HEALTH CARE-SEEKING BEHAVIOUR FOR SEXUALLY TRANSMITTED DISEASES IN SOUTH AFRICA

T. Wilson, A. Strebel, L. Simbayi, M. Andipatin, C. Potgieter, K. Ratele, N. Shabalala, and T. Shefer, Department of Psychology, University of the Western Cape, Private Bag X17, Bellville, 7535, South Africa

Abstract

This paper, which originates from a larger study on sexually transmitted diseases (STDs) in the South African public health sector conducted in 1998, aims to identify and examine health care-seeking behaviours for STDs in South Africa. It focuses particularly on STD patient responses to previous and current STD symptoms regarding their patterns of service utilisation, the use of medications (including alternative medications), and behaviour after treatment. A number of complementary methodologies were used to measure health care-seeking behaviour, including interviews with STD and non-STD patients attending Primary Health Care centres, as well as focus groups with community members in non-medical contexts. Results from the different methodologies produced contrasting pictures, particularly with respect to service utilisation and the use of alternative medications. Wider factors influencing health care-seeking behaviour are incorporated into the final interpretation of results.

Key words: health care-seeking behaviour, sexually transmitted diseases, South Africa

Résumé

Cette communication est le résultat d’une étude étendue sur des maladies sexuellement transmises dans le secteur public de santé en Afrique du Sud, faite en 1998. Elle a pour but d’identifier et d’examiner les comportements à la recherche des soins sanitaires pour des maladies sexuellement transmises en Afrique du Sud. Cette communication met l’accent particulièrement sur les
réactions des patients souffrant de ces maladies par rapport aux symptômes antérieures et actuels vis-à-vis leurs façons d’utiliser des services à leur disposition, l’utilisation des médicaments (y compris des médicaments alternatifs), et le comportement après le traitement. Plusieurs méthodologies ont été utilisées pour mesurer le comportement à la recherche des soins sanitaires, ceci comprend les interviews avec des patients ayant ces maladies et d’autres patients qui se rendent aux centres primaires de santé, ainsi que des groupes de membres de la communauté en dehors des contextes médicaux. Les résultats de différentes méthodologies étaient fortement différents particulièrement en ce qui concerne l’utilisation des services et l’utilisation des médicaments alternatifs. Les facteurs qui influencent le comportement à la recherche des soins sanitaires sont incorporés dans l’interprétation finale des résultats.

Mots clés: le comportement à la recherche des soins sanitaires, les maladies sexuellement transmises, l’Afrique du Sud.

INTRODUCTION

Sexually transmitted diseases (STDs) have been acknowledged as an important health problem for many decades, but their profile has increased dramatically since the discovery of a strong link between STDs and HIV (Laga, Nzila & Gorman, 1991; Legion, 1992; Wasserheit, 1992). In South Africa the need for the prevention and control of STDs is particularly urgent, given that it is believed to have one of the highest infection prevalence rates of classic STDs (Block & Dehaeck, 1987; Leiman, 1976; Pham-Kanter, Steinberg & Ballard, 1996) and is now considered to have the fastest growing AIDS epidemic in the world (McNiel, 1999). Health care-seeking behaviours for STDs (i.e., where, when and why STD-infected persons seek help, as well as how they go about making use of that help) obviously influence the patterns of STD transmission. Identifying and understanding such behaviour is crucial if South Africa is to develop effective strategies aimed at controlling STDs. Unfortunately there is not much literature that focuses specifically on health care-seeking behaviour for STDs internationally and very little information on such behaviour in South Africa. This paper, which emerges out of a larger study on STDs in South Africa, examines the health care-seeking behaviours of STD patients and the general public with respect to STDs.

Some of the key aspects of health care-seeking behaviour include local under-
standings of sexual health, patterns of service utilisation, as well as factors influencing the seeking of treatment and the use of medications (Evans & Lambert, 1997). Important measures of health care-seeking behaviour are: the occurrence of previous infections; the duration of time people wait before seeking treatment; their behaviour prior to seeking help from a health service; and the kind of health service(s) they choose to use (Moses et al., 1994). Behaviour after treatment, including the extent to which people comply with the treatment they are given, as well as the notification and treatment of sexual partners, is also crucial in the maintenance of sexual health care. Safe sex practices are obviously fundamental to maintaining STD control after treatment, and examining sexual behaviour was an important aspect of the larger project from which this paper is drawn, but is not focused on here.

In many developing countries, research on patterns of service utilisation has examined the relative use of traditional and biomedical treatment for STDs. It is well known that Africans do not always seek biomedical treatment for STDs but often rely upon self-treatment and traditional healers (Faxelid, Ahlberg, Ndulo & Krantz, 1998; Green, 1994; South African Institute of Medical Research (SAIMR), 1993). Furthermore, it was found that traditional healers in South Africa, Swaziland and Nigeria themselves believed that certain STDs were better dealt with by traditional rather than biomedical practitioners (Green, 1994). Many people consult traditional healers with the aim of hearing an underlying explanation for the STD, and this can delay appropriate antibiotic treatment (SAIMR, 1993). In Tanzania, Newell et al. (1993) found that traditional treatment was sought more frequently in rural villages than in urban areas. However, they also reported that there was a high proportion of both males and females with symptomatic STDs seeking treatment in the 'official' biomedical health sector.

Another 'choice' with respect to service utilisation is whether to seek treatment in the private or public sector. Evans and Lambert (1997), in their study on female sexworkers in India, found that the use of the private sector was very common, both because it took less time, and because there was a general perception of efficacy in relation to private practitioners. However, services were frequently switched in the middle of treatment and many went to more than one service for the same problem. In Kenya, Moses et al. (1994) found that a large proportion of STD patients had sought treatment previously in both the public and private sectors, but without relief of symptoms, implying a high proportion of failures in diagnosis or treatment.
The use of inappropriate self-medication has been a cause of concern among STD researchers (Green, 1994). Evans and Lambert (1997) noted that, among sexworkers in India, home remedies or self-treatment with allopathic medicines (from a pharmacy) were used for 'milder' complaints such as discharge and menstrual disorders, while external treatment was sought more quickly when the complaints were incapacitating (e.g., severe lower abdominal pain or painful ulcers). Faxelid et al. (1998) reported that an average of 55% of STD patients attending public health services in Zambia had taken some kind of medicine before coming to the clinic. Most of these had used modern rather than traditional medicine. Widespread misuse of antibiotics and automedication has led to the emergence of new strains of gonorrhoea that are resistant to penicillin and therefore more difficult and expensive to treat (Buve, Laga & Piot, 1993; Green, 1994; La Ruche, Lorougnon & Digbeu, 1995). Since undertreatment can lead to such resistance (Evans & Lambert, 1997), poor compliance with medication on the part of STD patients is also a danger.

Moses et al. (1994) emphasise that the length of time that individuals are infected with a STD is an important determinant of its transmission dynamics. Not only does this influence the chances of complications developing, but a longer period of infection increases the risk of the STD being transmitted. However, very few studies have been done on the duration of time people wait before seeking treatment. In their study on health-seeking behaviour for STDs in Kenya, Moses and colleagues found that overall, 42% of patients waited longer than 7 days before coming to a clinic. Women waited longer than men to attend clinics and were more likely to have sex while symptomatic.

Partner notification, a crucial aspect of health care-seeking behaviour, refers to the effort on the part of both health authorities and infected patients to locate, counsel and treat persons who have been exposed to a STD (Pavia, Benyo, Niler & Risk, 1993). Much of the literature is made up of evaluations of partner notification systems from the clinic's side and several studies focus on the efficacy of different partner notification strategies (e.g., Oxman et al., 1994). The need for partner notification to be improved has been stressed by many, both in South Africa and in other African countries (e.g., Coetzee, Visser, Mofokeng & Hennink, 1996; Faxelid et al., 1994). However, most partner notification strategies require patients to inform their own partners about the fact that they have been exposed to a STD, whether verbally or with a partner notification card. For this reason, patient behaviour around partner notification is as essential to its success as an efficient partner notification.
The larger study from which this paper is drawn was conducted in response to a need for more research (particularly at a national level) on the numerous factors influencing the rapid transmission of STDs in South Africa. This paper, in its examination of the above-mentioned aspects of health care-seeking behaviour in the South African public health sector, focuses on an area of STDs in which there is a conspicuous lack of research in South Africa.

METHODS

The study was a national one for which four provinces were sampled. Two of these were estimated to have amongst the highest rates of reported HIV infection in South Africa (Mpumalanga and North West), and two were estimated to have amongst the lowest (Western Cape and Eastern Cape) (Department of Health, 1997). Because of the broad aim of the larger study, which included investigating the quality of STD care in the public health sector, much of the research took place in the context of Primary Health Care (PHC) centres. A total of 24 PHC centres in the four provinces participated in the study. Six of these centres (three urban and three rural) were chosen in each province, in consultation with provincial, regional and district health structures.

Four complementary methods were used to examine health care-seeking behaviour specifically. These consisted of a combination of quantitative and qualitative methodologies, which allowed for the triangulation of results. Two sources were used to obtain quantitative data. First, a total of 126 semi-structured exit interviews with STD patients were conducted at the 24 PHC centres. Second, a total of 72 patients who presented with any ailment other than a STD were interviewed, with a semi-structured interview schedule, and asked about their own history of STDs.

The semi-structured interviews consisted largely of closed-ended questions, but included a few open-ended questions. Among the STD patients there were many who had experienced STDs prior to their current symptoms. Behaviour around previous STDs, particularly with respect to participants' choice of treatment, as well as whether partners were treated, was elicited. Similar questions were asked to those non-STD patients who had previously experienced a STD. For their current episode, STD patients had obviously already
made a choice about seeking help at the clinic where they were interviewed. Questions about health seeking behaviour therefore centred on 1) the symptoms that had prompted them to seek help; 2) the duration of time they had waited before seeking help; 3) whether they had sought alternative treatment or administered self-medication before coming to the clinic. In addition, questions were asked about patients' intentions with respect to compliance with medication and partner notification. A small number of patients (23) were 'follow-up' patients (i.e., they had been treated recently for their STD and had returned for a follow-up appointment). These patients could be asked about whether they had indeed complied with the medication and/or contacted their partners about being treated.

Each item of these interview schedules was analysed quantitatively. Answers to both closed- and open-ended questions were categorised, coded and, in most instances, frequencies were obtained and means were computed (using SPSS, version 8.0) in order to describe patterns and trends in the data. In addition, cross tabulations were conducted for comparative purposes, to ascertain whether any differences were apparent along gender, provincial (divided into high and low-risk provinces) and urban-rural lines. The Pearson Chi-square was conducted to test for the significance of the cross tabulations, using the 95% confidence interval.

With respect to the qualitative data, 28 depth interviews with STD patients were conducted at 12 clinics, 20 with females and 8 with males. In addition, 10 community focus groups were conducted in the four provinces. Two of these were with sexworkers (all female), while the others were conducted with groups of prisoners (all male); mineworkers (all male); university students (all female); community health workers (male and female); two community groups (male and female); a women's church group (all female) and 'housewives'(all female). Both the interviews and the focus groups were unstructured, and qualitatively explored patients' perceptions, experiences and health care-seeking behaviours relating to STDs. The main areas of discussion were service utilisation, the use of alternative treatment and home remedies, as well as participants' perceptions of the quality of STD care they received at the PHC centres. All qualitative interviews and focus groups were conducted in patients' preferred language, tape-recorded, transcribed verbatim according to standardised transcription conventions and translated into English. A thematic analysis of the translated and transcribed texts was done, drawing on the dominant themes that emerged out of each of these sources. The results of the
qualitative analysis were then triangulated with those from the quantitative sections of the study. See Simbayi et al. (1999) for further details about the methodology.

**QUANTITATIVE RESULTS**

**Previous STDs**

Of the 126 STD patients who took part in semi-structured interviews, just over half reported that this was their first (known) time to have a STD, while the rest reported to have contracted the illness previously. A breakdown of this information, providing the total number of STDs contracted for both men and women, is described in Table 1 below. No significant difference was found across gender. From these results it is clear that many patients had already had a number of STDs in the past, suggesting either that previous treatment had failed or preventive methods had not been used.

<table>
<thead>
<tr>
<th>Total number of STDs</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>One</td>
<td>28</td>
<td>64</td>
<td>45</td>
</tr>
<tr>
<td>Two</td>
<td>1</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Three</td>
<td>9</td>
<td>21</td>
<td>12</td>
</tr>
<tr>
<td>Four or more</td>
<td>6</td>
<td>14</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>44</td>
<td>100</td>
<td>80</td>
</tr>
</tbody>
</table>

*Note:* Total percentages in the tables do not always add up to exactly 100, since all percentages have been rounded off to the nearest whole number. However, for the sake of simplicity the total percentage will always be written as 100.
Behaviour around previous STDs was assessed and patients were asked specifically about their last episode. Table 2 provides a breakdown of the time period since their last episode. Once again no significant difference was found across gender. Most patients (64%) reported to have had their last episode more than 6 months previously, suggesting that they were probably presenting with a new episode rather than an uncured episode, and thus implying that multiple STDs result more from ongoing unsafe sexual behaviour than they do from failed treatment. However, a cohort study would be needed to assess more accurately whether repeat attenders are presenting with failed treatment or new episodes. Of the patients who had had previous episodes (n = 51), 73% went for treatment, while 27% did not go for any treatment. Most of those patients who went for treatment reported that they went to clinics (60%), while others went to private doctors (31%) and traditional healers (7%), and 2% mentioned 'other' treatments. There was no difference between urban and rural STD patients with respect to choice of health services.

While almost all of these patients reported that they had completed their treatment (94%), the majority of their partners (57%) were not treated at all. When questioned about why they thought their symptoms had returned, the reasons given ranged from partners not being treated to practising unsafe sex.

Table 2
Period of time since last STD episode for STD patients.

<table>
<thead>
<tr>
<th>Period of time since last episode</th>
<th>Male</th>
<th></th>
<th>Female</th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 month</td>
<td>1</td>
<td>6</td>
<td>6</td>
<td>18</td>
<td>7</td>
</tr>
<tr>
<td>1 - 6 months</td>
<td>2</td>
<td>13</td>
<td>9</td>
<td>27</td>
<td>11</td>
</tr>
<tr>
<td>6 - 12 months</td>
<td>6</td>
<td>38</td>
<td>8</td>
<td>24</td>
<td>14</td>
</tr>
<tr>
<td>More than 1 year</td>
<td>7</td>
<td>44</td>
<td>11</td>
<td>32</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>100</td>
<td>34</td>
<td>100</td>
<td>50</td>
</tr>
</tbody>
</table>
Non-STD patients were also asked about previous STDs. Of the 73 non-STD patients 13 (18%) reported to have had at least one STD. Only 10 of these reported on their behaviour relating to the STD: of the 10, nine had been for treatment, and all of these to clinics or hospitals. None reported to have used alternative treatment or self-medication.

Current STDs

**Duration of symptoms**

The duration of symptoms before the patients attended the clinic ranged from less than 7 days to more than a month, with the majority seeking treatment within 7 days (see Table 3). While this indicates that the majority of patients sought prompt treatment, 44% waited longer than 7 days to seek treatment, in this way increasing their risk of developing complications as well as increasing the risk of transmitting their infection.

<table>
<thead>
<tr>
<th>Duration of symptoms</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 7 days</td>
<td>70</td>
<td>56</td>
</tr>
<tr>
<td>8 - 14 days</td>
<td>17</td>
<td>14</td>
</tr>
<tr>
<td>15 - 30 days</td>
<td>14</td>
<td>12</td>
</tr>
<tr>
<td>more than 1 month</td>
<td>16</td>
<td>13</td>
</tr>
<tr>
<td>don't know</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>120</td>
<td>100</td>
</tr>
</tbody>
</table>

**Patterns of service utilisation: alternative treatment and self-medication**

Responses to questions as to what else these patients did about their illness revealed that the majority (85%) reported to have done nothing other than attend the clinic. Nine per cent administered self-medication, 3% received treatment from someone else and 1% said they did something other than the
above-mentioned. Those patients who reported using other treatment received it from private doctors, other clinics and pharmacies. The outcome of the treatment was reported to be both positive and negative, with 44% of patients reporting that the symptoms went away, 50% saying they stayed the same, and 7% saying the symptoms got worse. Once again there was no difference between rural and urban STD patients with respect to use of health services.

Thus, not much use of alternative treatment or self-medication was reported by STD patients in the semi-structured interviews and it is interesting to note that no STD patients reported to have gone to a traditional healer for their current infection, while very few of them reported to have consulted a traditional healer in the past.

**Compliance and partner notification**

Compliance with medication was not easy to assess in this particular sample, since the majority of STD patients were presenting with a STD for the first time and the question of whether or not they would complete their medication could not be answered accurately. However, there were high numbers of patients who had been treated for a previous STD as well as ‘follow-up’ patients who reported to have complied with the medication. Of the patients who had had previous STDs, 94% reported to have completed their medication for their last episode. Among the ‘follow-up’ patients who had been given medication for this episode already, 87% said that they had taken all of their medication.

Partner notification was equally difficult to assess as most people could only say whether they intended to notify their partners. Treatment of the regular partner was considered important by the majority of the patients: 97% reported that they intended to notify their regular partner. In terms of notifying the other sexual partners, however, only 65% said they intended to do so. In spite of the good intentions of STD patients, only 74% of ‘follow up’ patients had asked their regular partners to go for treatment, and only 37% of the partners of those patients who had been infected previously had actually been treated.
QUALITATIVE RESULTS

Patterns of service utilisation

Contrary to the quantitative findings, both the depth interviews with STD patients and the focus groups revealed that patterns of service utilisation were more complex than was implied by the semi-structured interviews. Within the biomedical realm, a number of participants visited a private doctor, although the cost of such treatment was sometimes an obstacle to continuing with treatment:

I thought if I came to the clinic they would refer me to a doctor and then I did not have the money to go there. So, now they have a doctor here at the clinic, one can come.

(Female STD patient)¹

What was interesting regarding the consultation of private practitioners was that men appeared to make more use of such services, being reluctant to come to the clinic for treatment, which was constructed as a female domain:

When I asked him to come to the clinic so as to get the same injection that I am getting he said he would not be able to do so, he became evasive and said a lot of other things [laughs] ... he said he does not want to be seen by people when coming to the busy-bodies who will want to know as to why he is at the clinic, considering that the clinic is mostly used by women. So he saw it best to go to the doctor.

(Female STD patient)

1. Transcription conventions

   P1, P2 Differentiates between different speakers
   ... Material omitted from quotation
   [text] Explanatory material or clarifying text
   :: Word drawn out
   /text/ Overlapping talk
There were contradictory trends in the use of traditional healers for the treatment of STDs. Some participants had made use of such services and taken the prescribed herbs, with some reporting positive outcomes and others negative. There also appeared to be suggestions that it was ‘others’ who made use of such services:

Participant (P): They are given herbs and other stuff to drink. They say these herbs ensure that everything comes out, thus they are cleansed from within. You can either get herbs to drink or get herbs to use for an enema.

Interviewer (I): Do these herbs help?

P: Yes they say the herbs do help because they get cured. (Female STD patient)

He [friend] advised me to go to another herbalist and get a mixture, but because I’ve never been to one I felt a bit uncomfortable about that so he gave me half of the mixture that he had ... what I find strange is nothing is happening, instead things are getting worse. (Male STD patient)

I consulted a certain woman [traditional healer] who told me that it is ‘lethopa’. She gave me a powder to smear on my vagina but it did not help at all. (Female STD patient)

Traditional healers were also viewed as more appropriate for men, because men experienced difficulties being examined by female staff:

P1: Most people go there [traditional healer] to avoid having their penises examined by nurses. Most people prefer the healers...

I: ... believe you said people tend to avoid going to the hospitals because they don't want to be examined. So are you then saying the traditional healers do not examine you?

P: No they do examine you but at least there you are examined by a male person. (Male prisoner group, Eastern Cape Province)

There also seemed to be a perception that traditional healers were the appropriate healers of some STDs (‘drop’) but not for others like ‘discharge’:

I: Does African traditional medicine help at times?

P: Yes it helps because it can heal ‘lethopa’. (Female STD patient)
P: I once had it [drop] ... my mother took me to another lady and I was given a herbal mixture to drink.

I: Were you successfully treated?

P: Yes, I was cured ...

I: So this time you did not go to this lady?

16: I did not. I've never heard that one can go to a healer for a discharge treatment ... some of the healers can treat these things ['drop']. I really do not see a person going to a healer and saying that she has a discharge.

(Female STD patient)

In some groups a wariness of western medicine and a clear support for indigenous healers emerged. Some spoke of how the clinics only deal with the symptoms while healers address the roots of the illness:

I am talking from experience. If I am sick they will be able to give me an injection and pills. But as time goes on you find that when you urinate the urine is burning but if you go to the traditional healers they are able to cure this illness completely. They give you traditional medicine and you get healed. In the Western way of treatment, the symptoms do seem to go away but when you have sexual intercourse with a woman the problem reappears. But if you go to a traditional healer the problem will not reappear at all.

(Male mineworker group, North West Province)

It also appears that if one goes to a hospital with a STD, the injection given does not cure one but it makes the symptoms dormant. I once had it [a STD] and I went to the clinic and I was given an injection. Within 5 days the symptoms reappeared after I had sex with woman. I resorted to going to see a healer who lives in [name of place]. I was cured. After a week I saw the reappearance of symptoms. I thought I had the ‘drop’ but now together with the burning urine I had sores. I had this ugly sore at the tip. At the hospital I was given ointments. I then received help from the traditional healer. From this I also agree these western pills don't help but they work temporarily.

(Male prisoner group, Eastern Cape Province)

Others argued for a combination of western and traditional medicine:

A person has to go to traditional healers to get mixtures. A person can also go to faith healers where they will be given enemas and stuff to drink that will make you throw up ... ensure that these things completely driven out of your body. I think its best to combine alternative medicine with western medicine. The person should come to the clinic to get pills that will help.

(Community member group, Eastern Cape Province)
There were some participants who claimed that they had not and would not consult a traditional healer:

I: Do you think traditional African medicine helps?
P: I do not believe in it.
I: What does that mean?
P: I have never used traditional African medicine, therefore I would not know whether it helps or not.

(Female STD patient)

P: They are given herbs to drink. I don't think it is possible to treat STDs or just diseases with herbs. These people pay for these herbs and yet they don't work ...
I: Have you ever been to see a traditional healer for a STD?
P: No ... a friend of mine once offered me some herbal mixture but I refused to drink it because I prefer to come here to the clinic or to the doctor.

(Female STD patient)

**Self medication and home remedies**

While the vast majority of patients reported that they made use of clinic services for the treatment of their STDs, and some reported to consult traditional healers, others resorted to home remedies or self-medication. Focus group participants, whose discussions took place outside of the clinic context, also frequently raised the use of alternative methods of intervention, both preventative and curative:

He has even gone to the extent of drinking herbal mixtures a lot ... he has even started using the holy water from a certain religious group ... Since he says it is not a disease but a man-made thing he has stopped using the herbal mixtures. He uses the holy water now. I believe the holy water is bringing about some improvement.

(Female STD patient)

I1: But otherwise if you insist on using condoms they look for someone else?
P1: Yes they do. So what we do - we drink 'ama double buy'.
I1: What do you drink?
P1: Double buy, that's 'uzifo zonke' and clean ourselves...
I1: Please tell me more about these 'double buys'
P3: Okay, that's potassium permanganate, something like that, that's what they use and Jeyes Fluid.
I: Do you drink it?
P: Yes/yes we do/all
I: What does it do?
P: It cleans you from within and it's also some sort of laxative.
I: Whoow.
I2: But I believe that the ladies are not aware that this kills.
P: It works - it cleanses us - but it's dangerous.
(Female sexworker group, Mpumalanga Province)

P2: We also drink dip. This is the dip you mix with water. We drink this in the morning so as to cleanse ourselves of this contaminated blood and leave it behind in the toilet if possible. You then are okay. You can do this for a week.
(Female sexworker group, Mpumalanga Province)

Men appeared to use equally painful alternative methods of intervention in attempting to 'drain' the infection, by putting physical pressure on the penis - 'hammering' it, in one case:

I: Is there anything else you used for treatment before going to the hospital?
P: I asked others and they said you should just put the penis on a hard surface then you hammer it.
I: What? [background laughter]
I: What did they say?
P: Someone said at the hospital they use the same kind of treatment. They just use a rubber hammer. Instead of going there I tried to do it myself. I did not use the rubber hammer as advised by [others], I tried to drain it myself. I realised then that it was not working.
(Male prisoner group, Eastern Cape Province)

**Attitudes towards clinics**

The willingness to go to a clinic for a STD appeared to be heavily influenced by patients' and the general public's experiences of and attitudes towards the clinics themselves. While many participants saw the local clinics as a first option for intervention, there was also a lot of negativity about these services, which were sometimes constructed as a 'last resort' if all else failed. The reputations of clinics are obviously of great importance, because they affect whether people choose to make use of a clinic or whether they choose an alternative form of treatment. The following examples indicate the extent to which patient attitudes towards clinics might influence their health care-seeking behaviour:
P2: That's why most people don't go to the clinic. Even our kids when we send them there for contraception won't go. They just turn right round and come home.
P7: Because they humiliate them ...
P2: The nurses are rude, they are so rude.
P4: Even the clerk.
P2: She is worse. She tells you they are knocking off and don't have the time ... These clinic nurses are the reason people don't want to go there. They make you feel like a fool, a piece of rubbish, until you don't even know yourself anymore. You regret why you actually went there and all the time they'll be shaking their butts and walking around ... You'd probably just think of leaving the place, if you think of how humiliated and put down you'll feel when she finds out what disease you have.

(Community group, Mpumalanga Province)

DISCUSSION

Very few STD studies in South Africa have focused on specifics of health care-seeking behaviour for STDs. In this study, the health care-seeking behaviour of STD patients was assessed by examining the behaviour of those who had had the illness previously, as well as those who contracted the illness for the first time. For most patients this was their first STD. However 41% of patients had contracted a STD previously, and 31% had contracted at least three STDs in their lives. The length of time since most previous STDs (usually over 6 months) suggested poor preventative practices, a hypothesis supported by the finding in the larger project that reported condom use was very low (Simbayi et al., 1999). Results demonstrated that patients were relatively aware of the importance of seeking care promptly, as more than half the patients did not wait too long before seeking assistance for their illness and almost all sought biomedical treatment. However, 44% of patients waited more than 7 days before seeking treatment, reflecting a similar pattern to that of Kenya (Moses et al., 1994), and suggesting that there is room for improvement with respect to promoting the importance of prompt treatment for STDs. Prompt treatment is essential in order to reduce the risk of further health complications developing, as well as to reduce the risk of transmission.

With respect to patterns of service utilisation, the majority of participants, including the focus group participants who were interviewed outside the clinic context, made use of clinic services for the treatment of STDs. In the semi-
structured (quantitative) interviews, only a very small number of patients reported to have visited alternative or additional services for treatment, and not much self-medication was reported. However, the qualitative interviews and group discussions brought out a different voice suggesting other forms of treatment were considered common by participants, and many had been used either as an alternative or a supplement to clinic treatment. Among the alternative forms of treatment mentioned were private doctors, traditional healers and a range of self-medication and home remedies. The use of private doctors appeared to be influenced by gender, with clinics constructed as a female domain (partly because of the high proportion of female nurses) and both men and women reporting that men made more use of private doctors. The use of traditional healers was contradictory, with a mixture of support and mistrust with respect to their capacity to treat STDs, as well as a mixture of experiences of traditional healers. A common notion was that traditional healers addressed the root of the illness, while western medicine treated the symptoms, a finding that supports previous South African research (SAIMR, 1993). Certain STDs were reported by some to be best treated by traditional healers while for others western medicine was seen to be more appropriate. The tendency of many patients to make use of traditional healers and biomedical treatment simultaneously is in line with findings by Newell et al. (1993) in Tanzania.

With respect to self-medication, contrary to findings elsewhere in Africa (Buve et al., 1993; Green, 1994; La Ruche, Lorougnon & Digbeu, 1995), there was no talk of taking unprescribed antibiotics. However, similar to Evan and Lambert's (1997) findings, a range of home remedies were utilised. Most concerning was the finding in this study that popular methods of self-treatment included drinking or applying 'cleansers' such as 'dip' (apparently those used to disinfect animals from ticks, fleas, etc.), potassium permanganate and Jeyes Fluid (popular as a toilet cleaner). Such methods highlighted the powerful perception of STDs as 'dirty', especially for women, and therefore needing to be sanitised by as stringent a cleanser as possible. The dangers, pain and discomfort involved in alternative 'cures' was also made apparent by such reports.

Thus, reports of the use of different services and treatments were sufficient to suggest that general practitioners, traditional healers and pharmacists play an important role in the larger picture of STD control. Certainly, the results from this study support other African studies which highlight the wide use of self-treatment and traditional healers (Faxelid et al., 1998; Green, 1994; SAIMR,
The low reporting of the use of alternative treatments from the semi-structured interviews with STD patients in this study was likely to have been influenced by the context of the clinic which, given its medical domain, may have prevented many patients from talking about their use of alternative treatments. Also, the fact that those STD patients who participated in the depth interviews were more open about alternative treatments, suggests that qualitative interviews were more able to elicit alternative experiences and beliefs. In order to gain a clearer picture of patterns of service utilisation in South Africa, further research is required on alternative constructions of sexual health and illness, that is, the parameters in which STDs, with their different symptoms, are experienced, defined, explained and treated by people in different communities. Such research would best be conducted outside of the biomedical context of PHC centres.

Some of the wider factors influencing health care-seeking behaviour were apparent in this study. Although clinics were commonly used for the treatment of STDs, the decision to visit a clinic seemed to be a complex one and was influenced by issues of gender, finances, and by negative impressions of the clinics. Sometimes clinics were used as a last resort, after home remedies and self-medication, because of general embarrassment or because of poor clinic reputations. Obviously, the health care-seeking behaviour of STD patients and the general public is strongly influenced by their experiences and perceptions of the kind of care provided by the clinics themselves. In the larger project from which this paper was drawn, ways of improving clinic services were explored, including the need for educational interventions, which provide clear information about the nature, causes and risks of STDs, as well as the need to address, without judgement, issues of sexuality, gender relations and communication within relationships. Clinics also need to be made more accessible to men, for example, by employing more male nursing staff and male health promoters. Those health services at which males have been more inclined to seek help (i.e., private doctors and traditional healers) need to be involved in tackling the wider issues relating to the transmission of STDs, especially the traditional gender roles taken on by men which serve to undermine safe sex practices.

For those who did make use of the clinics, compliance with medication was reported by patients to be good. This was confirmed in other parts of the larger project, where health providers themselves felt that the syndromic treatment protocols worked very well, and were reported to have emphasised the impor-
tance of compliance to STD patients. However, in line with many other South African studies (e.g., Coetzee, Visser et al., 1996; Harrison et al., 1998), partner notification emerged as a major problem, with patients' intentions in no way matching their actual behaviours. Partner notification requires particular attention, both in research and in practice. There has been some speculation about poor partner notification. For example, Coetzee Matthews and McCoy (1996) suggest that patients may not understand the purpose behind partner notification and the biomedical explanations of STDs may not be accepted by patients. Also, a high proportion of sexual partners may be casual contacts whom the patient is unable or unwilling to name and/or locate. Furthermore, South Africa's highly mobile population and its inherited system of migrant labour might make it difficult for patients to locate their partners. Difficulties faced by patients are also likely to be similar to those that make negotiating the use of condoms problematic (i.e., trust and fidelity issues, combined with the socialisation of men and women in particular sexual and power roles). Yet research in this area has only recently begun to emerge in the South African context. Difficulties faced by STD patients with respect to partner notification need to be researched in more depth. At a practical level, in their consultations at all health services, assistance should be given to patients in thinking about how they might approach their partner/s regarding partner notification.

CONCLUSION

In this paper key aspects of health care-seeking behaviour for STDs in South Africa were examined and discussed. Most participants in the study were aware of the need to seek treatment for their STDs promptly, and the vast majority sought treatment in the biomedical contexts of PHC centres or private doctors. Furthermore, most patients who had been treated for previous STDs reported to have complied with medication given at clinics. However, for many participants the delayed seeking of help, the use of alternative or supplementary treatments and poor records of partner notification affected the degree to which the treatment of their STDs might be effective. Factors influencing patient reluctance to visit clinics included poor clinic reputations (especially with respect to STDs), as well as the belief in, and use of, alternative cures. Clinics were also seen by males to be 'female territory'. Reasons for poor partner notification need to be researched in more depth, bearing in mind that South Africa has a very mobile population, as well as a history of violent gender relations, both of which would have a powerful influence on the possibility of an effective partner notification system.
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