

UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE
DEPARTMENT OF POST BASIC NURSING

THE UNIVERSITY OF ZAMBIA
MEDICAL LIBRARY (UTH)

P.O. BOX 32379,
LUSAKA, ZAMBIA.

**A STUDY TO DETERMINE KNOWLEDGE, ATTITUDES AND
PRACTICES OF WOMEN TOWARDS SEXUALLY TRANSMITTED
INFECTIONS IN KAOMA**

BY
RACHAEL M. LUNGWEBUNGU

ZAMBIA REGISTERED NURSE 1996 - NDOLA

SPR
MED
LUN
2002

**A RESEARCH STUDY SUBMITTED TO THE DEPARTMENT OF POST BASIC
NURSING, SCHOOL OF MEDICINE, UNIVERSITY OF ZAMBIA, IN PARTIAL
FULFILMENT FOR THE BACHELLOR OF SCIENCE DEGREE IN NURSING**

ACKNOWLEDGEMENTS

I wish to acknowledge my God, the lord of my life, for the favour He shows me and through His bounding grace which has enabled me to complete my studies.

Special thanks to the Zambian government for granting me the university scholarship through the Ministry of Health to pursue a Bachelor of Science Degree programme.

My sincere thanks to the Head of department of Post Basic Nursing, Ms. E. Lambwe, my supervisor Mrs. P. Ndele and all other lecturers in the department for their guidance, tireless efforts and understanding in supervising my research work.

Very special thanks to my mother for her support and encouragement and for taking care of my children while I was at school, and the whole family for their care and support in my life.

Thanks to management and staff at Kaoma District Hospital who made it possible for me to collect data.

I acknowledge the respondents without whose participation this research would have not been possible.

I thank all my friends and colleagues too numerous to mention for their support and encouragement throughout my training.

Finally, I thank Mr. D. Muleya for his secretarial services.

TABLE OF CONTENTS

	Page
Acknowledgement.....	i
Table of contents.....	ii
Appendices.....	iv
List of tables.....	v
List of figures.....	vi
List of abbreviations.....	vii
Declaration.....	viii
Statement.....	ix
Dedication.....	x
Abstract.....	xi

CHAPTER 1

1.0. Introduction.....	2
1.1. Background information.....	2
1.2. Statement of the problem.....	3
1.3. Justification for the study.....	10
1.4. Objectives of the study.....	10
1.4.1. General objectives.....	10
1.4.2. Specific objectives.....	10
1.5. Study hypothesis.....	11
1.6. Variables.....	11
1.7. Indicators.....	12
1.8. Operational Definitions of terms.....	12

CHAPTER 2

2.0. Literature review.....	13
2.1. Global perspective.....	13
2.2. Regional perspective.....	14
2.3. Zambian perspective.....	15
2.4. Conclusion.....	16

CHAPTER 3

3.0. Research methodology..... 19

3.1. Research design..... 19

3.2. Research setting..... 19

3.3. Study population..... 19

3.4. Study units..... 19

3.5. Sample size..... 19

3.6. Sample selection..... 20

3.7. Data collection technique and tools..... 20

3.8. Pilot study..... 21

3.9. Ethical considerations..... 21

CHAPTER 4

4.0. Data analysis and presentation of findings..... 23

4.1. Data analysis..... 23

4.2. Presentation of findings..... 23

CHAPTER 5

5.0. Discussion of findings..... 37

5.1. Introduction..... 37

5.2. Socio-demographic data..... 37

5.3. Knowledge..... 39

5.4. Attitude..... 41

5.5. Practice..... 43

CHAPTER 6

6.0. Health system implication..... 46

6.1. Conclusion..... 47

6.2. Recommendations..... 48

6.3. Limitations of the study..... 49

APPENDICES

Appendix 1:	References
Appendix 2:	Interview schedule
Appendix 3:	Letter requesting to carry out a research Study
Appendix 4:	Letter granting permission to carry out the research study

LIST OF TABLES

Table 1:	Respondents' knowledge in relation to age.....	27
Table 2:	Respondents' knowledge in relation to educational level.....	28
Table 3:	Respondents' knowledge in relation to marital status.....	28
Table 4:	Respondents' knowledge in relation to occupation.....	29
Table 5:	Respondents' knowledge in relation to residence.....	29
Table 6:	Respondents' attitude in relation to age.....	30
Table 7:	Respondents' attitude in relation to marital status.....	31
Table 8:	Respondents' attitude in relation to educational level.....	31
Table 9:	Respondents' attitude in relation to occupation.....	32
Table 10:	Respondent's attitude in relation to residence.....	32
Table 11:	Respondents' practice in relation to age.....	33
Table 12:	Respondents' practice in relation to marital status.....	34
Table 13:	Respondents' practice in relation to educational level.....	34
Table 14:	respondents practice in relation to occupation.....	35
Table 15:	Respondents' practice in relation to income.....	35
Table 16:	Respondents practice in relation to residence.....	36

LIST OF FIGURES

Figure 1: Respondents’ age..... 24

Figure 2: Respondents’ marital status..... 24

Figure 3: Respondents’ educational level..... 25

Figure 4: Respondents’ occupational level..... 25

Figure 5: Respondents’ monthly household income..... 26

Figure 6: Respondents’ residential area..... 26

Figure 7: Respondents’ knowledge on sexually transmitted
Infections..... 27

Figure 8: Respondents’ attitudes towards STIs..... 30

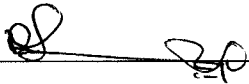
Figure 9: Respondents’ practice towards STIs..... 33

LIST OF ABBEREVIATIONS

AIDS	-	Acquired Immune Deficiency Syndrome
CSO	-	Central Statistical Office
HIV	-	Human Immune Deficiency Virus
MOH	-	Ministry of Health
NGO	-	Non Governmental organization
STIs	-	Sexually Transmitted Infections
WHO	-	World Health Organization
ZDHS	-	Zambia Demographic Health Survey

DECLARATION

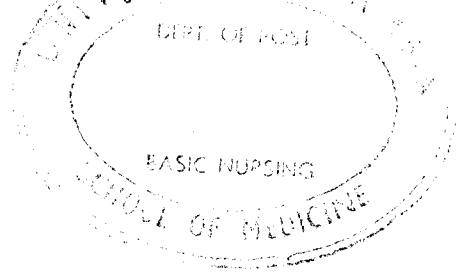
I hereby declare that this work presented in this study for the degree of Bachelor of Science in Nursing, has not been presented wholly or in part for any other degree or it is being currently submitted for any other degree.

Signed: 

Date: 08/03/02

Approved by: 
SUPERVISING LECTURER

Date: March 11th 02



STATEMENT

I hereby certify that this study is entirely the result of my own independent investigation. The various sources to which I am indebted are clearly indicated in the paper and in the reference.

Signed: RL

Name: R. M. LINSLEY BAKER

Date: 08/03/02

DEDICATION

This study is dedicated to my mother, Ms. Belita Samulyata, my children, Mubukwanu and Yvonne, and all my brothers and sisters.

ABSTRACT

Objectives
The objective of this study was to determine the knowledge, attitude and practices of women towards sexually transmitted infections in Kaoma. Fifty (50) respondents of women in the reproductive age group were sampled. Literature that has been reviewed showed that sexually transmitted infections are a public health problem which require urgent attention particularly the attitude of the general public and their choice of treatment.

Methodology
For the purpose of this study, a descriptive cross section survey was chosen. A systematic random sampling technique was used to select the sample size. A structured interview schedule was used as a data-collecting tool. The pilot study was conducted to test the suitability of the methodology. The data was analysed manually using a calculator and entered on a data master sheet. The findings were presented in the form of pie charts, bar charts and simple frequency tables.

Results
The study revealed that the majority of respondents had average knowledge (78%), positive attitudes (82%) and poor practice (96%) towards STIs. The study showed that the respondents were aware of STIs and its mode of transmission. Most of the respondents stated that they would go to a health care facility when infected with a sexually transmitted infection and would encourage their sexual partners to do the same. However, the majority do not use condoms and said that they would not initiate condom use during sexual activity for prevention of STIs. The few of the respondents who said were using condoms revealed that they did not use them always and they use them mainly for family planning.

Recommendations
The major recommendations made include the following; a similar study should be done on a larger scale, preferably on the entire district to determine the knowledge, attitudes and practices of the population towards STIs, and health workers should intensify information, education and communication (IEC) strategies to enhance better understanding of the facts about STIs. Women should be empowered economically by the government and the non-governmental organizations by giving them loans to improve their socio-economic status.

CHAPTER 1

1.0. INTRODUCTION

1.1. BACKGROUND INFORMATION

Zambia is a Sub-Saharan African country and covers an area of approximately 753,000 square kilometres. She has a population of about 10.3 million as per 2000 census report. 62% of this population reside in rural area while 38% are in urban areas. Zambia has a relatively young population with 45% of the total population being between 0-14 years. 49% of the population are males and 51% are females (CSO 2000).

Zambia has nine provinces of which western province is one of them. The province has seven districts of which Kaoma district is included. Kaoma district shares borders with all other districts in the province except Kalabo and Shangombo. It covers an area of 23,315 square kilometres and has a population of 181,912. The district is 400 kilometres from Lusaka and 200 kilometres from Mongu, which is the provincial capital of western province.

The main concentration of people in the district is found in the areas around Kaoma Township, along the Luena-Mongu Road and the Luena Barracks.

→ The district has three (3) hospitals of which one is the government hospital situated in the central part of the township, and 2 are mission hospitals. Just like any other health institutions in Zambia, Kaoma District Health Team emphasizes on primary health care delivery.

Back The district hospital has no special clinic for sexually transmitted infections but attends to all clients at the Outpatient Department (OPD). The current data at the

hospital shows that sexually transmitted infection attendance figures have been static from 1998 to December 2000.

Sexually transmitted infections are infections contracted through sexual intimacy. Apart from Acquired Immune Deficiency Syndrome (AIDS), gonorrhea, Syphilis and chancroid are the most common sexually transmitted infections. Patients usually have one of the four syndromes (sets of signs and symptoms).

- Genital ulcers.
- Genital discharge (urethral or vaginal or cervical).
- Pain in the lower abdomen or scrotum.
- Sexually transmitted infections affecting the newborn.

The Zambian government adopted the Health Reforms Policies whose emphasis is on Primary Health Care (PHC). Primary health care strategies offer health services, which are available, accessible and affordable to all Zambians. PHC also emphasizes distribution of these health services and aims at delivering the services as close to the family as possible. In line with primary health care, the Ministry of Health in 1980 developed a National Sexually Transmitted Infection and Leprosy Programme. In its strategy, the Programme emphasizes on primary and secondary prevention activities.

Sexually transmitted infections can also be transmitted from mother to baby via the blood and can also be transmitted through transfusion with infected blood.

The rate of spread of sexually transmitted infections is determined by three important factors.

- The rate at which susceptible individuals expose themselves to people who are infected with sexually transmitted infections.

- The efficiency of transmission of the sexually transmitted infection pathogen from the infected individual to the susceptible individual.
- The average time that a newly infected individual remains infectious and thus able to infect others in the community.

There is age influence, which displays gender differences. Incidence is higher among women aged 15-24 where as in men it is highest in those aged 25-34 (Matondo, et al, 1998). Sexually transmitted infections are important public health problem in Zambia due to a high prevalence, it's severe complications, sequelae and its facilitatory role in transmitting Human Immune Deficiency Virus (HIV). The available data in Zambia suggests that sexually transmitted infections are among the top six conditions for which adults attend outpatient clinics and account for about 5-10% of outpatient attendance at health institutions (Matondo, et al 1998).

Even without considering Acquired Immune Deficiency Syndrome (AIDS), the conventional sexually transmitted infections produce great hardships through complications such as Pelvic Inflammatory Diseases (PID), with it's risks of ectopic pregnancy and infertility, spontaneous abortions, cervical cancer and painful and disfiguring genital wounds.

Surveys in antenatal clinics in Zambia have shown that 10-15% of expectant mothers have syphilis antibodies, while at least 25% in urban areas and 10% in rural areas are infected with HIV virus (CBoH, 1997).

1.2. **STATEMENT OF THE PROBLEM**

Sexually transmitted infections are contracted through sexual intimacy (CBoH, 1997). The infections include HIV/AIDS, gonorrhoea, syphilis, chancroid and genital warts. These mentioned are the most common. The significance of STIs as a cause of morbidity and mortality in adults at present includes its synergistic

association with AIDS. Common behavioural risk factors and modes of transmission for HIV infection and other classical STIs is one point of association. STIs provide an ideal entry and exist point for HIV during sexual intercourse (World Bank Report, 1992). Sexually transmitted infections need to be addressed not only medically but also socially. This is so because the problem of STIs is more of a social than a biomedical one. Surveys in antenatal clinic in Zambia have shown that 10-15% of expectant mothers have syphilis antibodies, while at least 25% in urban areas and 110% in rural areas are infected with HIV virus (CBoH, 1997).

According to WHO report (1990), the greatest incidence of STIs is in the 20-24 year age group, followed by persons 15-19 years of age. The finding that lesions caused by some STIs can increase the risk of HIV infection by more than 30% has led the government to take more aggressive stance toward the prevention and treatment of STIs. There are many obstacles to prevention of STIs. These include the development of treatment resistant strains, inadequate infrastructure for diagnostic testing and treatment, resistance to changing sexual behaviour, increased travel and migration and the practice of exchanging sex for drugs. The full extent of the problem of STIs is hidden because many people seek treatment from informal health care providers such as traditional healers or drug vendors or because of asymptomatic cases in women in particular.

In order to reduce transmission of STIs and impact on the Zambian population, the Ministry of Health (MOH) in 1980 developed a national STIs and Leprosy Programme. In it's strategy, the programme followed WHO recommendation of primary and secondary prevention activities (WHO, 1985). Primary prevention activities include promotion of safer sexual behaviour, promotion of condom use and provision of condoms. Secondary prevention activities include promotion of health care seeking behaviour directed towards those at risk of acquiring STIs and provision of accessible, acceptable, affordable and effective services.

From the above information it is easy to see that STIs control is one of Zambia's health care system's priority. However, despite efforts that have been made regarding the control of STIs, these diseases still remain a problem. Although there has been awareness in terms of controlling STIs through educative programmes, improved diagnosis and treatment, one questions whether there has been a corresponding change in the people's attitudes towards STIs.

There are several factors that may influence people's knowledge, attitude and practices towards STIs. Some of these factors include the following: -

- **Knowledge**

Many people may not have adequate knowledge on transmission, prevention and management of STIs. This may affect their attitude and practices towards STIs. When these people acquire adequate knowledge on the condition, they can have a positive attitude towards STIs and can hence lead to a reduction in number of STIs cases.

- **Education**

Educational level can affect the attitudes and practices of people towards sexual transmitted infections. When people are educated, they are able to understand concepts easily. This helps even those involved in information, communication and education to be able to give the health education with fewer problems. On the other hand those with inadequate education have difficulty in understanding issues concerning sexual transmitted infections. It takes several explanations for one to assimilate the information being given.

- **Socio-Cultural Beliefs**

Traditional and **cultural beliefs** may affect attitude and practice of women towards STIs in several ways. Most traditions state that a married couple is not supposed to use condoms or any other barrier during sexual intercourse. This practice puts an innocent partner in danger of contracting sexually transmitted

infection. Most of our traditions allow a man to have more than one sexual partner not being formally married to them. A woman may be divorced or accused of not having respect if she continues to complain about her husband having extra marital affairs.

Religion is another socio-cultural factor which affect attitudes and practices of people towards STIs. People are not free to talk about their sexual lives for fear of stigmatization, since sex is considered 'sinful'. They may take long to seek medical advice if infected with STIs and this may lead to infecting to the other partner(s).

- **Marital Status**

Marital status may affect the attitudes and practice of women towards STDs. Many married people may fail to reveal to their spouses that they have contracted a sexually transmitted infection. An infected partner then will either seek treatment secretly without the knowledge of the other or delay treatment. This may lead to the other partner being infected. Some married people may choose to have extra marital relationships. This means that if one is infected, then the three are also affected. The above point also applies to polygamous marriages. On the other hand, those who are not married may tend to have more than one sexual partner for money and material gain and hence increase the risk of contracting STIs.

- **Self-Treatment**

Many people tend to go to private practitioners, surgeries or clinics when they suspect that they may have a sexually transmitted infection. These people may not receive the treatment. This may lead to drug resistance and increased number of people living with STIs.

- **Attitude of Health Workers**

The attitude of the health workers at clinics and hospitals may affect the attitude and practices of people towards sexually transmitted infections. Many workers

stigmatize people suffering from sexually transmitted infections. Clients are considered as “prostitutes” especially women and this may lead to people opting to go for self-treatment and traditional medicine. Health workers may also pretend to be too busy to attend to clients at the sexually transmitted infection clinics. Clients wait for longer periods and they may end up being discouraged. If these attitudes were improved, there may be more clients attending health services.

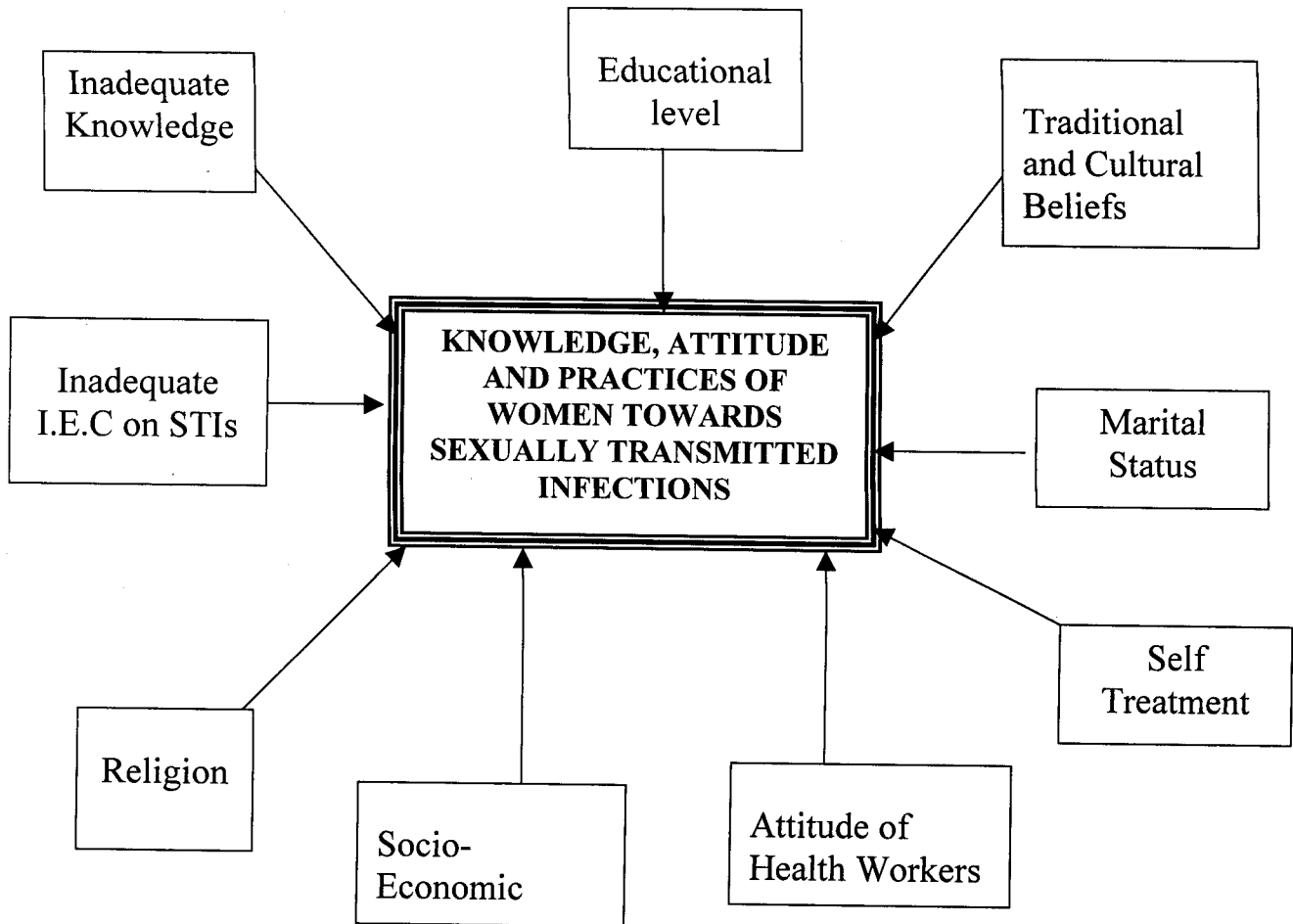
- **Socio-Economic factors**

These greatly affect the attitude of people towards sexually transmitted infections. People are poor and cannot afford money to pay for health services being offered. The other factor is distance to health facilities. Clients may not walk to these health facilities because of distance and they may not afford money to pay for transport to reach these places. Women in the low socio-economic class may also decide to have multiple sexual relationships for the sake of money or material gain.

- **Inadequate Information, Education and Communication on Sexually Transmitted Infections**

This implies both to prevention and management of sexually transmitted infections. If people are not adequately educated on the risk factors, dangers and management of sexually transmitted infections, they may not take measures to prevent transmission of these diseases to other people. It is therefore important that all those concerned and involved in preventing and management of sexually transmitted infections give adequate information to prevent the spread of these infections.

**A DIAGRAM OF ANALYSIS OF FACTORS INFLUENCING THE
WOMEN'S KNOWLEDGE, ATTITUDE AND PRACTICES
TOWARDS SEXUALLY TRANSMITTED INFECTIONS.**



1.3. **JUSTIFICATION FOR THE STUDY**

Sexually transmitted infections are infections posing a major threat to human population. The problem of sexually transmitted infections is more of the social than a biomedical one. This is because elimination of sexually transmitted infections, which cause high morbidity, disability and mortality, depends more on cultural and social attitudes than on medical management. If the knowledge gaps, attitudes and practices are identified and dealt with effectively, sexually transmitted infections will be reduced. It is for this reason, that this study was done to find out the knowledge, attitude and practices of women towards sexually transmitted infections. This information will be of importance to relevant authorities involved in developing prevention strategies for sexually transmitted infections.

1.4. **OBJECTIVES OF THE STUDY**

1.4.0. **GENERAL OBJECTIVE**

To determine the knowledge, attitude and practices of women towards sexually transmitted infections in Kaoma district.

1.4.1. **SPECIFIC OBJECTIVES**

1. To determine the knowledge, attitudes and practices of women towards sexually transmitted infections.
2. To identify factors influencing the women's knowledge, attitudes and practices towards sexually transmitted infections.
3. To identify socio-cultural factors that may influence the attitudes and practices of women towards sexual transmitted infections.
4. To determine the use of condoms among women as a measure of prevention against sexually transmitted infections

5. To make recommendations to relevant authorities, non-governmental organizations (NGOs) and policy makers, which would assist in improving sexually, transmitted infection control strategies.

1.5. **STUDY HYPOTHESIS**

1. Women with low education are more likely to have less knowledge on sexually transmitted infections.
2. Women with low education are more likely to have negative attitudes and poor practice towards sexually transmitted infections than those with high educational levels.
3. Women of low social economic status are more likely to have negative attitude and poor practice towards STIs than those of high social economic status.

1.6. **VARIABLES**

The dependent variables for the study are: -

- Knowledge
- Attitudes
- Practices

The independent variables include: -

- Age
- Marital status
- Traditional belief and culture
- Socio-economic status
- Educational level

A **dependent variable** is a variable that is used to describe or measure the problem under study. An **independent variable** is a variable that influence other variables. It contributes to causes or determinants.

1.7. INDICATORS

INDEPENDENT VARIABLES

VARIABLES	INDICATOR	CUT OFF POINTS
Knowledge	High	Correct Response
	Low	Wrong Response
Attitude	Positive	Seeks medical advice when ill
	Negative	Inability to seek medical advice
Practices	Good	Uses measures to prevent transmission of sexually transmitted infections (STIs)
	Poor	Does not use preventive measures

1.8. OPERATIONAL DEFINITIONS OF TERMS

1. Knowledge – The amount of insight someone has on nature of an infection.
2. Practice – An individual's action or performance in relation to prevention and transmission of STI.
3. Attitude - The feelings of women towards sexually transmitted infections, which may be positive or negative.
4. Women - Adult human females who are sexually active.
5. Sexually Transmitted Infections – Refers to any contagious condition Acquired predominately by sexual intercourse or genital contact.
6. Human Immuno Deficiency Virus (HIV) – Refers to the virus which is predominately transmitted through sexual activity and attacks the immune system.
7. Acquired Immuno Deficiency Syndrome (AIDS) – This is the disease that results from the destruction of the immune system.

CHAPTER 2

2.0. LITERATURE REVIEW

Sexually transmitted infections become an issue in which citizens, medical experts and government have expressed their concern. Numerous suggestions on how best to deal with the problem of sexual transmitted infections, in particular AIDS have been advanced. In this literature review, ideas, research work and suggestions that have been documented by other authors on the subject of STIs pertinent to the topic under study will be highlighted.

2.1. GLOBAL PERSPECTIVE

Studies on sexually transmitted infections have been carried out globally and these studies have shown that both men and women get infected with sexually transmitted infections everyday. A study done by Aubriot F, et al (1988), in Europe reveals that 60-80% of cases of salpingitis in women are believed to result from sexual transmission. From these cases, it has shown that 30-50% of cases result in female sterility.

Over twenty (20) organisms and multiple syndromes are now recognized as being sexually transmitted worldwide. According to the report by Cates and Raugh, (1985), the number of sexually active teenagers and the incidence of sexually transmitted infections grew to epidemic proportions in the United States. The majority of these were found to be females. A major thinking occurred during the same time among those concerned about sexually transmitted infections. They realised the complexity of these conditions and clinicians, public health workers and policy makers broadened their implementation strategies to fight the infections.

According to the report by Richard Morriset, (1984), Chairperson of the International Conjoint Sexual Transmitted Infections held in June, 1984 in Canada, every 6 seconds someone contracts a sexually transmitted infection.

In a study done in the United States by Dupont J, (1984), results showed that STIs are said to be responsible for a significant proportion of cases of Pelvic Inflammatory Diseases (PID) and ectopic pregnancies. The statistics of the same results also showed that when these diseases go undiagnosed in pregnant women, their newborns risk contracting conjunctivitis and pneumonia.

According to Reprowatch Report, (1999), a compilation of statistical records by the Department of Health revealed that as large a percentage as 10% of married women in Metro Manila, Philippines had acquired Chlamydia (a common sexual transmitted infection) from their husbands. The report supported an analysis, which stated that by the time a man reaches 30, he could usually earn enough to pay for the services of a female sex worker in the 19-29-age range.

2. **REGIONAL PERSPECTIVE**

The advent of Human Immuno Deficiency Virus has added a new and lethal dimension to the problem of STIs in Sub-saharan Africa. The rates of HIV infection in Sub-saharan African countries are among the highest in the world and the pattern of disease transmission is distinctly heterosexual (WHO, 1990).

According to recent estimates, there are some 22 million persons infected with the virus in Africa, accounting for 70% of the world's AIDS cases (USAID, 1998). A report by Wilkinson D, et al (1999) states that not all people with sexually transmitted infections are symptomatic, not all those who are symptomatic recognise the meaning or importance of their symptoms and seek care, and not all those who do seek care are adequately treated. In the same report, Wilkinson states that it is well established that 60-70% of gonococcal and chlamydial

infections in women are asymptomatic. In a study done on women booking for antenatal and family planning at Hlabisa (South Africa) by Duncan, (1994), most women (83%) reported abnormal symptoms and 52% were infected with at least one sexual transmitted infection.

The report from Pathfinder International, (1999) estimated that half a million African young people aged 15-24 would die from AIDS by the year 2005. In the same report, it was found that 22-30% of pregnant women in Malawi, Zambia and Rwanda were HIV seropositive. The same report states that South Africa has high rates of STIs than elsewhere in the world. It's estimates suggest that 10-20% of the sexually active population may have gonorrhoea.

A model proposed by Piot, (1990) suggest that only a minor proportion of STIs in developing countries are treated adequately because most cases never present for care.

2.3. **ZAMBIAN PERSPECTIVE**

Zambia is one of the developing countries most affected by sexually transmitted infections. It is among the six (6) most affected countries with HIV/AIDS in Sub-Saharan Africa. According to Ministry of Health (MOH), (1994) estimates, 500 people are infected with HIV everyday. It is further documented that there are 520,000 orphans in Zambia as a result of AIDS and the number is expanding rapidly due to the epidemic.

The report by Matondo, et al (1998) reveals that the rate of spread of sexually transmitted infections is determined by three important factors.

- The rate at which susceptible individuals expose themselves to people who are infected with STIs.

- The efficiency of transmission of the STI pathogen from the individual to the susceptible individual.
- The average time that a newly infected individual remains infectious and thus able to infect others in the community.

It is said that morbidity of STIs is higher in urban than rural areas. There is also age influence, which displays gender difference. Incidence is higher among women aged 15-24 where as in men it is higher in those aged 25-34. The general overall of the study showed that the most age group affected is between 20-29 years (Matondo et al, 1998).

In his study on STIs in Lusaka, Msiska R, et al (1995), confirmed the diversity and complex nature of the care options. The care options of those infected or suspected having an STI include self medication, traditional healers, medication sold in the markets, private clinics, health centres, drug dealers and health institutions. The same study revealed that people had difficulties in obtaining treatment for STIs at health centres because of the following: -

- Shortages of drugs.
- Lack of privacy.
- Long queues.
- Being examined by a member of the opposite sex.
- High medical fees.
- Requirements that one should bring a partner before being treated.

In the same report it was revealed that females indicated that suffering from a sexually transmitted infection was worse than having a child out of marriage because of the stigma associated with STIs. Another study done in Lusaka by Mulenga D (1995) revealed that reasons for indulging in sexual activity varied from adventure and peer pressure to it being an economic activity. In the same study, it indicated that some women believed that using condoms as a tool in the

prevention of STIs put them at a risk of being infertile. They believed that a condom would be sucked in during sex and block tubes and hence cause infertility.

According to Aggleton, et al (1990) high incidence of STIs among the youth and women in Zambia is attributed to social, economic and cultural factors. These factors according to these writers include urbanization, displacement of family norms and lack of employment. In his study “Prostitution in Urban Zambia and exploratory Study of Three Towns” Kapungwe (1982) revealed that prostitution and ignorance are also factors associated with high incidence of sexually transmitted infections among women.

Available data from Zambia suggests that sexually transmitted infections are among the top six (6) conditions for which adults attend outpatient clinics, and account for about 5-10% outpatient attendance at health institutions (Matondo et al, 1998).

A 1996 Demographic and Health Survey, states that about 10% of men aged 24-29 years reported having suffered from an STI and data from the maternal syphilis-screening programme in Lusaka shows that up to 17.5% of pregnant women are Reactive Plasma Reagent (RPR) positive.

In its report of 1990, WHO is urging governments to intensify STI prevention activities through funding research, health education, and having more accessible clinic services.

2.4. **CONCLUSION**

From the literature reviewed, one is able to deduce that sexually transmitted infections although preventable are still on the increase. Zambia, like many other developing countries does not have effective strategies that deal with prevention

and control of sexually transmitted infections. The literature reviewed has also shown that STIs are a factor of morbidity, disability and mortality because of their complications.

In order to gain ground against STIs including AIDS pandemic, women oriented programmes must effectively encourage behaviour change in terms of condom use and decreasing the number of sexual partners.

CHAPTER 3

3.0. **RESEARCH METHODOLOGY**

3.1. **RESEARCH DESIGN**

The design for this study was a descriptive cross section survey. This design was chosen to describe variables such as level of knowledge, attitudes, practices and cultural beliefs in relation to sexually transmitted infections in Kaoma district.

3.2. **RESEARCH SETTING**

The study was conducted at Kaoma District Hospital in western province. The clients were sampled from the women seeking Maternal and Child Health services which include children's clinic, antenatal, postnatal and family planning.

3.3. **STUDY POPULATION**

The study population comprised of women living within Kaoma Central of Western Province.

3.4. **STUDY UNITS**

The study units were women between 13 and 49 years living within Kaoma Central. The women were those in the reproductive age group.

3.5. **SAMPLE SIZE**

The sample size was 50. This number was thought to be reasonable for computation and management considering the limited resources and time in which the researcher was to complete the study.

3.6. SAMPLE SELECTION

The study units were selected using a systematic random sampling technique after obtaining a complete sampling frame from the hospital. The sampling interval was calculated from the following formula: -

$$K = \frac{N}{n}$$

$$n = 50$$

$$K = \frac{300}{50}$$

$$\underline{K = 6}$$

6 was the sampling interval.

The first respondent was selected using the lottery method.

3.7. DATA COLLECTION TECHNIQUE AND TOOLS

Data in this study was collected using a structured interview schedule. This technique was chosen to enable me collect sufficient responses from the subjects considering their level of education. The subjects dealt with were both literates and illiterates.

Advantages of an Interview Schedule

1. An interview is suitable for both literates and illiterate respondents.
2. Questions may be clarified if they are misunderstood.
3. There is high response rate rather than written questionnaire.
4. In-depth responses can be obtained.

5. Responses can be obtained from a wide range of subjects.
6. Non-verbal behaviours and mannerisms can be observed during the interview.

Disadvantages

1. Interviews are time consuming and expensive.
2. The presence of the Researcher can influence responses of the respondents.
3. Arrangements for interviews may be difficult to make.
4. Training programmes are needed for interviewers.
5. Interviewers may misinterpret non-verbal behaviours.
6. If the responses are not standardized, the responses may be difficult to quantify.
7. Analysis may be time consuming and difficult.
8. Interviews can only be used in small sample size for in-depth interview.

3.8. PILOT STUDY

A pilot study was conducted to test the suitability of the methodology, test interval, consistency of the questions and to determine the likely options for open-ended questions in order to facilitate coding. It was carried out on 10% of the total sample selected and was done at the District Hospital in Kaoma.

Following a pilot study, alterations were made to the instrument accordingly.

3.9. ETHICAL CONSIDERATIONS

Permission to conduct the research study was obtained from the Executive Director of Kaoma hospital. A written consent was obtained and was done in recognition of the respective authorities and to gain their co-operation.

Verbal consent was be obtained from the respondents after explaining to them the purpose of the study and how the results will be utilized. The respondents were assured of privacy, anonymity and confidentiality during data collection.

CHAPTER 4

4.0. **DATA ANALYSIS AND PRESENTATION OF FINDINGS**

The study sought to determine the knowledge, attitudes and practices of women towards sexually transmitted infections in Kaoma. The data was collected using a structured interview schedule.

4.1. **DATA ANALYSIS**

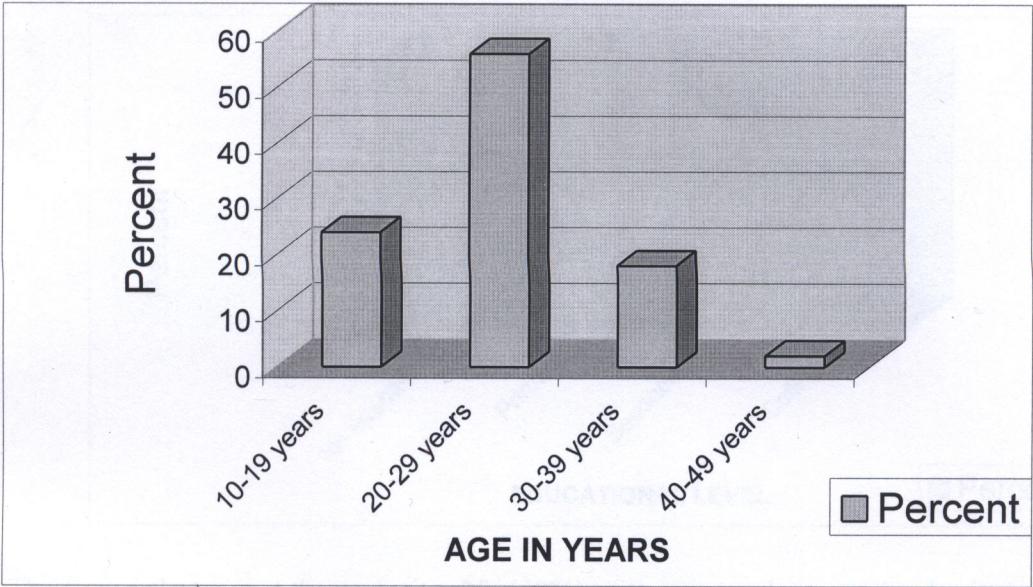
After collecting the data, it was edited for completeness and the interview schedules were numbered. Responses were coded using numbers and open responses were categorized and coded. All data processing was done manually and then entered on a data master sheet.

4.2. **PRESENTATION OF FINDINGS**

Data from the master sheet was presented in charts, graphs, and simple frequency tables and cross tabulations. These methods were used because they summarize the results in a meaningful way and enhance understanding of the findings, in relation to the intentions of the study.

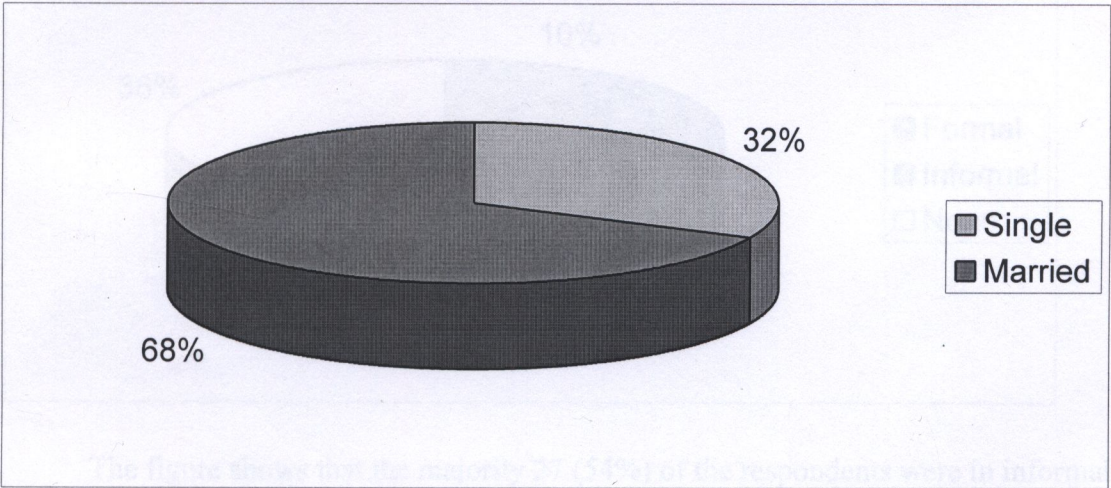
DEMOGRAPHIC DATA

FIGURE 1: FREQUENCY DISTRIBUTION OF RESPONDENTS' AGE



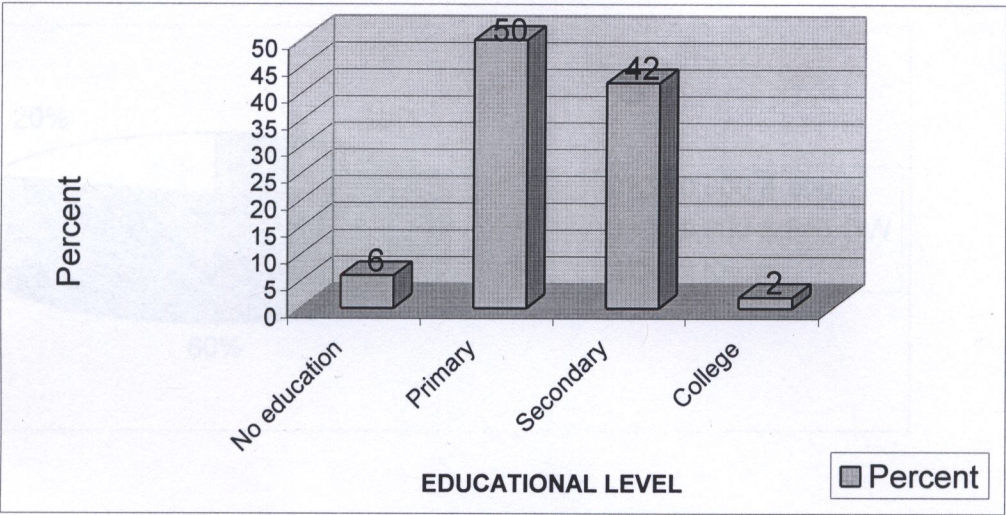
The figure shows that the majority, 28 (56%) of the respondents were between the age range 20-29 while only 1 (2%) was in the range 40-49.

FIGURE 2: FREQUENCY DISTRIBUTION OF RESPONDENTS' MARITAL STATUS



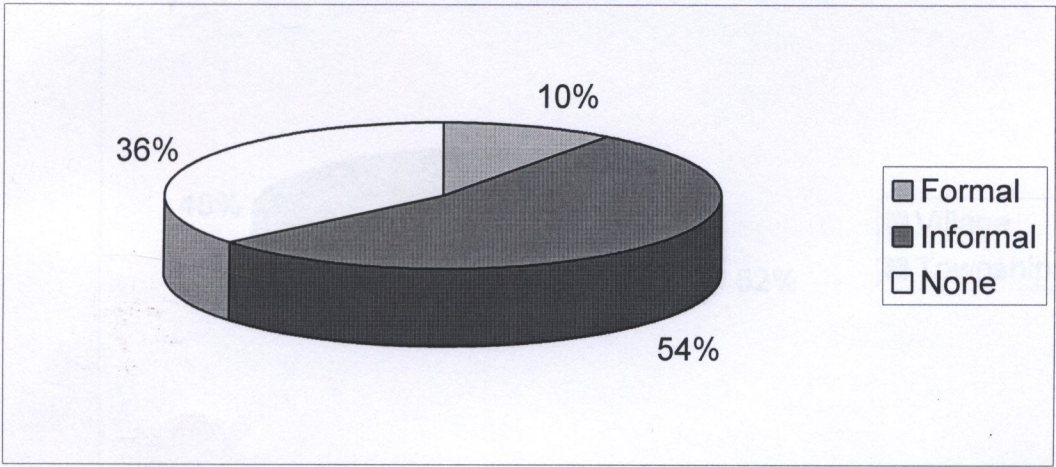
The figure shows that the majority, 34 (68%) of the respondents were married.

FIGURE 3: FREQUENCY DISTRIBUTION OF RESPONDENTS' EDUCATIONAL LEVEL



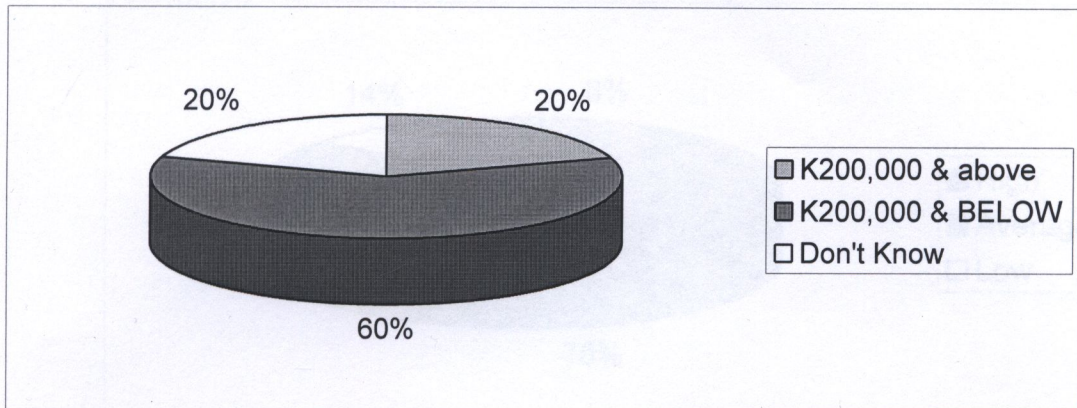
The figure shows that the majority, 25, (50%) of the respondents attained primary education while only 1 (2%) had college education.

FIGURE 4: FREQUENCY DISTRIBUTION OF RESPONDENTS' OCCUPATIONAL STATUS



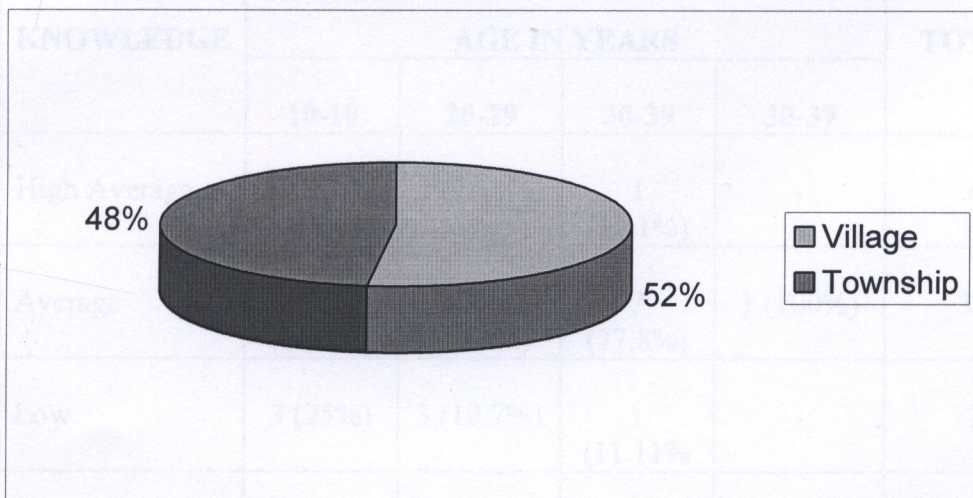
The figure shows that the majority 27 (54%) of the respondents were in informal employment.

FIGURE 5: FREQUENCY DISTRIBUTION OF RESPONDENTS MONTHLY HOUSEHOLD INCOME LEVELS



The figure shows that the majority 30 (60%) of the respondents had income level below K200, 000.00.

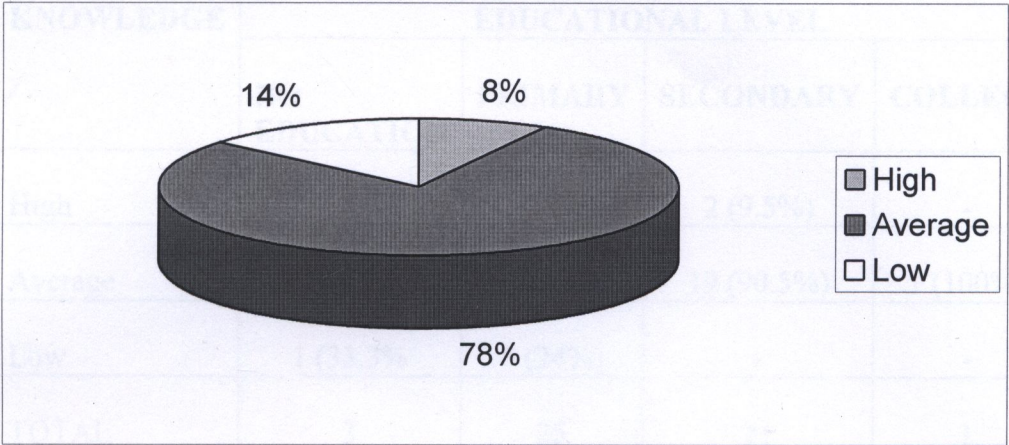
FIGURE 6: FREQUENCY DISTRIBUTION OF RESPONDENTS' RESIDENTIAL AREA



The figure shows that 26 (52%) of the respondents were from the village while 24 (48%) resided within the township.

KNOWLEDGE

FIGURE 7: FREQUENCY DISTRIBUTION OF THE LEVEL RESPONDENTS' KNOWLEDGE TOWARDS STIs



The pie chart shows that majority 39 (78%) of the respondents had average knowledge towards sexually transmitted infections STIs) and only 4 (8%) had high knowledge towards STIs.

TABLE 1: KNOWLEDGE OF STIs IN RELATION TO AGE

KNOWLEDGE	AGE IN YEARS				TOTAL
	10-19	20-29	30-39	30-39	
High Average	1 (8.3%)	2 (7.14%)	1 (11.1%)	-	4
Average	8 (66.7%)	23 (82.4%)	7 (77.8%)	1 (100%)	39
Low	3 (25%)	3 (10.7%)	1 (11.11%)	-	7
TOTAL	12	28	9	1	50

Table shows that the majority, 23 (82.4%) of the total number of respondents within the age range 20-29 had average level of knowledge towards STIs.

TABLE 2: KNOWLEDGE OF STIs IN RELATION TO EDUCATIONAL LEVEL

KNOWLEDGE	EDUCATIONAL LEVEL				TOTAL
	NO EDUCATION	PRIMARY	SECONDARY	COLLEGE	
High	-	2 (8%)	2 (9.5%)	-	4
Average	2 (66.7%)	17 (68%)	19 (90.5%)	1 (100%)	39
Low	1 (33.3%)	6 (24%)	-	-	7
TOTAL	3	25	21	1	50

The table shows that the majority of respondents in all categories had average knowledge, highest 19 (90.5%) being with secondary education.

TABLE 3: KNOWLEDGE IN RELATION TO MARITAL STATUS

KNOWLEDGE	MARITAL STATUS		TOTAL
	SINGLE	MARRIED	
High	2 (12.5%)	2 (5.9%)	4
Average	9 (56.25%)	30 (88.2%)	39
Low	5 (31.25%)	2 (5.9%)	7
TOTAL	16	34	50

Table shows that the majority 30 (88.2%) of the married respondents had average knowledge.

TABLE 4: KNOWLEDGE IN RELATION TO OCCUPATION

KNOWLEDGE	OCCUPATION			TOTAL
	FORMAL	INFORMAL	NONE	
High	-	4 (14.8%)	-	4
Average	5 (100%)	18 (66.7%)	16 (88.9%)	39
Low	-	5 (18.5%)	2 (11.1%)	7
TOTAL	5	27	18	50

Table shows that all 5 (100%) respondents with formal employment had average knowledge, 4 (14.8%) had high knowledge while 18 (66.7%) of the respondents in informal had average knowledge and 16 (88.9%) of those who are not in any employment had average knowledge.

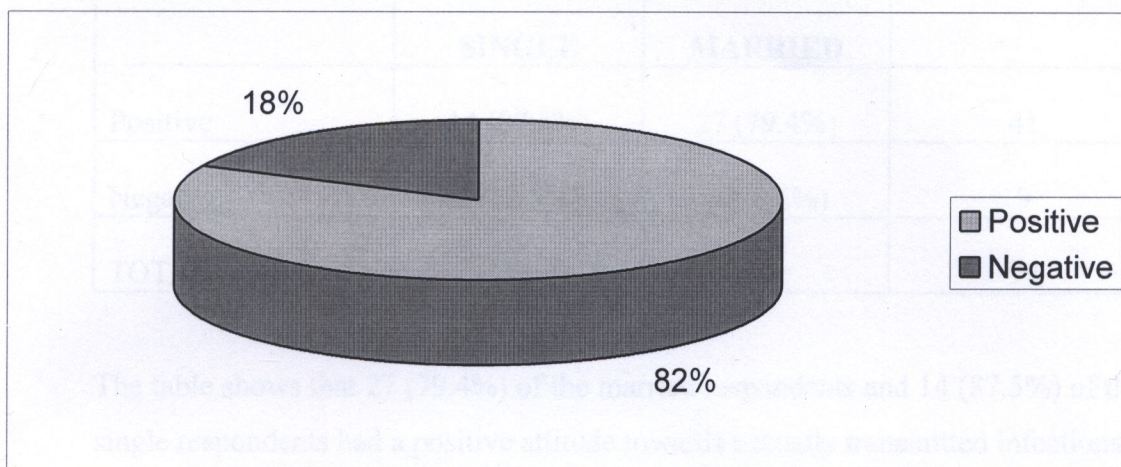
TABLE 5: KNOWLEDGE IN RELATION TO RESIDENTIAL AREA

KNOWLEDGE	RESIDENTIAL AREA		TOTAL
	VILLAGE	TOWNSHIP	
High	3 (11.6%)	1 (4.2%)	4
Average	18 (69.2%)	21 (87.5%)	39
Low	5 (19.2%)	2 (8.3%)	7
TOTAL	26	24	50

Table shows that 21 (87.5%) of the respondents living in the township area had average level of knowledge on STIs while 18 (69.2%) of those from the village had average knowledge on STIs.

ATTITUDE

FIGURE 8: FREQUENCY DISTRIBUTION OF RESPONDENTS' ATTITUDE TOWARDS STIs



The pie chart shows that the majority, 41 (82%) of the respondents had positive attitude towards sexually transmitted infections.

TABLE 6: ATTITUDE TOWARDS STIs IN RELATION TO AGE

ATTITUDE	AGE IN YEARS				TOTAL
	10-19	20-29	30-39	40-49	
Positive	9 (75%)	23 (82.1%)	9 (100%)	-	41
Negative	3 (25%)	5 (17.9%)	-	1 (100%)	9
TOTAL	12	28	9	1	50

Table shows that all 9 (100%) respondents in the age range 30-39 and 23 (82.1%) of those from the age range 20-29 had a positive attitude towards STIs.

TABLE 7: ATTITUDE IN RELATION TO MARITAL STATUS

ATTITUDE	MARITAL STATUS		TOTAL
	SINGLE	MARRIED	
Positive	14 (87.5%)	27 (79.4%)	41
Negative	2 (12.5%)	7 (20.6%)	9
TOTAL	16	34	50

The table shows that 27 (79.4%) of the married respondents and 14 (87.5%) of the single respondents had a positive attitude towards sexually transmitted infections.

TABLE 8: ATTITUDE OF WOMEN TOWARDS STIs IN RELATION TO EDUCATIONAL LEVEL

ATTITUDE	EDUCATIONAL LEVEL				TOTAL
	NO EDUCATION	PRIMARY	SECONDARY	COLLEGE	
Positive	3 (100%)	22 (88%)	15 (71.4%)	1 (100%)	41
Negative	-	3 (12%)	6 (28.6%)	-	9
TOTAL	3	25	21	1	50

Table shows that all respondents from the no education and college categories, 3 (100%) and 1 (100%) respectively had a positive attitude and 22 (88%) of those with primary education had positive attitude towards sexually transmitted infections.

TABLE 9: **ATTITUDE OF WOMEN TOWARDS STIs IN**
RELATION TO OCCUPATION

ATTITUDE	OCCUPATION			TOTAL
	FORMAL	INFORMAL	NONE	
Positive	5 (100%)	20 (74.1%)	16 (88.9%)	41
Negative	-	7 (25.9%)	2 (11.1%)	9
TOTAL	5	27	18	50

Table 9 shows that all the 5 (100%) respondents in formal employment had a positive attitude towards sexually transmitted infections and 16 (88.9%) of those not in any employment had a positive attitude.

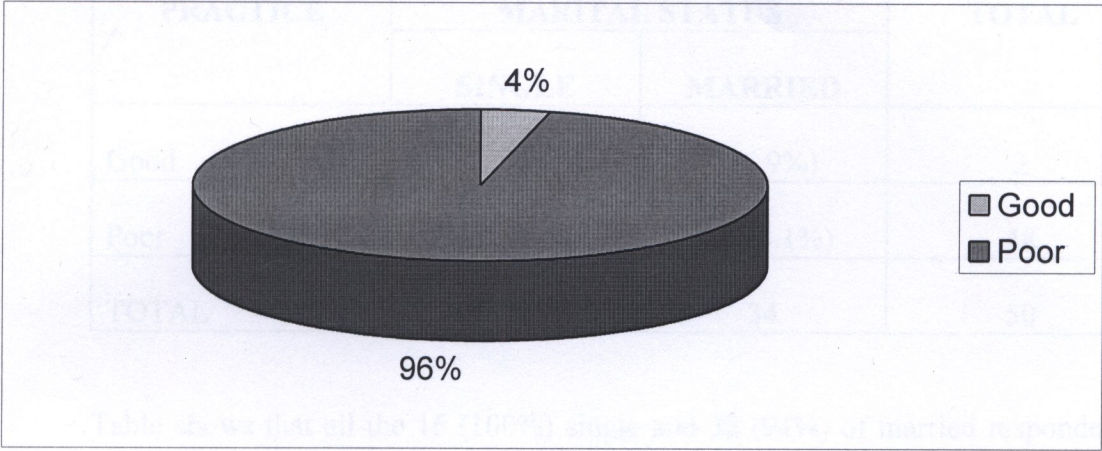
TABLE 10: ATTITUDE OF WOMEN TOWARDS STIs IN RELATION
TO RESIDENTIAL AREA

ATTITUDE	RESIDENTIAL AREA		TOTAL
	VILLAGE	TOWNSHIP	
Positive	22 (84.6%)	19 (79.2%)	41
Negative	4 (15.4%)	5 (20.8%)	9
TOTAL	26	24	50

Table shows that 22 (84.6%) of respondents from the village and 19 (79.2%) of respondents from the township area had a positive attitude towards sexually transmitted infections.

PRACTICE

FIGURE 9: FREQUENCY DISTRIBUTION OF RESPONDENTS' PRACTICE TOWARDS STIs



The pie chart shows that the majority, 48 (96) of respondents exhibited poor practice towards prevention of STIs.

TABLE 11: PRACTICE OF WOMEN TOWARDS STIs IN RELATION TO AGE

PRACTICE	AGE IN YEARS				TOTAL
	10-19	20-29	30-39	30-39	
Good	1 (8.3%)	-	1 (11.1%)	-	2
Poor	11 (81.7%)	28 (100%)	8 (88.9%)	1 (100%)	28
TOTAL	12	28	9	1	50

Table shows that all the 28 (100%) respondents in the age range 20-29 exhibited poor practice towards prevention of sexually transmitted infections.

TABLE 12: PRACTICE OF WOMEN TOWARDS STIs IN RELATION TO MARITAL STATUS

PRACTICE	MARITAL STATUS		TOTAL
	SINGLE	MARRIED	
Good	-	2 (5.9%)	2
Poor	16 (100%)	32 (94.1%)	48
TOTAL	16	34	50

Table shows that all the 16 (100%) single and 32 (94%) of married respondents exhibited poor practice towards the prevention of sexually transmitted infections.

TABLE 13: PRACTICE OF WOMEN TOWARDS STIs IN RELATION TO EDUCATIONAL LEVEL

ATTITUDE	EDUCATIONAL LEVEL				TOTAL
	NO EDUCATION	PRIMARY	SECONDARY	COLLEGE	
Good	-	-	2 (9.5%)	-	2
Poor	3 (100%)	25 (100%)	19 (90.5%)	1 (100%)	48
TOTAL	3	25	21	1	50

Table shows that all respondents with no education, primary and college education (3, 25 and 1 respectively) had exhibited poor practice and 2 (9.5%) of respondents with secondary education exhibited good practice towards STIs.

**TABLE 14: PRACTICE TOWARDS STIs IN RELATION TO
OCCUPATION**

ATTITUDE	OCCUPATION			TOTAL
	FORMAL	INFORMAL	NONE	
Good	-	2 (7.4%)	-	2
Poor	5 (100%)	25 (92.6%)	18 (100%)	48
TOTAL	5	27	18	50

Table shows that 5 (100%) of respondents in formal and 25 (92.6%) of respondents in informal employment exhibited poor practice towards STIs.

**TABLE 15: PRACTICE TOWARDS STIs IN RELATION TO
MONTHLY HOUSEHOLD INCOME**

PRACTICE	MONTHLY HOUSEHOLD INCOME			TOTAL
	K200, 000 & ABOVE	K200, 000 & BELOW	Don't Know	
Good	-	2 (6.7%)	-	2
Poor	10 (100%)	28 (93.3%)	10 (100%)	48
TOTAL	10	30	10	50

Table 15 shows that all respondents from those with household monthly income of K200, 000 and above and those who did not know their monthly income exhibited poor practice towards STIs.

TABLE 16: PRACTICE OF WOMEN TOWARDS STIs IN RELATION TO RESIDENTIAL AREA.

ATTITUDE	RESIDENTIAL AREA		TOTAL
	VILLAGE	TOWNSHIP	
Good	-	2 (8.3%)	2
Poor	26 (100%)	22 (91.7%)	48
TOTAL	26	24	50

Table shows that all (26) respondents from the village and 22 (91.7%) of respondents from the township area exhibited poor practice in prevention of sexually transmitted infections.

CHAPTER 5

5.0. DISCUSSION OF FINDINGS

5.1. INTRODUCTION

This study sought to determine the knowledge, attitudes and practices of women towards sexually transmitted infections in Kaoma district.

The study's assumptions were: -

- Women with low education are more likely to have less knowledge on sexually transmitted infections.
- Women with low education are more likely to have negative attitude and poor practice towards sexually transmitted infections.
- Women of low socio-economic status are more likely to have negative attitude and poor practice towards STIs than those of high socio-economic status.

The data pertaining to the topic under study was collected from fifty (50) study units from the Maternal and Child Health (MCH) at Kaoma District Hospital.

Data was then analyzed manually using a calculator and interpreted. The findings of the study are discussed below.

5.2. SOCIO-DEMOGRAPHIC DATA

The demographic data showed that the age range of the respondents was from ten (10) years to forty – nine (49) years. The majority, 28 (56%) of the respondents were within the age range 20-29 years. About 12 (24%) of the respondents were in the age range of 10-19 years, 9 (18%) of the respondents were within 30-39,

while there was only 1 (2%) respondent from the age range 40-49 years (Figure 1).

The majority of the respondents being within the age range 20-29 years could be attributed to the fact that this is the most reproductive age group. Literature has revealed that half the women in Zambia marry before they reach the age of 18 and 4 in 5 marry before the age of 22 years (ZDHS, 1996). The Alan Guttmacher Institute's Report (1997) states that the physical and social transitions to adulthood by females makes them enter sexual relationships or are already married and have children by age of 18 years. This means that by the time they are within age range 20-29, their sexual ^{wants!} needs increase. This, then explains why the majority of respondents who were drawn from Maternal and Child Health (MCH department during their antenatal, children's, postnatal or family planning clinic visits, were between 20-29 years of age.

The study also revealed that 34 (68%) of the respondents were married and 16 (32%) were not married. This is attributed to the fact that in our Zambian Society, females tend to marry early as a result of pressure from society culture encourages women to get married. Six in ten Zambian women of reproductive age are currently in a marital union (ZDHS, 1996). Half the women in Zambia marry before they reach age 18, and four in five females marry before the age of 22 years (ZDHS, 1996).

The results also showed that 25 (50%) of the respondents attained primary education, 21 (42%) had secondary education, 3 (6%) had never been to school and only 1 respondent had college education (Figure 3).

The low educational level of most respondents is assumed to be as a result of parents preferring to send their male children for higher education than their female children. The females may also be pressured by their families to marry at an early age because of their physiological development. While the nations of the

industrialized world have largely closed the gap in the ability of residents to get an education, disparities still exist in many developing countries, especially for young women (William H, 1995). In the same report it showed that half of the countries examined in Sub-Saharan Africa, six or fewer young women attend secondary education for every 10 young men enrolled, and if a family is poor in these same countries examined, they may choose to send only their male children to school.

The study revealed that 27 (54%) of the respondents were in informal employment, 5 (10%) were in formal and 18 (36%) of the respondents were not employed (Figure 4). This could be attributed to the low educational level most respondents have. According to the Alan Guttmacher Institute report (1997) it states that uneducated young women are either not in employment or in informal employment because they find it difficult to get the skills demanded for good jobs, thus limiting their ability to attain economic self-sufficiency.

In terms of residence, 26 (52%) of the respondents were from the village setting and 24 (48%) of the respondents lived within the township area (Figure 6). This distribution of residence, which seems to be equal, could be due to the fact that the hospital, which is serving the urban, the periurban and the rural, is centrally located in the district. This means that there is accessibility to health services by residents living within the township and the village.

5.3. **KNOWLEDGE OF WOMEN TOWARDS SEXUALLY TRANSMITTED INFECTIONS**

The findings from the study revealed that the majority, 39 (78%) of the respondents had average knowledge on sexually transmitted infections and only 4 (8%) had high level of knowledge (Figure 7). The study further revealed that increase in age had an advantage on knowledge level as the majority of the respondents within the age range 20-29 and 30-39 years had average knowledge

on sexually transmitted infections (Table 1). This increase in knowledge level with age could be attributed to exposure to peer groups. The more experienced someone is on sexual issues the more enlightened that person will be.

Other findings from the study are that there is a relationship between education and knowledge levels. There was average knowledge among those with primary, secondary and college education (Table 2). These findings support the hypothesis that women with low education are more likely to have less knowledge on sexually transmitted infections.

The level of knowledge, which tends to increase with education, could be attributed to exposure to learning sexual issues in school and informal discussions. This is also because media assists in disseminating information and that educated people are able to follow these issues. Indeed, in every region of the world, women who have completed their basic education are more aware of health issues than those without basic education (Williams H, 1997).

The study also showed that the majority, 30 (88.2%) of the married respondents had average knowledge towards sexually transmitted infections (Table 3). Sexual issues are more openly discussed within married cycles in our Zambian setting than with those not married. This could give an advantage to married respondents in the study. Older respondents, those who have been married, and those with more education are more likely to know about sexually transmitted infections than other respondents. The least knowledgeable group being adolescent girls and boys aged 15-19 (ZDHS, 1996).

Literature also reveals that knowledge about sexually transmitted infections is virtually universal among adults (ZSBS, 1998). Considering residential area, the study revealed that 21 (87.5%) of respondents living in the township area had average knowledge and 18 (69.2%) from the village had average knowledge (Table 6). The difference in knowledge levels towards STIs by these respondents

could be attributed to differences in socialization styles of respondents between the two groups. People in urban area are exposed to literature and other sources on STIs. Urban women may be more informed about sexual issues and sexually transmitted infections because they have better access than rural women to media and education (William H, 1997). The other reason is that women in rural areas are reserved and do not easily share information on sexual issues while those living in townships would have the courage to discuss sexual issues.

In relation to occupation, the study revealed that there was no significance between knowledge and occupation. All the categories of occupation, that is formal, informal and those not employed had almost same level of knowledge, with the majority having average knowledge (Table 4). From the above findings one can then assume that there is need for more information on sexually transmitted infections to women especially among the unmarried, the less educated and those in villages. There is also need to increase knowledge to all women in all social economic categories so that the level of knowledge could increase from average to high.

5.4. **ATTITUDE OF WOMEN TOWARDS SEXUALLY TRANSMITTED INFECTIONS**

An attitude has been operationally defined as the feelings of the respondent towards sexually transmitted infections.

Findings from the study indicated that the majority, 41 (82%) of the respondents had a positive attitude towards sexually transmitted infections (Figure 8). All the respondents indicated that they would go to the health care facility when infected with a sexually transmitted infection and most them indicated that they would inform their sexual partners if they were infected with sexually transmitted infection. However, the study also revealed that the minority 9 (18%) of the respondents had a negative attitude towards sexually transmitted infections.

Among these, were respondents who preferred not to inform their sexual partners if they were infected with a sexually transmitted infection. They stated that they would not inform their sexual partners for fear of being beaten or losing their relations. This could be so because of the Zambian tradition and culture, which does not allow women express their views and feelings especially in matters concerning sexual issues. From the study, it was noted that all (9) respondents in the age range 30-39 had a positive attitude and 23 (82.1%) of the respondents within the age range 20-29 years had a positive attitude towards sexually transmitted infections (Table 6). This showed that there is an increase of attitude towards sexually transmitted infections as people tend to grow. This relationship could be attributed to exposure to social activities and institutions and open discussions on sexual issues as a woman grows.

In relation to marital status (Table 7), the study showed that 27 (79.4%) of the married respondents had a positive attitude towards sexually transmitted infections. This could indicate that the women who are married are better informed about STIs. This could be attributed to having more experience in sexual relationships, having open discussions on issues concerning sexuality and sexually transmitted infections among their marriage groups. Older respondents and those who have been married before are more likely to know about sexually transmitted infections (ZDHS, 1996). This means that the women with adequate knowledge on STIs are more likely to have a positive attitude towards STIs.

The study indicated that there was no significance in terms of one's educational attainments and attitude towards STIs. All respondents (3) with no education, 22 (88.4%) with primary education, 15 (71.4%) with secondary education and the only respondent with college education had positive attitude towards sexually transmitted infection (Table 8). These findings rejects the hypothesis that women with low education are more likely to have negative attitude towards STIs than those with high educational levels.

The study also revealed that all (5) respondents in the formal employment and 20 (74.1%) of the respondents in informal employment had a positive attitude towards STIs (Table 9). This could be attributed to educational background of those in formal employment. Those in formal education have a good educational background and have had exposure to sexually transmitted infection discussions. The other reason could be that discussions on sexuality and STIs are held at their workplaces and places of social gatherings.

According to the study, 22 (84.6%) of respondents from the village and 19 (79.2%) of respondents from the township had a positive attitude towards sexually transmitted infections. This showed that the people from the rural areas have positive attitudes towards STIs. In his study on behavioural change among women in eastern province, R. Makichi, (1998) reported that those from the rural areas felt it was better to have one sexual partner to prevent STIs while those from the urban areas considered STIs as the same as other diseases existing.

Generally the study showed that most women had positive attitude towards sexually transmitted infections. This could be attributed to the average knowledge, which the majority of them had. It is assumed that the level of knowledge one has on a subject influences his/her attitude towards that subject.

5.5. **PRACTICE OF WOMEN TOWARDS SEXUALLY TRANSMITTED INFECTIONS**

Practice has been operationally defined as an individual's action or performance in relation to transmission and prevention of sexually transmitted infections.

The study showed that the majority 48 (96%) of the respondents exhibited poor practice towards prevention of STIs (Figure 9). However, the minority 2 (4%) had exhibited good practice towards transmission and prevention of STIs. Most of the respondents said they would not initiate condom use during sexual activity, as

they would be considered promiscuous. Some of the respondents still stated that they would not tell or inform their sexual partners if they were infected with a sexually transmitted infection for fear of losing their sexual relationships. All the respondents who stated that they use condoms for prevention of STIs do not use them always when they have sex. Some of the respondents stated that they used condoms mainly for family planning. However, all the respondents stated that they would report to a health care facility if infected with a sexually transmitted infection. This means that the respondents knew that they can be treated at a health care facility and that this is the way they can reduce the complications and spread of STIs.

According to the study, all (28) respondents in the age range 20-29 and 8 (88.9%) of the respondents in the age range 30-39 exhibited poor practice. The study also revealed that all (16) respondents and 32 (94%) of the married respondents had exhibited poor practice towards transmission and prevention of sexually transmitted infections.

The study revealed that there was no relationship with the level of education, occupation and monthly household income, with the level of practice. Most of the respondents from all the categories exhibited poor practice towards STIs. These findings reject the hypothesis that women of low socio-economic status are more likely to have poor practice towards prevention of STIs than those of high socio-economic status. This then reveals that practice of an individual does not depend on the level of knowledge and attitude one has.

Generally the study showed that the majority 39 (78%) of respondents had average knowledge and 41 (82%) of the respondents had positive attitude towards STIs. From this information, one would expect to see good practice from the respondents. However, this was not the case in this study as the majority of the respondents had exhibited poor practice.

In its report, WHO (1998), reported that many women do not protect themselves and that condoms were an unacceptable method within marriage. The results of the study showed that there were many different reasons why people do not use condoms or adopt preventive behaviour. These included sexual norms, attitudes towards condoms and women's restricted ability to negotiate safe sex with their partners. In a study done in Zimbabwe, one woman stated, "condoms are mostly used by commercial sex workers" (Richard L, 1998).

The poor practice exhibited by the majority 48 (96%) of the respondents could be an indication that the average knowledge most respondents had could not have addressed the real issues about transmission and prevention of STIs at individual level. It could mean that they have general knowledge on the topic but the real issues and facts about STIs are not well tackled. Despite the majority of the respondents having positive attitude, most of Zambian traditional and cultural values have forced women to remain passive on sexual issues. Women are socialized not to speak out and not to be assertive. This was shown in the study by the majority of the respondents indicating that they could not initiate condom use for prevention of sexually transmitted infections during sexual intercourse. The study also revealed that the women would not ask the whereabouts of their partners if they missed from home for a long time. Practice then, according to this study and to our Zambian scenario, is determined by cultural norms and until this is addressed, the practice of women towards STIs will still remain poor.

CHAPTER 6

6.0. HEALTH SYSTEM IMPLICATIONS

The study revealed that the majority of the respondents had average knowledge, positive attitude and poor practice towards transmission and prevention of sexually transmitted infections. There was no correlation between the levels of knowledge and attitude people had with their levels of practice. This is a poor indicator and one may ask why?

The findings of this study calls for all concerned to have immediate prompt attention considering the high levels of STIs in the country.

There is great need by health workers to provide more information, education and communication on transmission of STIs to increase the knowledge levels. This information should emphasize on how an individual person should be involved in reducing transmission of STIs. Individuals should be aware that their efforts play a major role in fighting the transmission of STIs in this country. When the communities will have adequate knowledge on STIs, their attitude towards STIs will improve and consequently, their practice will increase. To increase the levels of knowledge, the community should be encouraged and supported by various organs involved in STIs through provision of teaching aids, pamphlets and all health workers should show interest in the prevention and transmission of STIs.

Health workers have a responsibility to serve all citizens this country. They should disseminate knowledge on STIs especially to women as a means of equipping them with quality and reliable information. Such deliberate efforts will go a long way in enabling the women make responsible informed choices concerning their behaviour.

Health workers, particularly those working with women (e.g. mother and child health department) need to be sensitized on the unmet needs of women with regard to sexual issues and STIs. They need to know that they are key persons in reducing the spread and transmission of STIs. Such a positive attitude will promote good practice towards sexually transmitted infections among women.

1. CONCLUSION

The main objective of the study was to determine the knowledge, attitude and practices of women towards sexually transmitted infections in Kaoma. The study showed that the respondents were aware of STIs and its mode of transmission. However, knowledge on complications and on the absence of signs and symptoms despite the presence of the disease in the body is still lacking. The study showed that the majority of the respondents had positive attitude towards STIs. All respondents said they would go to a health care facility if infected with a sexually transmitted infection for early treatment. The majority of the respondents stated that they would tell their sexual partners if they were infected with sexually transmitted infection for both to receive treatment. However, some of the respondents said they wouldn't tell their sexual partners if they discovered that they were infected for fear of being victimized. They stated that they would prefer to get treatment privately than lose their sexual relationships.

The study also revealed that the majority of the respondents exhibited poor practice towards prevention and transmission of sexually transmitted infections. This did not correlate with the levels of knowledge and attitude people had. Some of the things revealed were that women cannot initiate condom use for prevention of STIs during sexual activity and that those who are using condoms are not using them all the time they have sex. This was head from both those who were married and not married. Most of those who were using condoms used them mainly for family planning.

The findings of this study calls for all concerned to combine efforts to increase the knowledge of women towards STIs. This will in turn improve their attitude and promote good practice towards STIs.

5.2. **RECOMMENDATIONS**

In view of the findings of the study, the following recommendations were made: -

- A similar study should be done on a larger scale, preferably in the entire district to determine the knowledge, attitude and practice of the population towards STIs.
- A study to focus on the attitudes and practices of persons suffering from STIs should also be done.
- Health workers should intensify information, education and communication (IEC) strategies such as face to face interaction, drama groups and mobile IEC groups where the audience can have the opportunity to ask questions to enhance better understanding of the facts about sexually transmitted infections.
- Health personnel should take each encounter with their clients (and women in particular) as an opportunity to discuss the risk of STIs and promote safer sexual behaviour.
- Women should be empowered economically by the government and non-governmental organizations (NGOs) by giving them loans so that they can start small scale business ventures and fight poverty, which could be a contributing factor to negative attitude and poor practice towards STIs.

3. **LIMITATION OF THE STUDY**

Sample Size

The sample size was chosen in considering limited resources and time to carry out the study. The number of sample size, which was 50, was not representative. A large sample size could have been chosen if the researcher had adequate resources for the study.

Data Collection

An interview-administered questionnaire was used, therefore interviewer bias could have occurred.

REFERENCES

1. Aggleton, et al (1990), **Sexual Health Promotion**. W. B Saunders Company, Toronto.
2. Birchall M and Murphy, (1995), **HIV Infection and AIDS**. Churchill Livingstone, London.
4. **Bosma, J, et al (1994), The National AIDS/STD/Tuberculosis/Leprosy Control Programme**. Report. No. 1 of the Visit of Zambia, KNCV, Netherlands.
5. CBoH (1997), **Integrated Technical Guidelines for Frontline Health Workers**. 1st Edition, Lusaka.
6. Fogel C. I et al (1981), **Sex in Historical and Cross Cultural Perspective**, CV Mosby Company, St. Louis.
7. Government of the Republic of Zambia and UNICEF (March, 1997), **Master Plan of Operations and Programme Plans of Operations for a Programme of Cooperation between the Government of the Republic of Zambia and UNICEF for the Children and Women of Zambia**.
8. Hunter, Susan (1998), **Orphans and HIV/AIDS in Zambia: An Assessment of Orphans in the Context of Children Affected by HIV/AIDS**. UNICEF.
9. Kapungwe, A. (1984), **Prostitution in Zambia: An Exploration of Three Towns**. Student Project, UNZA, Lusaka.
10. Macwan'gi Mubiana; Moses Sichone and Patricia Nalufu Kamanga (1994), **Women and AIDS in Zambia: Situation Analysis and Options for HIV/AIDS Survival Assistance**. Lusaka: National AIDS Prevention and Control Programme, Ministry of Health.
11. Makichi, R (1998), **Behavioral Change Among Women**, Lusaka.
12. Matondo, P et al (1998), **STD Syndromes: A Text and Atlas**, Lusaka.
13. MOH (1995), **National AIDS Prevention and Control Programmes**, Lusaka.
14. Ministry of Health and Central Board of Health (1999), **Zambia Sentinel Surveillance: Time Trends in the 1990s**. Lusaka.
15. Msiska, R and K, Thuo (October 1994), **Zambia's Experience in Decentralization of the National AIDS Programme and Development of the**

Second Medium Term Plan (1994-1998). Paper Presented at the Fifth AIDS Programme Manager's Meeting, Arusha, Tanzania.

16. Mukuka, L and Kalikiti, W (1995), **The Impact of HIV/AIDS on Education in Zambia.** Lusaka: Ministry of Health.
17. Nangawe, E et al (1995), **Towards Developing Rapid Appraisal Procedures for Assessing STD Programme Activities at the District Level.** Lusaka.
18. Pan American Organization (1994), **Annual Surveillance Report for HIV/AIDS and STI for the Region of the Americans.** PAO, Washington.
19. Pathfinder International (1999), **Adolescent Reproductive Health,** Pathfinder International, Nairobi.
20. Wilkinson, D et al (1999), **The International Journal of Public Health. Unrecognized STI in Rural African Women.**
21. WHO (1985), **Control of Sexually Transmitted Diseases.** WHO, Geneva.
22. WHO (1991), **Practical Guide for the Development of Surveillance Systems for STD,** WHO, Geneva.
23. WHO (1991), **Management of Patients with STDs. Report of a WHO Study Group,** WHO, Geneva.
24. WHO (1990), **STIs Increasing.** WHO, Geneva.
25. William H (1998), **Young Women's Sexual and Reproductive Lives;** Allan Guttmacher Institute Report, Washington D.C USA.
26. World bank (1997), **Controlling AIDS: Public Priorities in a Global Epidemic.** Oxford University Press, New York.

INTERVIEW SCHEDULE FOR WOMEN ON KNOWLEDGE, ATTITUDE AND PRACTICE OF SEXUALLY TRANSMITTED INFECTIONS.

DATE OF INTERVIEW:

SERIAL NUMBER:

INSTRUCTIONS TO THE INTERVIEWERS

1. Introduce yourself to the respondents.
2. Confidentiality will be ensured: no names or addresses of respondents will be asked.
3. Ensure respondents are free when answering questions through out the interview.
4. Tick in the spaces provided and fill in the space provided according to respondents' given answer.

A – BACKGROUND INFORMATION (DEMOGRAPHIC DATA)

Sex

Female

☐

Male

☐

For official use only

☐

How old are you?

15-19 years

☐

20-24 "

☐

20-25 "

☐

25-29 "

☐

30-34 "

☐

35-39 "

☐

40-44 "

☐

45-49 "

☐
☐

What is your tribe?

Lozi

☐

Luvale

☐

Nkonya

☐

Bemba

☐

Njanja

☐
☐

Other, specify.....

.....

.....

.....

ON A – BACKGROUND INFORMATION (DEMOGRAPHIC DATA)

Sex

Female

☐

Male

☐

For official use only

☐

How old are you?

15-19 years

☐

20-24 "

☐

20-25 "

☐

25-29 "

☐

30-34 "

☐

35-39 "

☐

40-44 "

☐

45-49 "

☐☐

What is your tribe?

Lozi

☐

Luvale

☐

Nkonya

☐

Bemba

☐

Njanja

☐☐

Other, specify.....

.....

.....

.....

4. What is your religion?

Catholic

SDA

New Apostolic

UCZ

ECZ

For official use only

5. Where do you live?

Village

Township

6. What is your highest educational level?

No education

Primary education

Secondary

College

University

7. How do you earn your living?

Formal Employment

Informal Employment

None

8. How much is you household income per month?

300 and above

300, - 200

Below 200

None

Don't know

9. If income is below K200,000 in question 8
explain your alternative source of income

For official use only

10. What is your marital status?

Single

Married

Divorced

Separated

Widow α

11. How many children do you have?

1-3

4-6

7-9

10 & above

**SECTION B – DATA ON KNOWLEDGE OF SEXUALLY
TRANSMITTED INFECTIONS**

12. Have you ever heard of sexually transmitted infections?

Yes

No

13. What are sexually transmitted infections?

.....

.....

.....

.....

How are sexually transmitted infections transmitted?
(tick as many as possible)

Official use only

Unprotected sexual intercourse with an infected partner

☐

Through sharing clothes

☐

Through hand shake

☐

Transfusion with unsafe blood

☐

Prick from contaminated sharps

☐

From infected pregnant mother to her unborn child

☐

I don't know

☐

Are sexually transmitted infections preventable?

Yes

☐

No

☐

Don't know

☐

If yes, how can they be prevented?

By having one sexual partner

☐

By getting treatment early

☐

By associating from sex

☐

Outside marriage

☐

Others, specify.....

Are sexually transmitted infections curable?

Yes

☐

No

☐

Don't know

☐

If answer is no to question to question 17 please explain

.....

.....

Where can one go for treatment of sexually transmitted infections?

Hospital

☐

Clinic

☐

Traditional healers

☐

Buy own medicines

☐

Other specify.....

What are the signs and symptoms of STIs in females?
(Tick as many as possible).

Increased vaginal discharge

☐

Genital warts

☐

Genital Ulcers

☐

Lower abdominal pains

☐

Dysuria

☐

Don't know

☐

Others specify.....

What are the signs and symptoms of STIs in males?

Genital ulcer

☐

Dysuria

☐

Genital discharge

☐

Others, specify.....

For official use only

☐☐☐

Is it possible to have a sexually transmitted infection without showing symptoms?

Yes ☐

No ☐

Don't know ☐

Do you know of any complications that many arise from STIs?

Yes ☐

No ☐

Don't know ☐

If the answer is yes in question 22, what are the complications?

Sterility ☐

PID ☐

Peritonitis ☐

Encephalopathy ☐

Don't know ☐

Others, specify.....

How can these complications be prevented?

By getting treatment early ☐

By taking proper medication ☐

By attending reviews ☐

By completing prescribed treatment ☐

Don't know ☐

Other specify.....

For official use only

☐☐☐☐

SECTION C.

DATA ON ATTITUDE TOWARDS SEXUALLY TRANSMITTED INFECTIONS

What would you do if you got infected with a sexually transmitted infection?

I would go to the hospital ☐

I would go to see the traditional healer ☐

I would buy medicine from the shops ☐

Other, specify.....

Would you inform your sexual partner if you had a sexually transmitted infection ?

Yes ☐

No ☐

If answer to 26 is yes, explain?

.....
.....

If answer to 26 is no, explain?

.....
.....

What would you do if your partner told you that he has a sexually transmitted infection?

Talk about it ☐

Ask where he got it from ☐

Encourage him to seek medical advice

End the relationship/ marriage ☐

Shout at him ☐

Other, specify.....

For official use only

☐☐☐☐☐

SECTION D

DATA ON PRACTICES ON SEXUALLY TRANSMITTED INFECTIONS

For official use only

31. Have you ever suffered from a sexually transmitted infection?

Yes

☐

No

☐

Not sure

☐☐

32. If yes, to question 31 did you seek medical advice?

Yes

☐

No

☐☐

33. If answer to question 31 is No, explain

.....
.....

34. How often have you suffered from a sexually transmitted infection in the last 2 years?

Once

☐

Twice

☐

More than twice

☐

None

☐☐

35. How many sexual partners do you have?

One

☐

Two

☐

More than two

☐

None

☐☐

What do you put in place to prevent transmission of sexually transmitted infections?

- Abstinence ☐
- Use condoms ☐
- Stick to one sexual partner ☐
- None of the above ☐

Other, specify.....
.....
.....
.....

☐

If you use condoms for prevention of STIs, where do you get them from?

- Government clinic ☐
- Private clinic ☐
- Shops/store ☐
- Chemists/Surgeries (private) ☐

Others, specify.....
.....

☐

8. How often do you use condoms?

- Always ☐
- Some times ☐
- Never ☐

☐

9. If you use condoms, who initiates condom use between you and your partner?

- My self ☐
- My partner ☐
- Either of us ☐

☐

40. Explain your answer to question 39

.....
.....

41. Do you know of any cultural practices that may prevent couples from not using condoms?

Yes ☐
No ☐

☐


42. If answer to question 41 is yes, explain.....

.....

43. In your opinion, how can STIs be prevented?

.....
.....

Thank you for taking your time and answering these questions!!!!!!!

***Property of UNZA Library**

3 3729 00481 9079