |

. How often did you have sex during the past six months?

1	Didn't have sex
2	Less than once per month
3	About once per month
4	About twice per month
5	About once per week
6	About twice per week
7	More than three times per week
8	I don't keep count

35 |

. During the past six months, did you have sex with more than one partner?

1	Yes
2	No
3	Not prepared to answer

36 |

.1 If **yes**, with how many different partners did you have sex with during the past six months?

.....

37 |

. Did you have unprotected sex (without using a condom) with any of these partners?

1	Yes
2	No
3	Not prepared to answer

38 |

FOR OFFICE USE ONLY

6.1 If **yes**, with how many of these partners did you have unprotected sex with (i.e. sex without using a condom) during the past six months?

.....

.....

39 ☐

7. Have you had sex since the symptoms you are presently experiencing, appeared?

1	Yes
2	No
3	Not prepared to answer

40 ☐

IF **YES**, CONTINUE WITH QUESTION 67.1
IF **NO**, GO ON TO QUESTION 68

7.1 With how many different partners did you have sex since your symptoms appeared?

.....

41 ☐

7.2 Did you have unprotected sex (i.e. without using a condom) with this partner/any of these partners?

1	Yes
2	No
3	Not prepared to answer

42 ☐

7.3 With how many different partners did you have unprotected sex since you became aware of the symptoms?

.....

.....

43 ☐

7.4 Are there any specific reasons why you did not use a condom when you had sex with this partner/any of these partners?

1	Yes
2	No
3	Not prepared to answer

44 ☐

FOR OFFICE USE ONLY

7.5 Did you tell your partner/s about the symptoms you are experiencing before you had sex with him/her/them?

1	Yes (to all)
2	No (to none)
3	Only to some

45 ☐

7.6 Are you going to tell the partner/s you had unprotected sex with since your symptoms appeared to come to the clinic?

1	Yes (all of them)
2	No (none)
3	Only some

46 ☐

8. Are condoms readily available in your area?

1	Yes
2	No
3	Don't know/Can't say

47 ☐

8.1 If **yes**, name the places you know where condoms are available

.....

.....

48 ☐

9. In general, do you have any objections against the use of condoms?

1	Yes
2	No
3	Don't know

49 ☐

9.1 If **yes**, what are your main objections against the use of condoms?

.....

.....

50 ☐

FOR OFFICE USE ONLY

Where would you go **first** to find condoms if you needed some?

.....

.....

51 [ ]

	1 Yes	2 No	3 Not prepared to answer
1. Do you ask a person about his/her previous experience before you decide to have sex with him/her?			
2. Do you intend to stop having sex until you are cured?			
3. Would you be prepared to use a condom if this would prevent the symptoms you are experiencing from being transmitted to your partner/s during sex?			
4. Do you think it is okay to have sex on the first date?			

52 [ ]

53 [ ]

54 [ ]

55 [ ]

Please give me any additional information you think is important for me to know regarding this study.

.....

.....

56-57 [ ][ ]

THANK YOU VERY MUCH FOR YOUR CO-OPERATION.

QUESTIONNAIRE

E SOCIAL EPIDEMIOLOGY OF SEXUALLY TRANSMITTED DISEASES AMONG OLESCENTS AND YOUNG ADULTS IN TRANSKEI

QUESTIONNAIRE NUMBER

A 1-3			

OGRAPHICAL INFORMATION

Igama le Kliniki .....

4-5		

Isigulo .....

6-7		

.....

Isini:

1	Male
2	Female

8	

Mingaphi imimyaka yakho? .....

9	

Utshatile/wendile

1	Zange ndende/okanye nditshate
2	Ndendile/nditshatile/ndiyahlalisana
3	Ndohlukene/ndaqhawula umtshato
4	Ndingumhlolokazi/umhlolo

10	

Uhlala phi? .....

11	

Uhlala nabani ekhaya?

1	Wedwa
2	Nomyeni/okanye nenkosikazi yakho
3	Uhlala nabantwana bakho
4	Umama nabantwana
5	Udada nabantwana
6	Chaza okunye ....

12	

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Uphumelele eliphi ibanga lemfundo

1	Zange Ndafunda
2	Sub-A - Std 1
3	Std 2 - Std 5
4	Std 6 - Std 9
5	Matric
6	Diploma
7	Degree
8	Chaza Okunye ....

13 ☐

Uyaphangela?

1	Ewe
2	Hayi

14 ☐

UKUBA UYAPHANGELA BUZA UMBUZO WE 9.1
UKUYA KOWE-11

.1 Usebenza phi? ..... 15 ☐

.2 Usebenza msebenzi mni chaza .....
..... 16 ☐

0. Wamkela malini? Ngenyanga/enye? ..... 17 ☐

1. Bangaphi abantu obaxhasa (obondla)
NGALO MVUZO WAKHO? ..... 18 ☐

2. Usafunda?

1	Ewe
2	Hayi

19 ☐

2.1 Ufundaphi? ..... 20 ☐

FOR OFFICE USE ONLY

. Ukuba akufundi akusebenzi uyichitha njani imini okanye usuku?
Chaza .....

.....

.....

21-22		

LNESS BEHAVIOUR: PATTERNS AND PREFERENCES REGARDING TREATMENT

. Zinto zini ozibone, nozive emzimbeni wakho ezenze weza apha kule kliniki? Chaza

.....

.....

.....

23	

. Ezi zinto zisemzimbeni okanye uzivayo ziqale nini? .....

24	

. Wakhe wanazo ngaphambili

1	Ewe
2	Hayi
3	Andikhumbuli/andazi

25	

.1 Ukuba ukhe wanazo kukangaphi? .....

26	

.2 Ukuba wawukhe wanazo iimpawu ezinje ngezi, wazinceda ngatoni?

1	Zange ndenzento zaziphelela
2	Ndaya eKliniki
3	Ndaya KwaGqira
4	Ndaya egqireni
5	Ndathenga iyeza eKhemisti
6	Ndathenga iyeza eVenkileni
7	Ndathatha ipilisi okanye iyeza elalikho endlini
8	Chaza okunye ....

27	

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. Kwathatha ixesha elingakanani ukuba uzive ubhetele? .....

28

. Ubukhe wafuna uncedo kwenye indawo phambi kokuba uze lapha?

1	Ewe
2	Hayi

29

.1 Ube ulufune phi olo ncedo?

1	Kugqirha
2	Khemist
3	Koosiyazi, amaxhwele, etc.
4	Chaza ukuba kukho enye indawo ....

30

. Ukho umntu obukhe wamxelela ngale mpilo yakho?

1	Ewe
2	Hayi

31

.1 Uxelele bani?

1	Abazali
2	Umyeni/inkosikazi
3	Abahlobo
4	Ubhuti/usisi
5	Xela ukuba ukhona omnye ....

32

.2 Kutheni ungaxeleli mntu nje ngale mpilo yakho? .....

.....

.....

33-34

FOR OFFICE USE ONLY

0. Ubukhe wasela okanye wathatha nto ngale mpilo yakho?

1	Ewe
2	Hayi

35 ☐

UKUBA UTHATHE NTO BUZA KU-20.1 KANTI UKUBA AKUNJALO BUZA KU-21

0.1 Uwathathe phi amayeza?

1	Uyithathe kugqirha
2	Ekhemisti
3	Evenkileni
4	Koosiyazi okanye amaxhwele
5	Ekhaya
6	Etshomini okanye izizalwane
7	Ukuba kukho okunye kuxele ....

36 ☐

0.2 Uthathe

1	Iipilisi
2	Into yokuqaba
3	Iyeza
4	Isitofu
5	Ukuba kukho okunye xela ....

37 ☐

0.2.1 Chaza uhlobo lweyeza oluthathileyo ....

0.3 Uye wancedakala phofu?

1	Ewe
2	Hayi

38 ☐

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21. Ukhona umntu okucebise ukuba uze apha?

1	Ewe
2	Hayi

39 ☐

21.1 Ucetyiswe ngubani? ..... 40 ☐

22. Uyakholwa ukuba iyeza lesintu lingakunceda kule mpilo?

1	Ewe
2	Hayi
3	Andazi/andingetsho

41 ☐

22.1 Kutheni uphendula ngolu hlobo nje? Xela isizathu soko .....

.....

.....

..... 42-43 ☐☐

23. Uyakholelwa kuncedo lwamayeza esintu?

1	Ewe
2	Hayi
3	Andazi/andingetsho

44 ☐

23.1 Kutheni ukholelwa nje/okanye ungakholelwa, xela .....

.....

..... 45-46 ☐☐

24. Bakho abantu obaziyo abakhe banyange ngamayeza esintu kule mpilo enjengale yakho?

1	Ewe
2	Hayi

47 ☐

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25. Xa ufika kwikliniki enje ngale unga ungabuzwa ngumntu onjani?

1	Obhinqileyo
2	Indoda
3	Nokuba ngowuphi
4	Xela omnye ukuba ukho .....

48 ☐

6. Unqwenela ukunyangwa kanjani ukuze uqonde ukuba uchaniwe? Chaza .....

.....

49 ☐

.....

7. Ukuba la mayeza akakuniki bubhetele obulindeleyo uza kuthini? .....

50 ☐

.....

VAILABILITY AND ACCESSIBILITY OF CARE

8. Uze ngantoni apha kwezi zilandelayo?

1	Ngeenyawo
2	Ngebhayisekile
3	Ngemoto
4	Ngetaxi
5	Ngebhasi
6	Ukuba yenye into yichaze ....

51 ☐

9. Ungakanani umgama owuhambayo xa usiza apha ekliniki?

1	Kungaphantsi kwe-kilometer
2	Phakathi kwe-kilometer ezimbini
3	Phakathi kwe-kilometer ezintlanu
4	Phakathi kwe-kilometer ezintlanu ukuya kwezilishumi
5	Ngaphezu kwe-kilometer ezilishumi

52 ☐

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. Ingaba zikhona iikliniki ezikufutshane kuwe ngcono kunale?

1	Ewe
2	Hayi
3	Andazi

53 |

.1 Xa ikhona ekufutshane kutheni ungasebenzisi yona nje? .....

.....

..... 54-55 | |

. Ukuba ukhwele xa usiza apha ubhatale malini?

1	Andikhwelanga
2	Ngaphantsi kwe- R1,00
3	R1,00 - R3,00
4	R3,00 - R5,00
5	R5,00 - R10,00
6	R10,00 - R15,00
7	Ngaphezulu kwe-R15,00

56 |

2. Zinjani iindlela eziza apha ekliniki?

1	Azikho
2	Zimbi kakhulu
3	Azihambeki ngemoto
4	Zimbi
5	Ziyahambeka nangona zimbi
6	Zintle

57 |

3. Ziziphi iingxaki othi ubenazo xa kufuneka uze ekliniki? .....

..... 58-59 | |

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TDs GENERAL KNOWLEDGE, PERCEPTIONS, ATTITUDES AND BELIEFS

4. Le mpilo yakho uyidibanisa nantoni okanye ucinga ukuba yintoni ebangela le mpilo yakho ibenje? .....

.....

60-61 | | |

5. Yintoni oyaziyo ngegcutshuwa okanye ipoka

.....

.....

62 | |

5.1 Ulufumene phi olu lwazi?

1	Akukho nto ndiyaziyo ngezi zigulo?
2	Kubahlobo
3	Kubazali
4	Kumyeni/inkosikazi
5	Kunompilo ojikelezayo
6	Isikolo
7	Radio
8	Magazine
9	Kumaphepha-ndaba
10	Kwitelevision
11	Kwiphamflethi
12	Xela apho ufumene khona ....

63-64 | | |

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	1	2	3	
	Ewe	Hayi	Andazi	
6. Ucinga ukuba unezigulo, ipoka okanye i-drop igcutshuwa okanye				B1
7. Wakhe weva nge-AIDS				2
8. Ucinga ukuba ukulala wabelane ngesondo kungayenza impilo yakho ibenje?				3
9. Ucinga ukuba xa unokulala wabelane nomntu ngesondo kungamenza naye impilo yakhe ibenje ngale yakho?				4
0. Uyakholelwa ukuba amadoda kufuneka azibonakalise ubudoda bawo ngokuthandana namabhinqa amaninzi (aliqela)?				5
1. Ucinga ukuba le mpilo yakho yenziwa kukufulathelwa zizinyanya?				6

FOR OFFICE USE ONLY

	1	2	3	
	Ewe	Hayi	Andazi	
2. Ucinga ukuba intombazana mayiqale izale phambi kokuba itshate khona ukuze ibonakalise ukuba iyazala?				7
3. Ungalala nomntu nabelane ngesondo ukuba uyamazi unegcutshuwa enganyangwanga?				8
4. Indoda ingakrexeza xa itshatile?				9
5. Umfazi angakrexeza xa etshatile?				10
6. Ucinga ukuba i AIDS ingakubulala				11
7. Ucinga ukuba igcutshuwa/ i poka ingakubulala				12
8. Ungalala wabelane ngesondo nomntu omaziyo ukuba ubethandana elalana nabantu abaninzi?				13
9. Ngaba ulutsha lwendawo yakho ilalana ithandane ngendlela apha enobuhule?				14
0. Uyayazi i-condom?				15
1. Ngaba igcutshuwa uyayifumana xa ulele kwakanye nomntu onayo?				16
2. Oonompilo/amanesi akhe akuhambela esikolweni/apho usebenza khona akuxelela ngegcutshuwa ipoka?				17
3. Ucinga ukuba ulutsha lolona kufuneka lunikwe ulwazi oluninzi ngezifo zokulalana?				18
. Wena ungathanda ukufumana ulwazi oluphangaleleyo ngezizifo zokulalana?				19

FOR OFFICE USE ONLY

5. Loluphi kanye ulwazi olufunayo ngezizifo? .....

.....

.....

.....

20-21

. Kwenziwa ndzame zithini kweyakho indawo ukwazisa abantu ngezifo zokulalana?

.....

22-23

.....

. Wena ucinga ukuba kwenziwe ntoni ukwazisa uLuntu ngezifo zokulalana? .....

.....

24-25

.....

. Ucinga ukuba zeziphi indlela ezingasetyenziswa ukwazisa abantu ngezizifo?

.....

26-27

.....

. Wena wenza ntoni ukuthintela ezizifo? .....

.....

28

.....

Ucwangcisa ngantoni ngoku? .....

.....

29

.....

Bangaphi abantu ocinga ukuba banezifo zokulalana ngoku? .....

.....

30-31

.....

Xela yonke into oyaziyo nge AIDS? .....

.....

32

.....

1 Uluthatha phi olulwazi nge AIDS? .....

.....

33

.....

FOR OFFICE USE ONLY

EXUAL BEHAVIOUR

3. Ube umdala kangakani ngexesha waqala ukulala nendoda okanye ibhinqa yeminyaka

.....

34

4. Wabelene ngesondo kangaphi kwinyanga ezi-6 ezidlulileyo

1	Andizange
2	Ngaphantsi kwenyanga
3	Kanye ngenyanga
4	Kabani ngenyanga
5	Kanye ngeveki
6	Kabini ngeveki
7	Ngaphezi kwesithathu evekini
8	Andibali

35

. Kwinyanga ezi-6 exigqithileyo ubukhe walala nomntu nabelana ngesondo?

1	Ewe
2	Hayi
3	Andizuphendula

36

.1 Bangaphi ke okhe walala nabo nabelana ngesondo .....

.....

37

. Ube uyisebenzisile idondom xa ulele naba bantu?

1	Ewe
2	Hayi
3	Akaphenduli

38

.1 Bangaphi olele nabo ungasebenzisi condom?

.....

.....

39

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7. Ubukhe walala nomntu nabelana ngesondo ngoku unale mpilo?

1	Ewe
2	Hayi
3	Akaphenduli

40 ☐

UKUBA KUNJALO BUZA KU 67.1
UKUBA AKUNJALO BUZA KU 68

7.1 Bangaphi olale nabo ekubeni unale mpilo inje? .....

41 ☐

.....

7.2 Ulale nabantu ngaphandle kwecondom?

1	Ewe
2	Hayi
3	Akaphenduli

42 ☐

7.3 Bangathi olele nabo ngaphandle kwe-condom bebonke? .....

.....

43 ☐

.....

7.4 Unazo izizathu zokungasebenzi icondom naba bantu obulele nabo nabelana ngesondo?

1	Ewe
2	Hayi
3	Akaphenduli

44 ☐

7.5 Ubaxelele abantu obulele nabo ngale mpilo yakho phambi kokuba nilalane?

1	Ewe kuba bonke
2	Hayi
3	Ewe kwabanye

45 ☐

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.6 Ngaba uza kubaxelela bonke aba bantu obulele nabo ukuba beze ekliniki?

1	Ewe
2	Hayi
3	Abanye

46 ☐

. Ingaba iicondoms zikhona kwindawo ohlala kuyo, zifumaneka lula?

1	Ewe
2	Hayi
3	Andazi

47 ☐

.1 Iicondoms zifumaneka phi? .....

.....

48 ☐

.....

. Ngaba ukuchasile na ukusebenzisa iicondoms?

1	Ewe
2	Hayi
3	Andazi

49 ☐

.1 Xa uzichasile unaziphi izizathu? .....

.....

50 ☐

.....

. Ungayaphi xa ufuna iicondoms? .....

.....

51 ☐

.....

FOR OFFICE USE ONLY

	1	2	3	
	Ewe	Hayi	Akaphenduli	
1. Ukhe umbuze ngezithandwa zangaphambili?				52
2. Akuzukulala namntu nabelane ngesondo de unyangeke?				53
3. Ungayisebenzisa icondom khona ukuze basinde olala nabo?				54
4. Ngaba kubalulekile na ukulala nomntu othandane naye ngomhla wokuqala nazene?				55

. Khawundixelele nayiphi na into ocinga ukuba ifanelekile ukuba iphandwe kwakhona kolu phando lwezigulo zolalano

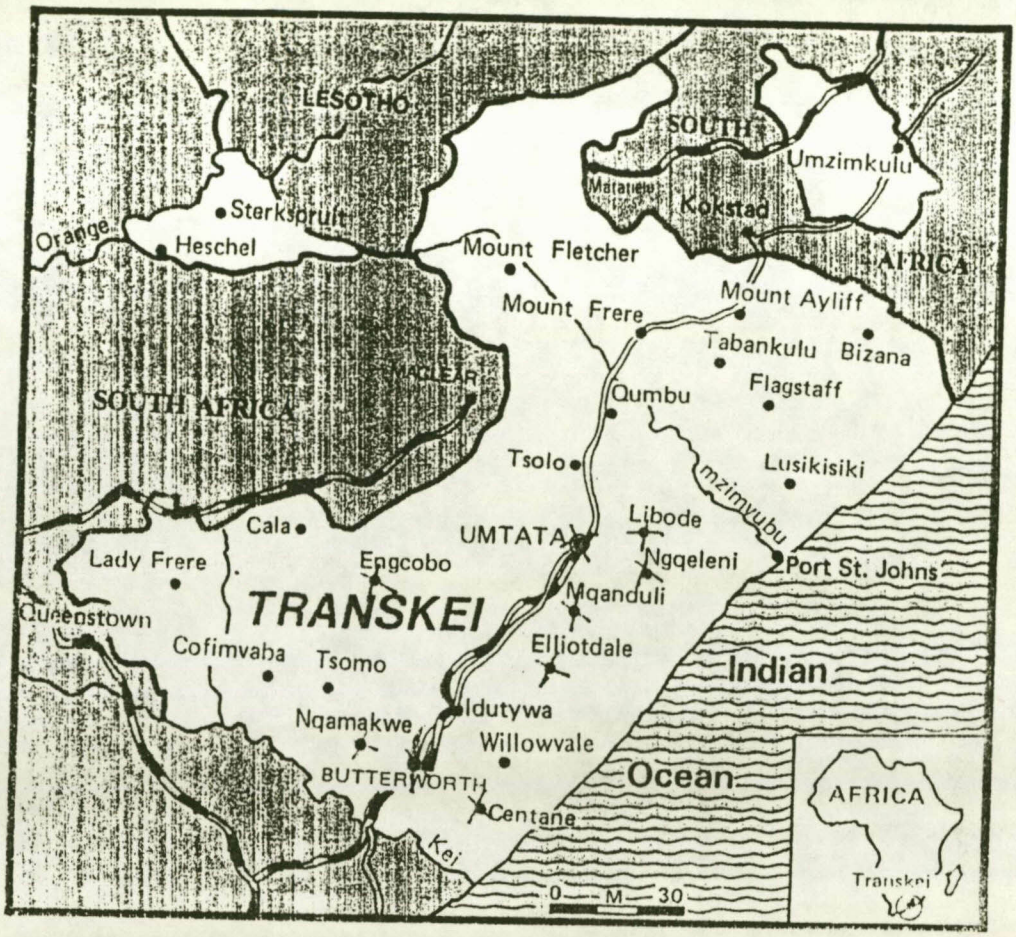
.....

.....

56-57

YABABULELA BONKE ABATHABATHE INXAXHEBA KOLU PHANDO.

ANNEXURE II



The Republic of Transkei