

**A STUDY ON FACTORS INFLUENCING PARTNER
NOTIFICATION IN PATIENTS WITH SEXUALLY TRANSMITTED
INFECTIONS AT QUEEN ELIZABETH CENTRAL HOSPITAL**

**A Research Dissertation Submitted to the faculty of nursing, in Partial Fulfillment
of a Bachelor of Science Degree in Nursing Education**

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Declaration

I hereby declare that this dissertation is a result of my own work and effort
and that it has not been presented for any degree.

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Signature M. C. Nyirado Date 24-06-02

Dedication

To God be the glory for great things He has done in my life. Thank you Lord for taking me through the two years of study.

I would like to dedicate this study to my beloved husband Rabson and my three beloved children, Joseph, Abigail and Alefa. I thank you for persevering the long periods of separation, your love, support, patience and much more your unceasing prayers for me, God bless you. To Esther and Rose, you have been wonderful sisters, thank you for taking care of the children, wishing you God's blessings.

This work is also dedicated to two special people, my deceased father and mother who encouraged me to study hard. Mum and dad I wish you were here to see me excel. I still honor and respect your love. May your souls rest in peace.

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Abstract

The purpose of this study was to explore factors that would influence partner notification in patients with STIs at Queen Elizabeth Central Hospital. The Health Belief Model by Rosenstock (1988) was used to guide the study. A descriptive study design was used and data was collected by face to face interviews of 30 patients with sexually transmitted infections. A structured interview guide was utilized in data collection. Data was analyzed using descriptive statistics and content analysis. Frequency tables, graphs and pie charts were used to present data. An equal number of males and females were enrolled into the study, 50% (n=15) males and 50% (n=15) female. The participants' ages ranged from 18 to 64 years but the majority ranged from 20 to 24 years falling in the sexually active group of 15 to 49 years.

Majority of the patients 80% (n=24) presented with symptoms which were commonly presented in most STI clinics for instance genital ulcers. It took less than 7 days for the majority to realize they had STI symptoms because symptoms caused discomfort in them. The results showed that upon realizing that they were infected, the majority 66.7%(n=20) did not tell their partners because they were scared and worried that their relationships would be disrupted.

All the patients 100% (n=30) indicated that sexual matters were not communicated openly because they were supposed to be kept a secret. Though they had been treated privately at the clinic, 40% (n=12) of the patients did not interact comfortably with the health workers because of the

nature and stigma of the infection. Attitude towards partner notification was good among the patients because it would prevent reinfection. In as much as they had good attitude towards partner notification the majority 63.3% (n=19) had no intentions to notify their partners because they had fears of relationship disruption. Therefore this calls for health workers to ensure that clinics are client friendly so that patients express their concerns on the infection freely. In-service education for health workers on counseling and communication skills should be organized to reinforce the skills so that patients are helped accordingly and they are encouraged to notify partners.

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List of abbreviations

STI:	Sexually Transmitted Infection
STD:	Sexually Transmitted Disease
HIV:	Human Immunodeficiency Virus
AIDS:	Acquired Immune Deficiency Syndrome
WHO:	World Health Organization
NACP:	National Aids Control Programme
IEC:	Information Education and Counseling
QECH:	Queen Elizabeth Central Hospital
BLM:	Banja La Mtsogolo
STAFH:	Support to AIDS and Family Health Project

OPERATIONAL DEFINITIONS

In this study,

Index Patient: Is the first patient treated for STI

Sexual intercourse: Insertion of man's penis into woman's vagina.

Sexual Partner: A person with whom one had sexual intercourse

Partner: A spouse, steady casual or high-risk individual/ friend partner
who had sex with an index STI patient.

Partner Notification:

Is the identification and notification of sexual partner(s) of an
index STI patient of their risk of infection.

Sexually Transmitted Infections:

Are infections, which are passed from person to person by
sexual contact.

CHAPTER 1

1.0 Introduction

1.1 Background of the study

Sexually transmitted infections (STI) remain a public health problem of major significance in most parts of the world (WHO, 1997). In 1995 there were approximately 333 million cases of STIs of which 65 million were in Sub-Saharan Africa and 150 million in South and South East Asia. World wide, there are almost 685,000 people who are infected with STI every day (population Report cited in National Aids Control Programme, 1998). Every year there are close to about 350 million new cases of STIs making it nearly as prevalent as Malaria.

In many developing countries through out the world, including Malawi, STIs rank among the top five conditions for which adults seek health care (NACP, 1995). The 1996 Malawi Knowledge Attitudes and Practice for Health Survey estimated STI prevalence of 6.3%. Taken as a group, STIs were the fourth most common reason for consultation in adult out patient department nation wide (MOH, 1991). Lilongwe Central Hospital in 1989, 44% of unselected out patients presented with STIs (NACP, 1994). These statistics are underestimated because many more people are not aware that they have an STI since they have no symptoms or are not aware of the symptoms. For

example, a study of antenatal women at an urban clinic in Blantyre found that while only 11% reported having had an STI in the last 3 years, 42% actually had an STI at the time of study (Dallabetta, Miotti et al, 1993 cited in NACP, 1998).

The complications of STI can be serious and devastating. They include women suffering from chronic abdominal pains, infertility, spontaneous abortions, ectopic pregnancy and cervical cancer. Social effects caused by STIs include men divorcing infertile wives and spouse abuse related to partner being infected. Economically STIs accounts for great financial expenditures (WHO, 1997). In Malawi, Banja La Mtsogolo in 1998 treated 65, 702 STI patients at K19,104,452.00 while as in 1999 they treated 88, 620 patients at K42,080,099.00 (BLM Annual Report, 2000).

The need for STI control has become urgent since most STIs are now recognized as independent risk factors for HIV transmission. The risk of STI transmission of HIV may be increased 5 to 10 fold in the presence of STI (NACP, 1994). Other STIs make it easier for HIV to pass from one person to another, for example chancroid, chlamydia, gonorrhoea, syphilis and trichomoniasis may increase the risk of HIV transmission by two to nine times (NACP, 1995).

WHO recommended that there should be a comprehensive management of patients with STIs within the context of control, prevention and care programmes. Ministry of health adopted the syndromic management of STIs

in 1992. This means managing STI patients by signs and symptoms (NACP, 1995). It also includes counseling of STI patients, reduction of high-risk sexual behavior, promotion of condoms and partner notification (NACP-MOH, 1994).

Partner notification is a process of encouraging a person who has a sexually transmitted infection to ensure that a sexual partner or partners come to the clinic for examination and treatment (Calteral, 1984). As far as the STIs are concerned, if the patient has had sex with more than one person other people could have been infected by the original patient.

Partner notification started in 1992 with the coming of syndromic case management of STIs (NACP, 1997). Partner notification is done through index patient referral. Index partner is the first patient treated for STI, he or she notifies a partner of the infection without direct involvement of the service provider. This is done by using partner notification slips where by the index patient is given to present to the partner to come for treatment.

Partner notification is important because it ensures that partners receive treatment for possible STIs to avoid adverse consequences of an STI. It could prevent the spread of the disease by the untreated partner and it might ensure that the patient is not re-infected after treatment (NACP, 1998)

Notification of STI infected patients has been identified as an effective way to reduce the transmission rate of STIs and it is especially effective way to

identify asymptomatic infected persons (Woodhouse et al, 1995 cited in NACP, 1997). Despite distribution of partner notification slips to index patients, through experience the researcher has observed that not all partners report to the health facilities. Results of the study done in 1994 involving 5 districts in Malawi showed that return rates of the distributed partner notification slips were low ranging from 18-19% (NACP, 1997). This then means that the partners are not notified or they are notified but they do not report for treatment and there is further transmission of the infection resulting to high incidences of sexually transmitted infections. There is need then to find out the factors that influence partner notification in STI patients.

1.2 Problem Statement

The coming of Human Immunodeficiency Virus, which might be transmitted sexually, has redoubled the need to prevent all STIs. It has been indicated that the presence of STIs increases the risk of HIV transmission by 3 to 5 fold (Wasserheit, 1992 cited in Health and Occasional paper, 1998). Furthermore it has been hypothesized that the risk of HIV infection from a single exposure has increased from 10-300 fold in the presence of an STI.

The cornerstone of STI control and prevention in Malawi is improved STI case management in health care facilities. Comprehensive STI management includes proper diagnosis of STIs, effective antibiotics treatment and preventing efforts beginning with patient education on risk reduction and partner notification (NACP, 1994).

Partner notification is an integral component in STI prevention (WHO, 1991). For effective STI prevention, it is best that patient notify their partners early to prevent further transmission of STIs. However, studies have shown that many patients do not inform their partners as observed by low return rates of the distributed partner notification slips (NACP, 1997). There is need to find out why patients do not notify their partners.

1.3 Purpose of study

The purpose of this study was to explore factors that influence partner notification in patients with STIs at Queen Elizabeth Central Hospital.

1.4 Significance of the study

It is hoped that this study will assist in reviewing STI policies and guidelines, which will help in prevention of further transmission of STIs. The results will guide practitioners on how to approach the index patients so that they have the eagerness to notify their partners. It will also help educators to include partner notification in the curriculum. Finally the results will assist develop health education programmes for individuals, families and community whereby STI patients will be made knowledgeable about partner notification and such knowledge will encourage them notify their partners to prevent further transmission.

1.5 Main Objective of the study

To explore factors that influence partner notification in patients with STIs at Queen Elizabeth Central Hospital.

1.51 Specific Objectives

1. To determine patient's personal factors which influence partner notification.
2. To identify patient's social cultural factors which influence partner notification.
3. To explore health care system factors that influence patients to notify partners about STI.

CHAPTER 2

LITERATURE REVIEW

INTRODUCTION

A review of literature shows that many studies have been conducted on STIs in general and STI prevention including partner notification. Review of literature has been done on the following subtopics: general information on STI, factors which influence partner notification which include sociaocultural, personal and health care system.

2.1 General information on Sexually Transmitted Infections

The World Health Organization has estimated that in 1995 there were 333 million cases of STIs of which 65 million were in Sub Saharan Africa and 150 million in South and South East Asia. The world development report states that STIs are the second most important cause of loss of healthy life years in women of childbearing age (Health and Population Occasional Paper, 1998). It further states that in developing countries, numerous surveys of women normally considered at relatively low risk for STIs such as those attending antenatal clinics show rates of infection as high as 40% while even high rates are reported among sex workers.

Extent of STIs in Malawi accounts for a significant burden on the health services in Malawi as in other African countries. Taken as a group STIs were the fourth most common reason for consultation in the outpatient department nationwide. At Lilongwe Central Hospital in 1989, 44% of unselected out patients presented with sexually transmitted infections

(NACP, 1994). As such prevention measures such as partner notification should be intensified.

2.2 Social Cultural Factors Influencing Partner Notification

Notifying a partner about an STI may be stressful for a patient for a variety of reasons. Most of the times it will depend on patients' relationship to the partner for example notifying one's wife or husband may require much more explanation, than telling a commercial sex worker (NACP, 1998). A study done in five pilot sites in Malawi in 1994 showed that knowledge of STI was more disruptive for married couples than for single individuals, however, it was even more disruptive for singles who had serious relationships and were contemplating marriage (NACP, 1998).

The study also showed that the index patient did not expect to have intercourse ever again with the sexual partner or until he she was recovered from the infection, this created a tendency not to tell the sexual partner about the STI.

Wives might not be taken to engage themselves in extramarital relations culturally as husbands. In another study, it showed that the wives were more tolerant about their husbands' infections than the husbands were about their wives (WHO, 1991). Therefore it could be easier for husbands to tell their wives than wives telling their husbands. Because of this if women are infected they would be looked at as outcasts, this therefore will make women

not notify their partners because if they do, they would be thought as having broken cultural values.

In another study in Nairobi, Kenya on partner notification of pregnant women infected with Syphilis, at delivery 377 women were found to be Rapid Plasma Regain (RPR) reactive (Achingi et al, 2000). 94% of the partners of the women who were tested during pregnancy over 67% of the partners had received syphilis treatment while 23% had not sought treatment mainly because they felt healthy. Six percent of the women had not informed their partners, as they feared blame or violence. Adverse pregnancy outcome was related to lack of partner treatment during pregnancy. Data suggested that messages focusing on the health of the unborn child had a positive effect on partner notification, innovative and locally adapted strategies for partner notification need more attention.

2.3 Personal Factors Influencing Partner Notification

The patients feeling towards the sexual partner is influenced whether or not they told them about STI (NACP, 1997). A study done in 1994 by STAFH project showed that the degree to which partner cared about one another, whether or not the partner believed the other was faithful or not, and the openness between husbands and wives concerning their bodies and sexuality and for the single people, the seriousness or closeness of the friendship and their openness with each other contributed to partner notification.

In the study patients had less difficulty telling the person from whom they attributed the STI transmission than telling the person to whom they

transmitted the infection. Studies have also shown that severity of symptoms contributed to urgency in notifying partners (Health & Population Occasional Paper, 1998). For example it frequently takes longer for symptoms to manifest in women than men, therefore women will take long in notifying their partners than men.

Perceived consequences of telling also contribute to partner notification (NACP, 1997). A study done in 1994 by STAFH project showed that since there was a tendency for the married couple to assume that the STI was transmitted through a husband, then the wives had less fears of the consequences of telling their husbands than the husbands had of telling their wives. If the wife told the husband the implication was an accusation of his infidelity, whereas when the husband told the wife it was an admission of his own infidelity.

2.4 Health Care System Factors Influencing Partner Notification

According to the study done by STAFH project, health system factors contribute to partner notification (NACP, 1997). The study identified factors like irregular hours of STI clinic, some clinics provide services on particular hours per week and sometimes patients would come and wait in vain for a provider who would not come as a result this tendency would be known to people and if STI patients notify their partners they would hesitate to go to the hospital because of such inconveniences. This also include distance to a clinic whereby partners feel lazy to report to the clinic after all they are not sick, hence delaying in getting treatment.

World Health publication (not yet published) states that judgemental staff attitudes strain patients even partners to go for treatment, therefore, time should be taken to retrain health workers in order that STI care is given without undesirable judgemental and moralistic attitudes.

The publication also cites poor staff communication skills as a factor that influences partner notification. If a patient is not handled well he or she would not want his or her partner to meet the same situation. Communication needs to suit the audience for which it is intended and health workers should be aware of this, where necessary training of health workers should be started to improve communication skills.

Stigmatization is also a factor that influences partner notification. Stigma originates in societal values and can be increased by institutional systems (WHO, 1991). Partners will think if they are seen at the STI clinic they will be taken as harlots or prostitutes. Measures should be taken to destigmatise STIs for example serving STI patients in an integrated clinic.

WHO (1997) stipulates that lack of privacy and confidentiality contributes to partner notification. Confidential matters need to be handled in an environment of privacy; STI should be seen to provide both privacy and confidentiality. An STI clinic should have rooms where consultation and treatment is done in privacy. If privacy is ensured, partners will be encouraged to come for treatment.

Another factor to be considered in health system factors is client education. It is necessary to ensure treatment compliance and prevent future infections (NACP, 1998).

Among the items to be discussed on client education are, the nature of infection, its mode of transmission and complications associated with the infection, how to avoid infecting others, how to avoid future infection of oneself, helping the client to discuss with his or her partners to achieve safer sex and how to ensure treatment of the partners and follow-up care. The education given will make the patient have an idea on the infection and appreciate importance of notifying the partner or partners.

CONCEPTUAL FRAMEWORK

Health Belief Model

Health belief model was chosen for the study because it helps to explore why some people take specific health action to prevent disease and while others fail to prevent it (Becker, 1978 cited in Polit and Hungler, 1991).

The model is derived from a psychological theory of decision-making attributed to Lewin. In the theory, Lewin predicts that the behavior depends on value placed by the individual on a particular outcome and the individual's estimate of the likelihood that a given action will result in that outcome (Leay, Cobb & Jones, 1982).

In this model individuals are assumed to exist in a life space composed of regions, which are positively, negatively valued and neutral regions. Individuals are assumed to take preventive health actions to avoid situations, which are negatively valued. This implies that individuals take actions to avoid situations, which predispose them to disease so that they remain in positive regions.

The model also suggests that people are most likely to take preventive action or comply with professional medical advice if they feel concerned about health when they feel susceptible or at risk of disease in question and if they feel the consequences of the disease would be serious if advice is not taken (King, 1994).

The model defines the following major components:-

Perceived susceptibility:- is a person's perception that a health problem has a personal relevance or the diagnosis is accurate.

Perceived benefits:-refers to individuals belief that given a particular treatment will cure illness or prevent disease.

Motivation: includes the desire to comply with treatment, belief that people should do what is prescribed, concern about health matters and the individual's willingness to seek health care and engage in positively valued activities (Polit and Hungler, 1991, Leay et al 1982).

In general the health belief model postulates that health seeking behavior is influenced by a person's perception of a threat posed by a health problem and the value associated with the actions and reducing the threat (Becker, 1978 in Polit and Hungler, 1991)

3.1 Application of Health Belief Model to the Study

The health belief model illustrates that the individual's perceived susceptibility and seriousness of the disease will influence the individual to take recommended preventive health actions. This implies that the treatment of partners will be influenced by STI patient's perception of their partner's susceptibility to STI. King (1994) suggests that when considering personal susceptibility most people do think in terms of concrete examples of people they know and if this evidence is contrary to what they hear or read, it is unlikely that they will take the recommended preventive health action. Since many patients take time to realize that they are infected, it means that it is difficult for them to perceive that their partners are susceptible to STIs.

The health belief model therefore, is an essential tool to predict the likelihood of STI patients to notify their partners to get treatment. The likelihood of patients to accept notifying their partners will be influenced by their educational background, individual motivation, and social cultural factors about partner's health. Hann (1995) pointed out that health belief model is based on the assumption that perception of ones subjective world will predict health behavior and likelihood of that person to take a

preventive health action. This implies modifying factors such as personal and social cultural factors, these are critical in decision making regardless of reality perceived by health professionals.

The health education therefore, should take into account the varying degrees of such factors, which patients hold about partner notification. This is because these factors influence people's willingness to accept or reject health education messages.

The health belief model will therefore help explore those factors that influence patient's willingness to notify their partners. The model assumes that perceived benefits of taking a particular action should outnumber the barriers to take an action (Leay et al, 1982). Thus individuals are presumed to weigh the perceived benefits on any particular action.

Perceived barriers such as attitude of staff at the clinic and distance to the clinics contribute to the patient's reluctance to encourage partner to come for treatment. It is only when the patients have seen the benefits of STI treatment that they will notify their partners.

The benefits include prevention of spreading the infection further and prevention of re-infection of the patient. These benefits will act as motivation factors for patients to encourage their partners to come for treatment. The higher the motivation, the more likely the patients will influence their partners to come for treatment.

CHAPTER 3

METHODOLOGY

This section aims at describing the research methodology, which was used in the study. The areas to be highlighted are research design, setting, sampling, instrumental development, pilot study, data collection, data analysis and ethical consideration.

3.1 Research Design

The purpose of this study was to explore factors influencing partner notification in patients with STIs. For this purpose, a descriptive research design was used. Descriptive research is designed to summarize the status of phenomena of interest, as they currently exist (Polit and Hungler, 1991). Furthermore descriptive studies do not focus on relationships among variables, their purpose is to observe, describe and document aspects of a situation as it naturally occurs. Seaman (1987) states that descriptive designs are basic in that many researchers refer to these as essential for providing information upon which later studies may build. In this study the descriptive design was used in order to obtain information upon which later studies may be built.

3.2 Setting

The study was conducted at Queen Elizabeth Central Hospital in Blantyre district at the STI clinic within the Lepira department. The location was chosen because it was one of the places where more STI patients sought care.

3.3 Sampling

A sample is a smaller part of target population selected in such a way that the individuals in the sample represent the characteristics of the target population (Dumpsey & Dimpsey, 1981). Potential subjects were recruited from STI clinic at QECH. Non-probability convenience sampling method was used in sample selection. This entails the use of the most conveniently available persons for use as subjects for the study (Polit & Hungler, 1991). The sample size was thirty, 15 male patients and 15 female patients. The sample size was chosen because it was representative of the population.

3.4 Instrument Development

The researcher developed an interview guide, which was used as a tool for data collection. Included in the instrument were items with open-ended question on the following areas; sociodemographic data, socio-cultural, personal and health care system data.

3.5 Pilot Study

Polit and Hungler defined pilot study as a small-scale version, or trial run, of a major study. It is performed to assess appropriateness of data collection technique feasibly of the entire research procedure and to test validity of the interview guide (Polit & Hungler, 1991). Before conducting the main research study the researcher carried out a pilot study at QECH to minimize the possibility of having significant difficulties. The pilot study was done at QECH because the subjects had similar background as to those in the main study.

3.6 Data Collection

Data was collected using a face to face interview method using a structured interview guide. An interview refers to a carefully developed set of questions (Polit & Hungler, 1991). Data was collected for a period of two weeks. Questions were in English and the same questions were interpreted into Chichewa. The face-to-face interview was chosen considering the low levels of education of some of the subjects who would not be able to read, understand and fill the appropriate answers to the questions and observations.

3.7 Data Analysis

The data was analysed by descriptive statistics whereby frequencies, percentages were used. Statistical Package for Social Sciences (SPSS) was used to analyse quantitative data. Data has been presented in tables, graphs and pie charts.

3.8 Limitations of the study

The researcher had limited time because the study was conducted concurrently with other courses. This resulted in the researchers decision to choose a small sample of thirty.

3.9 Ethical Consideration

In order to ensure protection of the subjects, clearance was sought through a Technical Committee of the Ministry of Health & Populations. See Appendix A. Potential subjects gave informed consent to participate in the study or not. Informed consent means that the subjects have full knowledge and understanding about the research project (Seaman, 1987). To do this the researcher explained to the subjects the purpose, benefits, time to be spent, privacy, confidentiality and anonymity that was guarded. The subjects signed a consent form. See Appendix C. to maintain anonymity data was coded with numbers instead of names. At the end of the research all records were destroyed. The coding of data with numbers ensured privacy.

3.10 Dissemination of findings

The researcher intends to make the findings available to all health workers and to Ministry of Health with a view of broadening their knowledge and understanding of sexually transmitted infections especially partner notification.

CHAPTER 4

PRESENTATION OF RESEARCH FINDINGS

Introduction

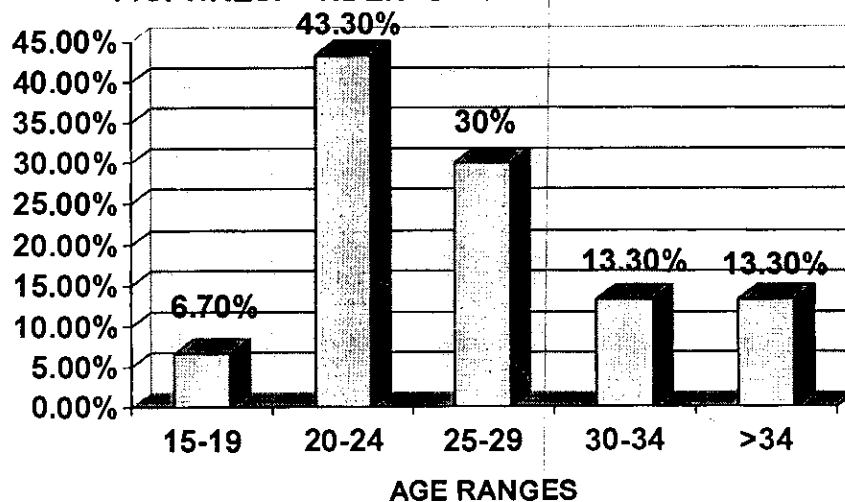
This chapter presents research findings on social demographic data, background to the infection, personal factors, social cultural factors and health care system factors found to influence partner notification among clients attending STI clinic at QECH. Tables, graphs, figures and descriptions have been used to present the data.

Social Demographic Data

Age and Sex

A convenient sample of 30 subjects was obtained. There were 15 males and 15 females. The age distribution ranged from 18-64 and the majority 43.3% (n=13) were in the age range of 20-24 years. Figure shows the details.

FIG. 1: RESPONDENTS AGE DISTRIBUTION



Marital Status

The results indicated that most of the subjects (n=16) were married, 40% (n=12) were single and 6.7% (n=2) were divorced.

Among those who were married the majority 50% (n=8) had been married for 1-5 years. Details are shown in table 1.

Table 1: YEARS IN MARRIAGE

Years in marriage	Frequency	Percentage
<1	2	12.5
1-5	8	50
6-10	3	18.75
>10	3	18.75
TOTAL	16	100

Religion

The results revealed that majority of the subjects were Christians representing 90% (n=27) and the rest were Moslems representing 10% (n=3)

Education

The results indicated that most of the subjects had been to school representing 93.3% (n=28) while the remaining had no education representing 6.7% (n=2).

Among those who were educated, it was found that 37% (n=10) had tertiary education, 33% (n=9) had secondary education and 33% (n=9) had primary education.

Occupation

The results indicated that 56.7% (n=17) of the respondents were working, 40% (n=12) were not working and 3.3% (n=1) was a student. Table 2 shows the details.

Table 2: RESPONDENTS OCCUPATION

Occupation	Frequency	Percentage
Student	1	3.3
Working	17	56.7
Not working	12	40.0
TOTAL	30	100

Living together in the same house

Majority were staying with their husbands and wives representing 30% (n=9). Those staying with their husbands, wives, children represented 16.7% (n=8) and those staying with their sisters represented 13.3% (n=4). Those staying with parents represented 10% (n=3) and those staying their brothers represented 6.7%(n=2) and those staying with friends represented 23.3% (n=7).

Background of the infection

Nature of symptoms

Respondents were asked as to what was the nature of symptoms they were having. Details are shown in table 3.

Table 3: NATURE OF SYMPTOMS

Nature of symptoms	Frequency	Percentage
Pain/ ulcer/ edema	24	80
Foul smell	1	3.3
Itching / irritation	2	6.7
Bubo	2	6.7
Red eye	1	3.3
TOTAL	30	100

Duration for recognition of problem

Respondents were asked as to how long it took them to realize that they had a problem. The majority 47.7% (n=14) indicated that it took them 7 days, 23.4% (n=7) indicated that it took them 7-14 days while 29.9% (n=9) indicated that it took them more than 14 days.

Type of discomfort

The respondents 100% (n=30) indicated that the signs and symptoms caused discomfort because of pain, irritation and itching.

Source of infection

Respondents were asked to whom the infection was attributed and the majority 60%(n=18) indicated that it was attributed to boy/ girl friends. Details are presented in table 4.

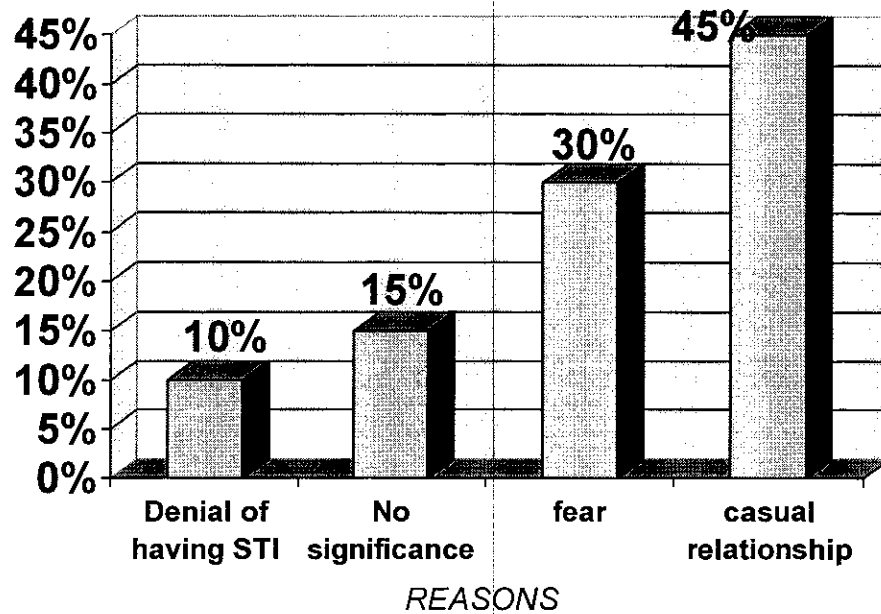
Table 4: SOURCE OF INFECTION

Sources of infection	Frequency	Percentage
Boy/ girl friend	18	60
Husband/ wife	5	16.7
Don't know	7	23.3
TOTAL	30	100

Partner Notification

Majority of the respondents 66.7% (n=20) did not inform their partners about the infection they had and 33.3% (n=10) informed their partners. Most of those who did not inform their partners 45% (n=9) stated that it was because their relationship was casual. Figure 2 gives the details.

FIG. 2: REASONS FOR NOT INFORMING PARTNERS



Response to STI Notification

Respondents were asked as to what responses partner had on telling him/ her about the infection, 50% (n=5/10) accepted the situation because partners had trust in each other while 50% (n=5/10) did not accept the situation because they felt they were not responsible.

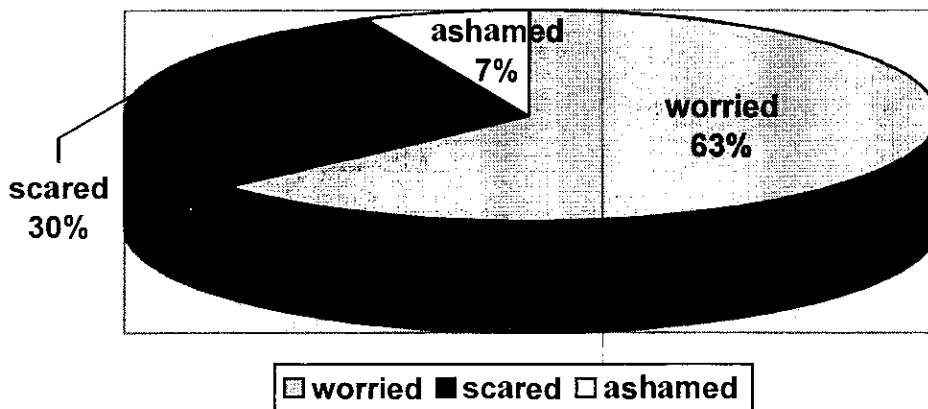
Intra-infection sexual intercourse

Respondents were asked whether they had sexual intercourse with their partners after the symptoms. 73.3% (n=22) did not have intercourse and 26.7% (n=8) had intercourse after symptoms.

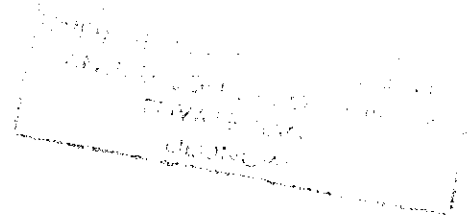
Feelings about having the infection

Realizing that they had a problem the majority 63.3% (n=19) were worried. Figure 3 shows the details.

FIG. 3: FEELINGS ABOUT HAVING THE INFECTION



Respondents were asked why they felt scared, worried and ashamed. The reasons given were as follows: because it would create untrust between partners 36.7% (n=11), because of pain 26.7% (n=8), because they had never suffered from the infection 23.3% (n=7), because it was embarrassing 6.7% (n=2), because it was a casual friend 3.3% (n=1) and because he doubts of being healed 3.3% (n=1).



Seeking advice

Respondents were asked whether they sought advice from anyone on their problem. The majority 63.3% (n=19) sought advice while 36.3% did not seek advice. Among those who sought advice 78.9% (n=15) sought it from friends, 10.5% (n=2) sought advice from their husbands and 10.5% (n=2) sought it from sisters. Those who were given advice 36.8% (n=7) were advised to go to the hospital and 63.2% (n=12) were advised to seek traditional help.

The majority of the respondents followed the advice representing 68.4% (n=13) and 31.6% (n=6) did not follow the advice.

Those who followed the advice the majority 55.6% (n=10) went to the hospital while 44.4% (n=8) consulted traditional healers. Those who went to the hospital believed they would be healed with drugs from the hospital and those who consulted traditional healers believed that STIs do not heal with hospital drugs.

Length of time taken to seek treatment

Respondents were asked as to how long they waited to seek treatment from the time symptoms appeared. The majority 46.8% took less than one week. Details are in table 5.

Table 5: LENGTH OF TIME TAKEN TO SEEK TREATMENT

Length of time	Frequency	Percentage
Less than one week	14	46.8
1-2 weeks	8	26.6
Above 2 weeks	8	26.6
TOTAL	30	100

Results show that respondents took different times to seek treatment. 23.3% (n=7) thought symptoms would go, 26.7% (n=8) were trying traditional medicine, 20% (n=6) because symptoms were becoming worse, 20% (n=6) were not sure of what it was and 10% (n=3) because symptoms were not serious.

Information by health worker on nature of infection

When respondents came to the hospital, 86.7% (n=26) were informed by the health worker as to what their problem was and 13.3% (n=4) were not informed. Those who were informed were told it was sexually transmitted infection.

Availability of treatment

Subjects were asked whether they had been given treatment. 80% (n=24) were given treatment and 20% (n=6) were not given treatment. All respondents who were given treatment were advised to comply to treatment.

After getting treatment respondents were asked to whether they were told by the health worker to inform their partners. 96.7% (n=29) were told and 3.3% (n=1) was not told to inform the partner.

PERSONAL FACTORS INFLUENCING PARTNER NOTIFICATION

Attitude towards partner notification

The results indicated that 60% (n=18) expressed that partner notification was important while 40% (n=12) expressed that partner notification was not important.

Those who stated that partner notification was important, 22.2% (n=4) said it would prevent re-infection, 72.2% (n=13) said partners would come for treatment and 5.6 % (n=1) said it was important for the partner to know. Those who said partner notification was not important said it would cause misunderstandings between the partners.

Intention to notify partner

Respondents were asked whether they intended to notify their partners. 36.7% (n=11) had intentions to notify their partners because they had feelings of being healed while 63.3% (n=19) had no intentions to notify their partners because they had fears of relationship break up.

Inhibitions on informing partner

Respondents were asked whether they had any inhibitions about informing their partners to come for treatment. 40% (n=12) had inhibitions while 60% (n=18) had no inhibitions.

Those who had inhibitions 75% (n=9) were afraid of breaking up the relationships due to the infections, 8.3% (n=1) was bitter, 8.3% (n=1) was afraid of accusation and 8.3 (n=1) had denial of having STI.

Perceptions on partner response to being informed

Respondents were asked as to what responses they expected from their partners. The majority expected their partners to understand. Details are shown in table 6.

Table 6: PARTNER'S RESPONSE TO BEING INFORMED

Response expected	Frequency	Percentage
Will understand	4	36.4
Will not understand	4	36.4
Doesn't know	3	27.2
TOTAL	11	100

SOCIAL CULTURAL FACTORS INFLUENCING PARTNER NOTIFICATION

Communication of Sexual Matters

Respondents were asked whether culturally partners openly communicate sexual matters. All of them 100% (n=30) indicated that partners do not communicate sexual matters openly and all of them indicated that these matters are not communicated openly because they are secret issues.

Views on Gender and Partner Notification

Respondents were asked as to who easily communicates to partners between males and females. 59% (n=15) indicated that males easily communicate because they are not ashamed, sociable and free to talk. 46.7% (n=4) indicated that females easily communicate because they are not blamed in sexual immorality and that they are concerned about the well being of the family. 33% (n=1) indicated that no one easily communicates.

Views on Tolerance of Extramarital/ Multiple Partners Relationship

Respondents were asked to specify who was more tolerant to extramarital relations or multiple partners between males and females. 73.3% (n=22) indicated that women were tolerant, 26.7% (n=3) indicated that no one was tolerant. Those who stated that women were tolerant was because culturally men may be allowed to have extramarital relations without being questioned. Those who expressed that men were tolerant indicated that it was because of the trust they had in their partners. Those who were of the opinion that no one was tolerant was because noone likes to have several women or several men.

Views on Partner Notification in Polygamous Families

Respondents were asked if a polygamous husband would find it easy to inform all his wives if he is infected. 13.3% (n=4) indicated it would be easy because the man is a breadwinner and the wives respect him and also because he has authority over the wives. 70% (n=21) indicated that it would not be easy because the wives would accuse the husband and reject him.

Respondents were asked as to how the wives of the polygamous man would respond. 53% (n=16) indicated that there would be misunderstandings among the wives because they would be suspecting each other to have infected the husband. 16.7% (n=5) would agree for treatment, 10% (n=3) would accuse the husband and 20% (n=6) would not know the response.

Views of Relatives on STI Issues

Respondents were asked whether relatives had a role in dealing with STIs. 57.7% (n=17) indicated that relatives had a role to play while 43.3% (n=13) indicated relatives had no role to play.

Those who indicated that relatives had a role, 58.8% (n=10) indicated that they have culturally counseling roles especially elderly relatives. 41.2% (n=7) indicated that relatives have interest in knowing every detail of the relationships for example in sicknesses they would look for traditional healers to help.

HEALTH CARE SYSTEM FACTORS INFLUENCING PARTNER NOTIFICATION.

Views on accessibility to the clinic

The respondents were asked on how accessible was the clinic from their homes. 63.3% (n=19) indicated that it was far from their homes. And 56.7% (n=11) indicated that it was near to their homes.

Views on Reception at the Clinic

Respondents were asked whether the reception at the clinic was friendly. 46.7% (n=14) indicated it was friendly while 53.7% indicated it was not friendly. Among those who indicated that the reception was not friendly, 68.8% (n=11) indicated that it was because of late service and 31.2% (n=5) expressed that it was because of shortage of drugs.

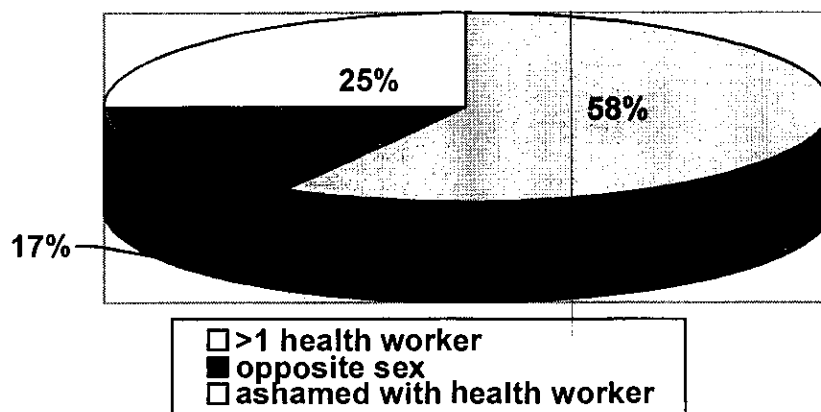
Views on Privacy at the clinic

Respondents were asked whether consultation and treatment in the clinic was done privately. 93.3% (n=28) indicated that it was private while 6.7% (n=2) pointed out that it was not private. Among those who expressed that consultation and treatment were done in private they made it known that they were in a room with a closed door and were two of them with the health worker and those who indicated that there was no privacy due to the presence of student nurses.

Views on Interaction with the Health Worker

Respondents were asked as to how they interacted with the health worker. 60% (n=18) interacted comfortably while 40% (n=12) did not interact comfortably. Among those who indicated that they did not interact comfortably, 58.3% (n=7) expressed that it was because there were student nurses around, 25% (n=3) was because they were ashamed of the health worker, 16.7% (n=2) was because they met a male health worker. Figure 6 shows the details.

FIG 6: VIEWS ON INTERACTION WITH HEALTH WORKER



Views on Confidentiality

Respondents were asked whether the health worker assured them of confidentiality. 6.7% (n=2) indicated they were assured and 93.3% (n=28) indicated they were not assured. Those who were not assured doubted if the student nurses would keep a secret and that the health worker did not mention of keeping a secret while those who were assured of confidentiality had trust in the health workers that they keep secrets.

Clients Suggestions on Best Way of Partner Notification

Respondents were asked as to what would be the best way of notifying the partners. 40% (n=12) indicated that the best way would be by discussing with the partner while 60% (n=18) expressed that the best way was to take the partner to the hospital so that the health worker can notify him or her.

CHAPTER 5

DISCUSSION

Introduction

This study explored factors influencing partner notification in patients with sexually transmitted infections at Queen Elizabeth Central Hospital. A discussion of results and conclusion of the study will be presented in this chapter. The discussion will focus on the following sections: socio demographic data, background to the infection, personal factors, social cultural factors and health care system factors influencing partner notification.

Socio Demographic Data

Sex

A sample of thirty patients with sexually transmitted infections at QECH STI clinic participated in the study. There was 50% distribution of both male and female participants as a result gender bias was minimized.

Age

The ages of participants ranged from 18-64 years but the majority were in the range of 20-24 years which falls in the sexually active group of ages 15-49 years (NACP, MOHP, 2000). Arya et al (1998) agree with above statement, which estimated STI prevalence rate in adults aged 15-49 years to

be high. Most studies have shown that the greatest number of cases occur in the age group of 13-35 years. However there was a 64 year old patient in the study which reflects that those who might not be sexually active may also suffer from sexually transmitted infections.

Marital Status

The results showed that the majority of the participants were married representing 53.3% (n=16). This indicates that there may be no mutual fidelity in marriages resulting into the majority of married people having sexually transmitted infections. The results also showed that most of the married people 50% (n=8) stayed in their marriages for one to five years. When it is expected that the first five years in marriage there should be fidelity, however, partners are being infected. This contradicts with the statement, which states that a stable marriage with partners living together protects the couple from STIs (Arya et al, 1988).

Religion

The study found that all the participants had religious affiliations. The majority were Christians representing 90% (n=27) and Moslems were in minority representing 10%. The results support the National Family Welfare Council of Malawi (1996), which states that the majority of Malawians are Christians while Moslems are in minority. Religious beliefs may affect individual's beliefs, customs, and practices related to health for example Christians advocate abstinence rather than condom use (Chiluzi, 1997).

Education

The majority of the respondents had education representing 93.3% (n=28) and interestingly higher percentage of 37% (n=10) had tertiary education which means participants were expected to have better knowledge of sexually transmitted infections. Furthermore they were expected to know protective measures and take heed. Lack of knowledge may be one of the basic factors in the spread of many infectious diseases as knowledge produces rational preventive measures, early diagnosis and treatment (Arya, 1988). However even with high level of formal education shown in the study individuals could not be assumed to have acquired adequate knowledge relating to STIs. Even if knowledge is acquired, it does not necessarily lead to appropriate action and high rates of STIs have been reported among university students in some tropical countries (Thin, 1982).

Occupation

Majority of the subjects were working representing 56.7% while 40% of the subjects were not working. All those who were not working were women representing 40% (n=12). This could have been the reason why some clients indulged in sexual activities especially women to get income. Furthermore, those who were working might have had more income to spend even paying for sexual intercourse especially men, and poor women fell victims. In developing countries social, cultural, and economic issues often make women poor and disempowered that they have sex on commercial basis against their will (Adler, 1998).

Living together in the same house.

Majority were staying with their husbands and wives in the same house representing 30% (n=9). Others stayed with their sisters, brothers, and parents which could have made them have a chance of sneaking out to meet their sexual desires contracting STI in the process.

Background of the infection

Nature of the symptoms

The results show that the majority of the patients came to the hospital with signs and symptoms such as pain, ulcers and edema representing 80%. This confirms the fact that 20-70% of the patients seen at STI clinics worldwide present with genital ulcers which result into patients having swelling of the genital area causing a lot of pain (Adler, 1988).

The study revealed that the majority of the subjects 46.7% took less than seven days to realize they had a problem, 23.4% took 7-14 days while 29.9% took more than 14 days. It took different times to realise they had a problem because it took different lengths of time to recognize the symptoms. In spite of different times of symptom appearance it is worthy noting that many STIs are asymptomatic in both men and women making the detection complex (Health Population Occasional Paper, 1998).

All respondents, 100% (n=30) felt uncomfortable with the symptoms especially with pain, irritation and itching and these quickened some of them to notify partners and seek treatment.

Source of infection

The main source of infection for majority of the participants was boy or girl friend relationships, which were unstable. For married women it might have been due to infidelity behaviors of their husbands. This may indicate that there are loose sexual practices in the society resulting to STIs. Whoever the source was, the fact is that the spread of STIs is due to change of sexual partners, those who trust each other and stick to each other are spared from the infection.

Informing the partner about the infection

Upon realizing that they were infected, the study shows that the majority of the participants did not tell their partners representing 66.7% while 33.3% told their partners. The majority of those who told their partners were women, this was because most of the women attributed the transmission to their husband's infidelity because alongside informing them they would accuse them of extramarital relations. The high percentage of participants who did not inform their partners showed that they had problems in sharing issues with their partners and this would affect partner notification. Adler (1998) concurs with the above statement when he states that once a patient knows he/ she has an STI, its presence is feared and informing a partner would be the last thing she/he can do.

Majority of those who did not inform their partners 45% states that it was because of casual relationships where by they met once and did not follow each others' whereabouts. Health and Occasional Paper (1998) confirms it that it is often seldom to notify casual contacts successfully and this seriously compromises the effectiveness of partner notification.

The study revealed that 50% of the respondents indicated that their partners accepted the situation on being told of the infection because partners had trust in each other, they would discuss together and seek treatment. In a study done by STAFH project in 1997, it was reported that both male and female where after the husband showed or told their wives about their symptoms, the wives then revealed to them that they also already had symptoms, this was a manifestation of trust. 50% of the participants' partners did not accept the situation because they felt they were not responsible for the infection. This accusation was disruptive in their relationships and this created high threat situations to the relationship like broken relationship. Therefore informing partner can have negative implications on the relationship as it is noted by Catterall (1984) that informing partners may result to bitterness of the partner and may result to breakup of the relationship.

Intra-infection sexual intercourse

Concerning sexual intercourse after infection, 73.3% of the participants did not have intercourse after the infection while 26.7% had intercourse after the symptoms. Those who did not have intercourse, it was because of the casual partners they had of which was difficult to trace. They might also have avoided intercourse for fear of being known by partners about the infection (Thin, 1982). In addition they avoided sexual intercourse because of the discomfort they were experiencing and they might have had thoughts of protecting the partner. In a related study, N.A.C.P. (1997) male index patients would not have sexual intercourse with extramarital partners because they were angry with them since they had transmitted the infection to them and this would hinder partner notification. Nevertheless, it is expected that partners should not have sexual intercourse till both of them are healed or use condoms.

Feelings about having the infection.

On having the infection the majority 63.3 % (n=19) were worried, 30% (n=9) were scared and 6.7% (n=2) were ashamed. They felt ashamed, scared and worried because it would create distrust between partners. Partners have mostly a feeling that STIs are associated with having extra partners (Schoefield, 1985). This results into partner having fears of notifying the partners. They were also ashamed because it was embarrassing to have STI due to the stigma it has, and when one is embarrassed cannot communicate to a partner about it, making partner notification a failure. Coyne (2000) stipulates that STIs are associated with extra marital relations, these are

culturally a moral transgression hence the feeling of being ashamed. Married men felt ashamed because they had broken a trust of fidelity that they believe their wives had in them and they also expressed a public shame due to their status in the community.

Seeking Advice

The study showed that the majority 78.9% (n=15) of the participants sought advice about STI from friends because most of them would rather talk to friends than partners or relatives because they felt free with them. They sought advice so that they would be directed on where to go for treatment. Those who did not seek treatment perceived STI as shameful which should be kept private (N.A.C.P., 1997).

The results showed that 36.8% (n=7) were advised to go to the hospital and 63.2% (n=12) were advised to consult traditional healers. Clients seem to have a tendency to follow advice of people they trust without questions and go wherever as suggested. Clients who consulted traditional healers had a strong cultural belief that STIs do not heal with hospital drugs (WHO, 1997). Traditional healers are believed to be powerful in the villages and are better or able to treat the illnesses than the hospital. Furthermore, the general atmosphere at the traditional healer is thought to be more comfortable because it resembles more the atmosphere of the village. This inviting atmosphere encourages patients to notify their partners.

Length of time taken to seek treatment

The results showed that the majority of clients 46.8% (n=14) sought treatment before a week after symptoms appeared, others waited for 1-2 weeks while others sought it after two weeks. This reflects that some recognized symptoms early and others late. If patients seek treatment it means they are concerned and most likely they would inform partners to be treated early. Schofield (1985) emphasizes that all infected patients should be rapidly treated with their contacts.

Despite the majority being advised to go for traditional help, the majority 55.6% (n=10) went to the hospital while 44.4% (n=8) consulted traditional healers and later went to the hospital. It is common for clients with STIs that they seek traditional help first then go to the hospital allowing the symptoms to get worse (Health and Population Occasional Paper, 1998).

Information on nature of infection

When the participant came to the hospital 86.7% (n=26) were informed by the health worker as to what their problem was. This was good because this would motivate clients to inform their partners, as they would have known the infection better from the health worker. Health workers are encouraged to disclose all matters concerning the infection to clients as there is a tendency of mistaking STI symptoms with urinary tract infections (N ACP, 1998). When clients are aware of the problem they will not have problems in informing their partners and they will appreciate the need for all of them to be treated because most of the clients resist informing their partners due to

knowledge deficit. Therefore health workers should have good counseling skills to help the clients.

Availability of treatment

The study indicated that the majority of the clients (80%) got treatment and 20% did not get the treatment. Those who got treatment were advised to comply to treatment as it is stipulated in WHO (1999) that STI clinics should emphasize compliance to treatment to ensure cure. For those who did not get treatment, it was due to shortage of drugs. Sometimes there are no resources in the clinics. This puts off the clients and they will be discouraged from informing partners saying even if they are informed what will they get from the hospital. STI prevention efforts fail most of the times due to poor economic status of the developing countries (Barlow, 1985).

After the clients got treatment 96.7% (n=29) were told to inform their partners. This was good because without telling them they would keep it to themselves and contacts would not be treated. 3.3% (n=1) was not told, this was not good and it implies that health workers dealing with STI should have good communication skills so that they do not hold important information for patients.

PERSONAL FACTORS INFLUENCING PARTNER NOTIFICATION

Attitudes towards partner notification

The results indicated that 60% (n=18) expressed that partner notification was important. This was good because it showed that they had a positive attitude towards partner notification. With good attitude they would easily motivate

their partners to come for treatment. However 40% (n=12) of the clients expressed that partner notification was not important. This shows that some clients still do not understand the importance of partner notification. Intensification of education and counseling should be regarded a priority in STI clinics (Adler, 1998).

It is interesting to note that 60% (n=8) expressed that partner notification was important. Those who stated that partner notification was important recognized that it was important because it would prevent re infection and that partners would come for treatment. Having known the reasons for partner notification the clients would not hesitate to notify their partners.

Intention to notify partner.

While clients had knowledge on the importance of partner notification, the majority 63.3% (n=19) had no intentions to notify their partners, this confirmed the fears the clients had related to partner notification. Those who intended to inform represented 36.7% (n=11). These had information on the infection and it correlated with the positive attitude that they had on partner notification. In a related study, Health and population occasional paper (1998), if threats to relationship was high clients resisted informing their partners until it was impossible to keep the fact that they had STI a secret.

Inhibitions on informing partner.

Results showed that 40% (n=12) of the clients had inhibitions on telling their partners. The inhibitions were that they were afraid of breaking up the relationship, the partner would be bitter about it and were afraid of accusations. They were afraid of all these because they wanted to secure their relationships on the expense of partner notification. In a similar study in North California, the providers ranked fear of abandonment, physical violence, emotional abuse and loss of emotional support as the reasons inhibiting clients to notify (Rothenberg, 1995).

Perceptions of partner's response to being informed.

Results showed that index clients perceived their partners would understand about the infection representing 36.4% (n=4). In a similar study NACP (1997), there was a tendency for married couples to assume that STI was transmitted through their husbands, then the wives had less fear of the consequences of telling the husbands their symptoms than husbands had of telling their wives. When a wife told the husband of her symptom, the implication was an accusation of his infidelity. Those patients who perceived their partners would not understand represented 36.4% (n=4) and those who did not know partners response represented 27.2% (n=3). Those who said partners would not understand and those who said they did not know the response were in a denial of informing the partners due to the fears of relationship breakdown.

Social Cultural Factors Influencing Partner Notification

Communication of sexual matters.

The study showed that sexual matters are not communicated openly. They are kept a secret and it is a taboo to do so culturally. Health workers need to know these taboos as they are challenges to health care and there is a need to address such challenges to promote partner notification. Sexual behaviors are taken to be hidden issues in tropical countries (Arya, et al., 1998). This is a true situation in Malawian culture especially in rural areas, however in urban areas sexual behavior can openly be discussed due to the influence of mass media, from the observed behaviours of tourists and the intermixing of cultures.

Views on gender and partner notification.

The results showed that the majority of the respondents indicated that males communicate easily to partners than females, representing 59% (n=15) and 46.7% (n=4) indicated that females easily communicate. Respondents had divided opinion on who could easily communicate but culturally men do because they are not ashamed, sociable and free to talk. Similarly, economic needs, lack of job opportunity, poor access to education, training and cultural expectations of female submission and male dominance prevent women from actively making choices and decision about their lives (WHO, 1997). Like wise, Wilson and Lavelle cited by Gello (1999) contended that African women might be less open in talking about sexual behavior. These gender differences are expected and need to be addressed by health workers during education and counseling in the STI clinics.

Views of tolerance of extramarital/ multiple partners relationships.

The study showed that women might be more tolerant to extramarital multiple partners because of cultural influence whereby it is expected for men to have other women than women have other men. This entails that women would be more acceptable to partner notification than men.

Views on partner notification in polygamous families.

The results showed that partner notification in polygamous families would be difficult because the husband would be accused of bringing the infection to the wives and there might be misunderstanding among the wives as they would be suspecting each other of infecting the husband. Health workers should consider polygamy as added constraints in dealing with STIs because there is increased risk of spreading the infection.

HEALTH CARE SYSTEM FACTORS INFLUENCING PARTNER NOTIFICATION.**Views on accessibility to the clinic.**

The study indicated that the majority of the clients 63.3% (n=19) lived far from the clinic and 56.7% (n=11) lived near the clinic. Distance to the clinic may hinder clients and partners from coming to the clinic for treatment. In another study WHO (1999) clients delayed seeking treatment because of traveling long distances.

Views on reception at the clinic.

The majority of the clients 53.3% (n=16) indicated that the reception at the clinic was not friendly because of late services and inadequate drugs. Health workers should have knowledge that STIs have a stigma which, makes patients not attend clinics, therefore when they come they should be saved quickly and proper explanation should be made when there are no drugs.

Views on Privacy and Confidentiality at the clinic.

The majority of the clients 93.3% (n=28) indicated that they experienced privacy during consultation and treatment at the clinics because they were seen in a closed room. The very nature of STIs may give the impression eroding the principle of confidentiality (Coyne,2000). In addition failure to keep confidences will dissuade patients from seeking attention or notifying partners (Adler, 1998). It is important that patients realize that their diagnosis or indeed any information is never given to anyone else.

Views on interaction with the health worker

In the study clients interacted comfortably with the health workers. The way the health workers receive the clients entails whether clients will be comfortable when interacting or not. Communication needs to suit the audience for which it is intended and health workers should be aware of this (Coyne, 2000). Most patients who attend STI clinics will talk relatively freely about sexual matters if the health workers are sympathetic and empathetic (WHO, 1999). With gentleness they will also discuss their

psychological problems and fears hence the health workers will find a chance of allaying their anxieties and convince them to notify their partners.

When clients were asked as to what was the best way of partner notification interestingly the majority 60% (n=18) indicated that the best way was to take the partner to the hospital for the health worker to notify him or her confirming patients' fears in notifying partners.

Interviewing patients about their partners requires tactic, sensitivity and special communication skills. Some patients feel that being asked about partners is unnecessary or an infringement of their privacy, therefore the reasons for notifying must be explained to the patients and their active cooperation sought.

CONCLUSION

In conclusion the study has shown that if partners do not share other issues in their relationship, it would be difficult to notify each other about the infection. Furthermore, the fears of bitterness of the partner and relationship breakdown, hinder partner notification.

In as much as partner notification is for the patient's partners, they seem to be free to talk about their infection with friends and even seek advice, than with their partners making partner notification a failure.

It has also shown that when health workers give full information of STI to patients they are motivated to inform their partners hence health workers should be knowledgeable on STIs to impart that knowledge to the clients. Good communication skills of health workers also contribute to partner notification. Good interaction with the patients and type of reception will encourage them to inform their partners because they will experience the same.

The study also has shown that socio-cultural factors of the society should be well known to the health workers because they pose a challenge in dealing with STIs especially partner notification. Privacy and confidentiality are to be considered in STI clinics if partner notification is to be effective.

CHAPTER 6

IMPLICATIONS AND RECOMMENDATIONS

Introduction

This section aims at providing information pertaining to the implications of the study to nursing education, practice and research. Recommendations of the study will also be outlined.

Implications to Nursing Education

The study has revealed that patients have fears to notify partners because of personal, social and cultural factors, which may result to disruption of relationships. Nurse educators therefore as curriculum determines should include counseling skills in the curriculum so that they are instilled in student nurses in so doing be equipped to deal with STI patients especially on partner notification.

Implications to Nursing Practice

The results have shown that there isn't much interaction between health workers and STI patients. This could have resulted from poor preparation of health workers dealing with STI patients. Therefore, orientation of the health workers through in service education would help. Health workers should at all means ensure privacy and confidentiality of STI issues.

Implications to Nursing Research

The study has shown that despite the introduction of partner notification slips clients are still hesitant to notify their partners, therefore there is need to explore more on patterns of communication in relation to sexual matters.

Recommendations

- Inadequate counseling skills by health workers affect partner notification as such there is need to reinforce counseling skills in the health workers through in service education.
- Health workers need to be vigilant in reinforcing IEC on STIs and partner notification.
- Safe sex practices should be advocated for example use of condoms to prevent transmission of STIs
- Stakeholders such as Ministry of Health and Population and non-governmental organization such as Banja La Mtsogolo to ensure there are enough resources like drugs for treatment of STIs.
- Health workers should ensure that STI clinics are client friendly, reinforce privacy and should be confidential.
- Curricular for health workers to be reviewed so that it incorporates partner notification as an important tool in STI prevention.

- A similar type of research to be done on a large scale so that the results can be generalized to the whole nation of Malawi.

TIME LINE

TASK	No. of weeks	Responsible person
Selecting and delimiting topic	4 weeks	Principle investigator
Introduction-background, statement of problem and objectives	4 weeks	"
Literature review	On going	"
Conceptual framework	2 weeks	"
Methodology	2 weeks	"
Budgeting	1 weeks	"
Compilation of research proposal	2 weeks	"
Personal commitment	2 weeks	"
Data collection	2 weeks	"
Data analysis and report writing	8 weeks	"
Presentation of complete research project	2 weeks	"

RESEARCH BUDGET

Item	Cost in Kwacha
Stationery	
1 ream typing papers at K500	500.00
2 reams photocopying at K500 each	1,000.00
4 folders at K60 per folder	240.00
10 pens at K10 each	100.00
5 pencils at K2 each	10.00
1 tippex set	250.00
10 medium envelopes	50.00
1 sharpener at K50 each	50.00
1 copy hardcover for draft at K80	80.00
3 diskettes at K110 each	330.00
1 stapler machine at K250 each	250.00
Transport	
Transport and lodging for literature search and consultation with supervisor and data collection	9,000.00
Typing and Printing Costs	
Typing and printing research proposal	1,000.00
Binding a research Proposal	100.00

Typing and printing questionnaires (80 copies)	3,500.00
Printing and Typing National clearance (3 copies)	90.00
Typing and Printing Hospital Directors' letters @ K30/copy	90.00
Binding 3 copies of research dissertation @ K500.each	1,500.00

Sub Total	18,090.00
Contingency (10%)	1,809.00
	=====
Grand Total	19,899.00
	=====

Justification of the Budget

Stationery

Typing and photocopying papers were required for writing research proposal and dissertation. Folders were necessary for keeping of questionnaires and literature. Pens, pencils, tippex and sharpener were required for writing during proposal writing, data collection and analysis and in the final write up of the dissertation. Postage materials such as envelopes, stamps were also purchased.

Transport Bills

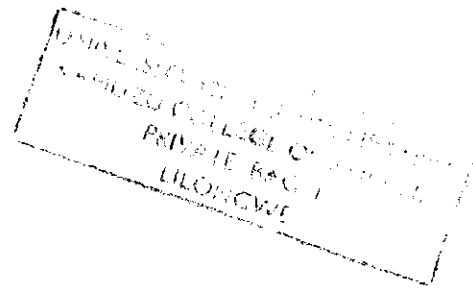
Money was required for use by the principle investigator when traveling between Lilongwe and Blantyre, and also to collect data at Queen Elizabeth Central Hospital. Transport money was also required to travel to and from Blantyre for literature search.

Typing and Printing Costs

The final copies of the research proposal was typed and printed at a fee. Similarly questionnaires, letters of permission and dissertation were typed and printed at a fee.

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APPENDIX A

The University of Malawi
Kamuzu College of Nursing
Private Bag 1
Lilongwe

The Secretary for Health,
Ministry of Health & Population
P.O. Box 30377
Lilongwe 3

ATTENTION: THE RESEARCH CO-ORDINATOR

Dear Sir,

PERMISSION FOR NATIONAL CLEARANCE

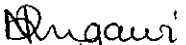
I am a student currently studying for a Bachelor of Science degree in Nursing at Kamuzu College of Nursing.

In partial fulfillment for the degree, I am required to carry out a research project on a topic of my choice. The topic of the research is "Factors Influencing Partner Notification in STI patients at Queen Elizabeth Central Hospital".

The purpose of this letter therefore, is to ask for national clearance for me to carry out this research.

Looking forward to your favourable response

Yours Faithfully,


NORAH MGAWI (Mrs.)

Principle Investigator
Mrs. Norah Mgawi
Kamuzu College of Nursing
Private Bag 1
Lilongwe

Research Advisor
Ms E. Mbweza
KCN
P.O.Box 415
Blantyre

APPENDIX B

University of Malawi
Kamuzu College of Nursing
Private Bag 1
LILONGWE

The Hospital Director
Queen Elizabeth Central Hospital
P O Box 95
BLANTYRE

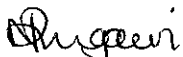
Dear Sir

**APPLICATION FOR PERMISSION TO CONDUCT A RESEARCH
STUDY AT QUEEN ELIZABETH CENTRAL HOSPITAL**

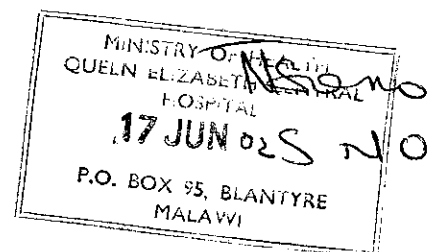
I am a second year Bachelor of Science in Nursing student at the above mentioned college and as part of partial completion of the programme, a research project is required. I therefore would like to ask for permission to conduct a research study at your hospital, especially at the STI clinic. The title of the study is "Factors Influencing Partner Notification in STI Patients at Queen Elizabeth Central Hospital".

Your favourable consideration on this matter will be greatly appreciated.

Yours faithfully


NORAH MGAUI (MRS)

Approved to conduct
the Stated Research



APPENDIX C

INFORMED CONSENT

I am a second year Bachelor of Science degree in Nursing student at Kamuzu College of Nursing. I am doing a research in partial fulfillment of the degree programme. The topic is "Factors Influencing Partner Notification in STI patients at Queen Elizabeth Central Hospital.

I will ask you questions to answer. The information obtained will be confidential and will be used for educational purposes only. Your identity will remain anonymous and your name will not be written on the questionnaire. I would appreciate your response to the questions.

I understand that I may make any enquiries concerning the study. I understand that my participation or non-participation will not affect me in any way.

I understand that I am free to withdraw my consent and discontinue participation in the study at any time. I have understood the explanation given and I hereby give consent to participate in the study.

DATE:.....Subject's

Signature.....

DATE:.....Investigator's

Signature *Dugawi*.....

APPENDIX D

CHIKALATA CHOVOMERA KAFUKUFUKU

Ine ndine mmodzi wa anthu omwe akuchita maphunziro a ukachenjede ku Koleji ya anamwino ku Kamuzu College of Nursing. Mbali imodzi ya maphunziro athu imafuna kuti ophunzira apange kafukufuku. Ine ndikuchita kafukufuku ofuna kudziwa zomwe zimapangitsa odwala matenda opatsirana kuti asakawauze omwe anpatsirana nawo matenda p chipatl cha Queen Elizabeth Central Hospital.

Ndikufunsani mafunso ndipo zones zomwe mudzandiyankha zizakhala za chinsinsi komanso dzina lanu sililembedwa paliponse. Muli ndi ufulu wovomera kapena kukana kulowa nawo mu kafukufuku uyu..

Ndamvetsetsa zones zomwe mwfotokoza ndio ndikuvomereza kulowa nawo mukafukufuku uyu.

.....
Tsiku

.....
Posayina wodwala

.....
Tsiku

.....
Posayina mboni/ mkulu wa kafukufuku

**FACTORS INFLUENCING POARTNER NOTIFICATION IN
PATIENTS WITH STIs AT QUEEN ELIZABETH HOSPITAL
QUESTIONNAIRE**

Socio-demographic Data

1. Sex: a) Male []
 b) Female []
2. Age:
3. Marital status (tick one)
 a) Married []
 b) Single []
 c) Divorced []
 d) Widowed []
4. If male how many wives?.....
5. How long have you been married?.....
6. If married are you staying together?
 Yes [] No []
7. What religion are you? (Tick one)
 a) Christian []
 b) Moslem []
 c) Others, specify.....

8. How you ever been to school?

Yes [] No []

9. If yes to Q8, what is your highest level attained?

a) Primary upper []

Lower []

b) Secondary form II or IV []

c) Tertiary Certificate []

Diploma []

Degree []

10. What is your current occupation?

a) Student []

b) Working, specify

c) Unclear []

11. Where do you stay?

12. Who do you stay with?

a) Parents []

b) Wife/ husband []

c) Wife/ husband, children []

d) Brother []

e) Sister ☐

f) Others specify.....

13. What is your source of income?

a) Employment ☐

b) Business ☐

c) Casual employment ☐

d) Others specify.....

Personal Factors

14. What is the nature of the problem you are having?

.....

15. How long was it that you thought you had a problem?.....

16. What happened first that made you think you had a problem?

.....

17. How severe were the symptoms?

a) Visible ☐

b) Not visible ☐

18. Did it cause a lot of discomfort in you?

Yes ☐

No ☐

19. If yes, why

20. To whom do you think this infection was attributed?

.....

21. Did you tell your partner about it?

Yes ☐ No ☐

If no, why.....

22. If yes, what was his/her response

23. Were you able to have sex with your partner after the symptoms?

Yes ☐ ☐

24. Realizing that you had a problem how did you feel about it?

a) Scared ☐

b) Worried ☐

c) Ashamed ☐

What are the reasons?.....

25. How do you think you got the problem?

a) Natural infection ☐

b) From wife/husband ☐

c) From sex workers ☐

d) From a friend ☐

e) Is it witchcraft ☐

26. When you realized you had this problem did you seek advice from anyone on what to do? Yes ☐ No ☐
27. If yes, from whom and what was the advice?.....
28. Did you follow the advice? Yes ☐ No ☐
Explain.....
29. How long did you wait to seek treatment from the time symptoms appeared? Why?.....
30. Did you wait for the symptoms to be worse?
Yes ☐ No ☐
31. When you came today, did the health worker tell you what you are suffering from? Yes ☐ No ☐
32. Have you been given treatment?
Yes ☐ No ☐
33. What advice have you been given concern treatment?
34. Have you been told to inform your partner?
Yes ☐ No ☐
35. Do you intend to inform your partner?
Yes ☐ No ☐
36. What response do you expect from your partner?

37. Do you think partner notification is important?

Yes ☐ No ☐

Explain.....

38. Do you have any personal inhibitions about informing your partner to come for treatment?

Yes ☐ No ☐

If yes, what are they?.....

Socio-Cultural Factors

39. Culturally do partners openly discuss *sexual matters*

Yes ☐ No ☐

40. If no to Q39, why?.....

41. Did you have any cultural inhibitions in telling partners about STIs?

Yes ☐ No ☐

42. If yes to Q41, what are the inhibitions?.....

43. Do relatives have a role in dealing with STIs?

Yes ☐ No ☐

If yes, what roles?.....

44. Between males and females who are more eager to inform partners? Why?

.....
.....

45. Between males and females who are tolerant to extra marital relations or multiple partners? Why.....

46. What do you think are the consequences when partners are notified about the infection?.....

47. In polygamous family if the husband is infected is it easy to inform all wives?

Yes [] No []

48. How would these wives respond?

49. Do you think partner notification is important at all?

Yes [] No []

Explain.....

50. What would be the best way to do it?.....

Health Care System Factors

51. How accessible is this clinic from your home?.....
52. Was the reception friendly?
Yes [] No []
53. If no to Q52, explain.....
54. Was the consultation and treatment done privately?
Yes [] No []
55. Explain your answer on Q54.....
56. Did you have a comfortable atmosphere with the health worker?
Yes [] No []
57. Were you assured of confidentiality?
Yes [] No []
Explain.....
58. From what you have experienced in this clinic what will inhibit you to inform your partner?
.....
59. What would hinder you from coming for treatment?

KAFUKUFUKU WOFUFUZA ZOMWE ZIMAPANGHITSA
ANTHU ODWALA MATENDA WOPATSILANA KUTI ASAUZE
OMWE ANAGONA NAWO ZA MATENDAWA

GAWO LOYAMBA

1. Mkazi / Mwamuna
2. Muli ndi zaka zingati?
3. Kodi ndinu:
 - a) Wokwatiwa
 - b) Wosakwatiwa
 - c) Banja linatha
 - d) Namfedwa
4. Ngati mwamuna – muli ndi akazi angati?
5. Mwakhala muli m'banja kwanthawi yayitali bwanji?
6. Mumakhala limodzi ndi banja lanu?
7. Mumapemphera mpingo wANJI?
 - a. Katolika
 - b. CCAP
 - c. Pentekositi
 - d. Anglikani
 - e. Apositoli
 - f. Ena (tchulani)

8. Munaphunzirapo sukulu?
 - a) Inde
 - b) Ayi
9. Sukulu munalekeza pati?
10. Kodi mumagwira ntchito?
11. Ngati ayi mumatani?
12. Mumakhla kuti
13. Mumakhala ndi ndani?
14. Ndalama mumapeza bwanji?
 - a. Ntchito
 - b. Bizinesi
 - c. Ganyu
 - d. Zina (tchulani)

GAWO LA CHIWIRI

15. Muli ndi vuto lanji?
16. Munadziwa liti kuti muli ndi vuto?
17. Chinachitika ndi chiyani kuti mudziwe kuti muli ndi vuto?
18. Zisonyezo za vutoli zinali zooneka kapena ayi?
19. Kodi vutoli munasowa nalo mtendere?
 - a) Inde
 - b) Ayi

Ngati inde longosolani.
20. Mukuganiza kuti vutoli anayambitsa ndani

27. Ngati inde kuchokera kwa ndani?

28. Munatsatira upangiriwo ?

a) inde

b) ayi

Longosolani

29. Munadikila nthawi yayitali bwanji mutaona zizindikilo mpaka
nthawi imene mumafuna chithandizo ? chifukwa chiyani ?

30. Kodi munadikila kuti zizindikilo zifike povuta ?

a) Inde

b) Ayi

31. Mutabwera lero kodi achipatala anakuuzani zomwe mukudwala ?

Ndi chiyani

32. Mwalandila mankhwala ?

33. Kodi ndi upangili wanji womwe mwalandira wokhudzana ndi
mankhwalawa ?

34. Kodi mwauzidwa kukauza womwe munagona nawo?

35. Kodi mukawauza womwe munagona nawo ?

a) inde

b) ayi

Pelekani zifukwa

36. Mukuganiza kuti akalandira bwanji zoterezi ?
37. Kodi mukuona kuti kuwauza amene munagona nawo za matenda ndi kofunika ?
- Longosolani
38. Kodi muli ndi zoletsa zoti musauzire amene munagona nawo kudzalandila mankhwala ?
- a) inde
- b) ayi
- Ngati inde, ndizoletsa zANJI ?

GAWO LA CHITATU

39. Kodi pa mwambo wathu anthu pa ubwezi, pa banja kapena pa chinzake amakambilana zogonana poyera ?
40. Chifukwa chiyani
41. Kodi pa cikhalidwe chathu muli ndi zoletsa zoti musamudziwitse amene munagonana naye za matenda opatsirana ?
- a) inde b) ayi
42. Ngati inde zoletsa zake ndi ziti?

43. Kodi achibale ali ndi gawo pa zamatenda opatsirana ?

a) inde

b) ayi

Ngati inde, gawo lanji?

44. Pakati pa mayi ndi abambo amene amamasuka kuuza amene
anagona nawo ndi ndani ?

45. Pakati pa mayi ndi abambo amene amalolera kuti mnzake akhale
ndi anthu ena apadera oti ogonana nawo ndi ndani?

46. Kodi mukuganiza kuti zotsatira zake ndi zotani wogonana nayeyo
akauzidwa za nkhaniyi ?

47. Amene amakhala pamitala ngati mwamuna watenga matenda kodi
nzaafupi kuuza akazi ake onse ?

a) inde

b) ayi

48. Akaziwo angaitenge bwanji nkhani imeneyi ?

49. Kodi kuuza ogonana naye nkofunika ?

Longosolani

50. Mukuganiza kuti njira yabwino yowauzira ogonana nawo ndi
yotani?

GAWO LACHINAYI

51. Mumakhala kutali bwanji ndi chipatala ?
52. Munalandilidwa bwanji ?
- a) bwino
 - b) udyo
53. Ngati udyo talangosolani
54. Kodi munali malo obisika pomwe mumalongosola zamatenda ndi
kulantila mankhwala
55. Longosolani
56. Kodi munali omasuka pomwe mumaonana ndi adokotala ?
57. Kodi anakutsimikizilani kuti zomwe mwakambirana zikhala
zachinsisi ?
58. Zomwe mwaona kuchipatala kuno chingakuletseni kuuza omwe
mumagonana nawo ndi chiyani ?
59. Chimene chingakuletseni kudzalandira mankhwala ndi chiyani ?