

Knowledge, attitudes and behaviour of reinfected patients - Suva STD clinic, Fiji 1994/5

PHYLLIS HOTCHIN*

PENEHURO TAPELU, BSc.*

VANDHANA CHETTY*

ROBERT HAKWA*

DAVID PHILLIPS, MB, FAFPHM, MRCCGP*

Abstract

A survey of individuals attending the principal STD treatment facility in Fiji was conducted over a twelve week period spanning 1994/5. 42 people agreed to participate. 55% were presenting with their second STD, 25% with their third and 20% with fourth or subsequent infections.

The majority were single (69%), Fijian (78%), males (83%) in the 20 to 31 year age group (85%). The majority (78%) had completed at least three years of secondary schooling. Employment status was variable with sailors (20%) and drivers (22%) being the two groups most prominently represented.

Knowledge of both modes of transmission and causation of STD was generally good (100% knew sex to be a mode of transmission), with some confusion over toilet seats (25% gave it as a mode of spread). 63% "sometimes" used condoms; a further 35% "never" used condoms with a solitary person claiming to always use them. The "sometimes" groups was questioned as to when they do use condoms, all responses were either "when available" or "when sober". 88% knew that condoms prevented STD but only 5% used them in their last sexual encounter. 70% gave the reason for not using them that they were not readily available, all claiming they would have used them had they been to hand; a further 25% claimed they were "too drunk."

Encounters with the health care system, with one to one education and effective treatment, would appear to have had little effect on subsequent behaviour in this group. Despite adequate knowledge of modes of transmission and preventive actions, environmental factors such as alcohol consumption and non availability of condoms at "critical" times, would seem to be the principal determinants of the likelihood of enjoining behaviour that could lead to the contracting of an STD.

The large numbers of sailors and drivers, groups known for their ability to traverse geographical and cultural boundaries, is disquieting. More work is clearly needed on the effectiveness of current strategies with approaches addressing the situational determinants of behaviour more directly, with perhaps less "disease specific" emphasis. The targeting of such groups is needed to include consideration of anonymous testing for HIV, if we are to be able to effectively tailor responses to the pandemic in this country.

" 88% knew that condoms prevented STD but only 5% used them [condoms] in their last sexual encounter. "

Introduction

The reported prevalence of notifiable STD in Fiji has shown little change over many years albeit with some changes in the geographical and ethnic composition, Gonorrhoea has accounted for approximately 70% of cases with Syphilis a further 20%^{1,2,3,4,5}. Easy and cheap access to effective treatment gave little incentive for either the authorities or individuals to attempt to change behaviour until the arrival of the HIV pandemic. One of the main approaches of the response to the epidemic has been that of IEC (Information, Education and Communication) focusing principally at raising awareness.

Strategies must be shown to be effective and sustainable if they are to maintain public, professional, financial and political support, especially as the epidemic is at an early stage in the region; their impact must be demonstrable and measurable. General knowledge of STD and AIDS has grown but there is little published work in the region to suggest how this has impacted on behaviour. This study selected one of the groups with highest risk behaviour i.e. those presenting to an STD clinic with a second or subsequent infection, to assess their STD related knowledge, attitudes and behaviour.

* Department of Community Health, Fiji School of Medicine, Private Mail Bag, Suva, Fiji.

Methodology

Setting: Suva STD clinic. The principal government funded treatment facility for STD in Fiji. It is situated distant from hospital or other clinic in the middle of a bus terminus, from where buses depart to all parts of the main island of Viti Levu.

Subjects: Randomly selected patients presenting to the STD clinic with a documented STD reinfection over two six week periods in late 1994 and mid 1995, 80% agreed to participate. Reinfection was defined as those who had presented on two or more separate occasions with new infections. Diagnosis was based on history, examination and laboratory testing.

Design: All individuals were approached to explain the nature and rationale of the study and were asked for their consent before inclusion in the study. Questionnaires were then administered by four of us (PH, PT, VC and RH) in a private area. Confidentiality was explained and ensured.

Results

Demography

40% of patients were in the 20-25 age group and a further 35% in the 26-31 age group. The youngest was aged 15 and the oldest aged 37. 83% were males and 17% females. 78% were indigenous Fijians with Indians and others making up the remaining 22% of cases. 69% were single with 26% married or in a de facto relationship, the remaining 5% were divorced.

These were fairly widely distributed, however there were one or two groups with significant numbers these included 22% giving their employment as a driver; 20% as sailor and 15% as dockworker.

78% had completed both primary school and at least three years of secondary schooling, while a further 12% had some level of tertiary education.

55% were presenting with their second STD, 25% with their third and 20% with their fourth or subsequent STD.

Knowledge

Knowledge was tested in a number of areas, these were: a) knowledge of disease entities as STD; b) knowledge of mode of transmission of STD and c) knowledge of causes of STD. The results were as follows:

Diseases and STD: Five disease names (AIDS, Gonorrhoea, Syphilis, TB and Diabetes) were given and respondents were asked if they were STD. Answers were either Yes, No or *Don't Know*. AIDS was the condition most commonly identified as being an STD (83% of cases), Syphilis and Gonorrhoea were correctly identified by 57%, with 33% not knowing whether they were STD or not, and the remaining 10% saying they were not STD. Of the other diseases 30% of respondents gave TB as an STD with a further 20% not knowing.

Mode of Transmission: Seven different options were given i.e. kissing; mosquito bites; sex; infected blood transfusion; sharing razors; from mother to child and from toilet seats. With each having the same response options as above. The notable features of the responses were 100% knowledge of sex as a means of transmission with 90% believing that mother to child and infected blood were sources of infection, 25% however believed toilet seats to be a cause of spread.

Causation of STD: 75% identified "germs" as the cause of STD with 20% not knowing. and the remainder giving "other" responses.

Practices

This category of questioning related primarily to condom use and factors influencing this.

Compliance with Medication: 85% claimed to have completed all their previous course of medication for their STD with 15% admitting to non compliance of varying degrees.

Condom Use: Responses to the question of condom use were either "always", "sometimes" or "never". 63% sometimes used condoms; a further 35% never used condoms with a solitary person claiming to always use them. The "sometimes" groups was questioned as to when they do use condoms and virtually all responses were either "when available" or "when sober." The "never use" group were divided 50/50 between "partner doesn't like it" and "not available" as the reasons for their non use; further more 50% said "nothing" would make them use a condom.

88% knew that condoms prevented STD but only 5% used them in their last sexual encounter. 70% gave the reason that they were not readily available for not using them, all claimed they would have used them had they been to hand, whilst a further 25% claimed they were "too drunk."

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Discussion

This study has limitations in extrapolating to the wider population, primarily sample size and recall and selection biases, if however one accepts these caveats the study does indicate a number of important issues which merit further investigation.

Firstly it might have been "hoped" that this group of individuals would have displayed some changed behaviour; it would appear that is not the case. It is clear that their first, or in many cases subsequent encounters with the system, bringing with it one to one education and effective treatment had little effect on their subsequent behaviour. It would appear that they have adequate knowledge of modes of transmission of STD and ancillary risk factors.

Secondly, environmental factors such as alcohol consumption, in combination with non availability of condoms at crucial times, would seem to be the principal determinants of their vulnerability to contracting an STD.

Thirdly it would suggest that effective STD campaigns are going to have to include less disease specific and more broader based approaches to lifestyle change. Authorities will, amongst other things, need to accept that availability of condoms in the appropriate place at the appropriate time is a key need for people whose judgement is impaired by a combination of 'intoxicating' substances and intoxicating subjects. The ability of condoms to promote promiscuity in such situations (as is feared in some quarters) is minimal, but their ability to prevent ill health is substantial. Some useful work has been done on the subject of condom use locally but more is clearly needed^{6,7}.

Fourthly, the mode of delivery of IEC activities must be questioned. At an individual level the people giving the education are often health professionals, doctors or nurses. They often do not possess any special training in communication or counselling, professional/peer group counselling

both in the environment of the STD clinic and other high risk situations. Coverage of the subject in the press is extensive with health education materials increasingly widely available, but a significant number are still of the 'AIDS Kills' variety, although there are some encouragingly innovative responses. Young people do not, nor should fear death. More imaginative and alluring spectres need to be designed alongside systematic trialing and evaluation of these innovative strategies.

It is disconcerting to see the high percentage of drivers and sailors in the occupational groups. This trait is worrying as these are recognised globally as being individuals who by dint of their occupation travel widely and are thus conduits for the introduction of HIV from foreign countries. Finally it suggests that some of these groups might well be targeted for more intensive efforts at this stage of the pandemic in the region; anonymous testing of some of these groups for HIV merits further consideration if we are to tailor our responses to the pandemic usefully and effectively.

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“ AIDS has opened up people's minds. We can't go back. It is time to discuss things openly. ”

Cecilia Short, Curriculum Development, Cook Islands