

Health Seeking Behaviour Towards Sexually Transmitted Infections among Students of a Nigerian Tertiary Institution

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Abstract

Sexually Transmitted Infections have a very serious impact on sexual and reproductive health worldwide and they rank among the top five disease categories for which young adults seek healthcare. Therefore this study assessed the health seeking behavior of undergraduate students of Tai Solarin University of Education (TASUED) towards STIs.

The study was a descriptive cross-sectional survey that applied both qualitative (focus group discussion) and quantitative methods (questionnaire) of data collection. Four hundred and thirty-one respondents participated in the study. Data was analyzed using SPSS version 21 to generate descriptive (frequency tables and charts) and inferential statistics (correlation).

Results showed that majority (74.2%) of the respondents have heard of STIs; HIV (80%) was the most commonly known, and Trichomoniasis (128; 29.7%) as least. The major source of information was television (350;81.2%); most preferred treatment source was private hospitals (205; 47.6%). Self -preference, inconvenience as a result of symptoms and knowledge of a place to get treatment were the best motivators of seeking treatment. Perceived risk of ill-health was high at 19.25 on a 28 point scale. There was a positive significant relationship between treatment options and perceived risk of ill-health ($r = .318, p < .01$).

Respondents had a fair health seeking behavior towards STIs, but misconceptions still exist. More synchronized actions need to be made by schools, the government, NGOs, the media and other stakeholders to enhance young people's health seeking behavior towards STIs.

Keywords: *Health seeking behavior, STIs, Youths, Ill-health, Source of care, Students*

Background

It has been observed that a considerable population of young people, are sexually-active and increasingly engage in risky sexual behaviours (Okereke, 2010) which continues to expose them to a number of sexually transmitted infections. Globally, it is estimated that 357 million new cases of curable STIs occur each year (WHO, 2015) of which the largest burden occurs in 20 to 24 and 15 to 19 year olds each year (WHO, 2016). Nigeria, which happens to be the most populous country in Sub-Saharan Africa, has a high prevalence of STIs among young people (Adedimeji, Omololu, & Odutolu, 2007; Oladepo & Fayemi, 2011). It is also estimated that about 3 million Nigerians get infected with STIs every year (NAS COP, 2015), and STIs are one of the top five reasons for which adults seek care in developing countries (WHO, 2014).

In rural southeast Nigeria, the prevalence of STIs was found to be as high as 17% among adolescent females (Mmari, Oseni & Fatusi, 2010). When only sexually active women were considered, 17–19-year-olds had the highest prevalence of Chlamydia (11%) and candidiasis (26%), and were also the age-group most likely to have had any STI (44%). Women younger

than 17 had the highest prevalence of trichomoniasis (11%), and nearly 20% also had symptomatic candidiasis (Mmari et al, 2010).

A study carried out in 2010, showed that amongst adolescents who reported having sex, 27.2 percent had STIs, mostly gonorrhea (33.9%) and Syphilis (22.8%) and they were not willing to patronize any formal health facility because sexual activities were greatly perceived as a preserve for the married, while premarital sex a sub-culture of deviants. This rigid idea had a negative effect on their health seeking behavior when confronted with STIs (Okereke, 2010). Although there is increasing evidence that STIs are a common problem among youth in Nigeria (Mmari et al, 2010), it has remained a very silent epidemic due to the stigma surrounding its occurrence (Kadiri, Ahmad & Mustafa, 2014).

The consequence has been sustained STI epidemics with increased spread of HIV/AIDS, leading to huge personal and economic loss. A number of studies (Olakolu et al, 2011; Isiaka-Lawal et al, 2014; Oyewole et al, 2010) carried out in Western Nigeria have shown a strong relationship between the presence of other STIs and the easy transmission and high infectivity of HIV, which could be a consequence of delay in seeking care or not seeking care at all. In a country where healthcare seeking remains a highly complex and poorly understood subject even more so where competing systems of traditional, informal and western medicine coexist (Mmari et al, 2010), efforts need to be made to provide empirical evidence to ease understanding which has practical and scientific relevance for the effective control of STIs.

A good understanding of health seeking behaviour can promote effective treatment which influences the duration of infectiousness and helps to further reduce complications (Jayabasker, 2007). Furthermore, information obtained can promote the provision of more sensitive youth health systems. Therefore this study sought to describe the health seeking behaviour of a youth population towards STIs.

Methodology

Study design, setting and subjects

A descriptive cross-sectional survey that applied both qualitative and quantitative methods of data collection was done. The study was carried out among 431 undergraduate students in a public premier university of education in southwest Nigeria. The total sample was determined using the formula for calculating single proportions by Abramson and Gahlinger (2002). Participants were selected using multistage sampling method. The 4 colleges in the University were considered for the study. By balloting, 3 departments were chosen from each college.

A questionnaire which was pretested (Cronbach's alpha coefficient = 0.87) sought out information on the sociodemographic characteristics, sources of information and knowledge, factors influencing choice of treatment, treatment options, and perceived risk of ill-health if treatment is delayed or ignored. Data was cleaned, coded and analyzed with the Statistical Package for Social Sciences version 21.

Instrument for data collection and technique

The instruments used to collect data for this study were: a structured, self-developed, 83-itemed questionnaire and a semi-structured, self-developed, focus group discussion guide.

Two focus group discussions (boys and girls separately) were conducted in English language. Each session lasted an hour and was made up of 8 undergraduate students who were comfortable discussing issues on sexuality and STIs and possessed the ability to express themselves in a group setting.

The focus group discussion guide was made up of 2 main sections. These included (1) the introductory section. In this section the moderator introduced herself and the co-moderator/recorder. All the participants were given the opportunity to introduce themselves. This was followed by a thorough explanation of the study, its purpose and objectives, and the process of carrying out the research including verbal informed consent. This section was made up of eight (8) main interview questions and twenty eight (28) probing questions.

The boys and girls were separated in order to ensure that every participant contributed and felt comfortable to discuss freely. The sessions were recorded using a phone recorder and the co-moderator took notes of verbal responses, and notable body languages such as feet shuffling, excessive eye blinking, nudging and other forms of non-verbal communication.

Data analysis

Four hundred and thirty six questionnaires were distributed but only 431 of them were filled correctly and returned. Hence only 431 questionnaires were included in the analysis. Univariate analysis was used to derive percentages and frequencies. Recorded data was played severally and transcribed verbatim. Transcribed data was compared with the handwritten data to ensure consistent tally and was then organized into themes.

Test of hypothesis

A test of hypothesis using bivariate analysis was carried out to determine the association between perceived risk and source of care stated as.

H₀= There is no association between perceived risk of ill health and source of care for STIs.

H₁= There is an association between perceived risk of ill health and source of care for STIs.

Ethical consideration

The research was duly approved by the Babcock University Health Research Ethics Committee. Other permissions to ease access to the student population were obtained from the student affairs office of the study area. The recruitment of respondents was voluntary and based on their informed consent in a letter attached on each questionnaire. Participants were given the choice to freely withdraw their participation whenever they decided not to continue with the study. To ensure maximum confidentiality and anonymity during and after data collection, names of respondents and other forms of identification were not required on the questionnaires.

Results

Table 1 shows the demographic profile of respondents. The mean age was 20 ± 4 years. The highest represented age range was 20-24 years. Two hundred and thirty respondents (53.4%) were females and 123 (28.5%) were in relationships.

Table 1: Demographic distribution of respondents

Variable	Frequency	n=431 Percentage (%)
Age		
15-19	93	21.6
20-24	248	57.5
25-29	83	19.3
30 and above	7	1.6
Gender		
Female	230	53.4
Male	201	46.6
Relationship status		
Single	281	65.2
Dating	123	28.5
Married	23	5.3
Separated	4	0.9
Level		

100 level	90	20.9
200 level	60	13.9
300 level	155	36.0
400 level	126	29
College		
Applied Education and Vocational Technology	90	20.9
Science and Information Technology	38	8.8
Humanities	212	49.2
Social and Management Sciences	91	21.1

Table 2 outlines the respondents' knowledge about STIs. A total of 320 (74.2%) respondents had heard of STIs while 111 (25.8%) had not. The three major sources of information in decreasing order of importance were television, 350 (81.2%), social media, 338 (78.4%) and the internet, 337 (78.2%). The least source of information on STIs was parents 283 (65.7%). Hospital/Health 320 (76.1%) workers were also significant sources of information for the respondents.

When participants of the focus group discussion were asked if they had heard of STIs before and what their source of information was, a female participant had this to say:

"I've heard about STIs before. I'm the kind of person that checks my HIV status every December so I'm really exposed to it".

During the male session, a participant said:

"I have heard about STIs from health workers outside the school and other groups of people".

The 3 most known STIs were HIV, (345; 80%), Gonorrhoea (319; 74%) and Syphilis, (236; 64.8%). The least known was Trichomoniasis (128; 29.7%) and some noted Diabetes (79; 18.3%) and Sickle Cell (79; 18.3%) as types of STIs. Whereas during the focus group discussions the only STIs mentioned were gonorrhoea and HIV.

The most popularly known routes of transmission were unprotected sex (397; 92.1%), sharing unsterilized needles and syringes, (342; 79.4%) and blood transfusion, (335; 77.7%). Similarly, the routes of transmission mentioned during the discussion were sex including oral sex, unsterilized sharps, blood transfusion and toothbrush sharing.

There were misconceptions about the routes of transmission, such as via cough and sneeze from infected persons (178; 41.3%), touching an infected person (55; 12.8%), and sharing the same toilet with an infected person (224; 52%). The most commonly known symptoms of STI were abnormal discharge from penis/vagina (349; 81%), painful urination (341; 79.1%) and weight loss (324; 75.2%). The least known was rashes on the body (205; 47.6%). Discussants similarly mentioned weakness, fever, rashes, weight loss, and vaginal/penile discharge as symptoms of STIs. When asked if there were differences between males and females in the manifestation of STI symptoms, they all agreed there were gender differences. A male participant said:

"Boys and girls may have the same discharge but the way it will come out from their ovaries is not the way it will come out from the guy's penis"

A female participant also said:

"There is difference because the symptoms appear quicker in ladies than in guys"

The most common mode of prevention known by the respondents was making use of condoms during sex (379; 87.9%), avoiding contact with the blood of an infected person (344; 79.8%) and having one sex partner (309; 71.1%). There were also misconceptions on the modes of prevention such as avoiding toilets used by infected people (257; 59.6%) and taking antibiotics before and after sex (241; 55.9%).

The knowledge score revealed a very substantial level of high knowledge among respondents as 349 (81.1%) had a high level of knowledge while 82 respondents (19%) had low level of knowledge. The mean score for knowledge was 19.28 which also connotes that generally, the level of knowledge on STIs was quite high among respondents.

In determining the level of knowledge of each respondent about STI, a thirty (30) point scale was developed. Question eight (8) with 8 stems on names of STIs known; question nine (9) with 9 stems on knowledge of routes of STI transmission, question ten (10) with 7 stems on knowledge about symptoms of STIs and question eleven (11) with 6 stems on knowledge of how STIs can be prevented, were scored on the questionnaire. Therefore, the total points obtainable by a respondent were thirty (30). Each correct response was scored one and no response or wrong response was scored zero.

Those who scored fifteen points or less (≤ 15) were considered as having low knowledge while those who scored sixteen points and above (≥ 16) were considered as having high knowledge.

Table 2: Respondents knowledge about STIs

Have you ever heard of STIs?	Frequency n = 431	Percentage (%)
Yes	320	74.2
No	111	25.8
Sources of Information		
Television	350	81.2
Social media	338	78.4
Internet	337	78.2
School	332	77.0
Hospital/Health workers	328	76.1
Public talks/Seminars	306	71.0
Friends	303	70.3
Print media e.g. newspapers, fliers etc.	294	68.2
Radio	299	69.4
Parents	283	65.7
Type of Sexually Transmitted Infection		
HIV	345	80.0
Gonorrhoea	319	74.0
Syphilis	236	64.8
Human Papilloma Virus	154	35.7
Chlamydia	130	30.2
Trichomoniasis	128	29.7
Diabetes	79	18.3
Sickle Cell	79	18.3
How can a person contract an STI?		
	Fr	
Through unprotected sex	397	92.1
By sharing unsterilized needles & syringes	342	79.4
Through blood transfusion	335	77.7
From mother to child through childbirth	271	62.9
From mother to child through breastfeeding	237	55.0
By sharing same toilet with an infected person	224	52.0
From exposure to cough and sneeze from infected person	178	41.3
By kissing an infected person	124	28.8
By touching an infected person	55	12.8
What are the common Symptoms of STIs?		
Abnormal discharge from penis/vagina	349	81.0
Painful urination	341	79.1

Weight loss	324	75.2
Swelling or boils around the genitals	298	69.1
Wound on penis or vagina	278	64.5
Fever	250	58.0
Rashes on the body	205	47.6

In reference to table 3 below, out of 431 respondents only 71 (16.47%) admitted to have contracted an STI before and had sought treatment for STIs from private hospitals (30; 7.0%) most times and the least, chemist shops (4; 0.9%).

Top reasons for seeking treatment included knowledge of treatment sites (238; 55.2%), Inconvenience from symptoms (249; 57.8%) and self-preference (252; 58.5%). Religious reasons (143; 33.2%) had the least influence on choice to seek or not seek treatment.

Table 3: Respondents who have had STIs and health seeking behaviour

Have you contracted an STI before?	Frequency n = 431	Percentage (%)
Yes	71	16.47
No	360	83.53
If yes did you seek treatment?		
Yes	41	57.75
No	30	42.25
If yes, where did you seek treatment?		
Private hospital	30	7.0
Government hospital	26	6.0
Chemist shop	4	0.9
Traditional clinic	11	2.6
None	360	83.5
What motivates you to seek treatment for an STI?		
Low cost of treatment	215	49.9
Proximity to clinic, hospital, traditional clinic	214	49.7
Self-preference	252	58.5
Inconvenience as a result of symptoms	249	57.8
Knowledge of a place to get treatment	238	55.2
Attitude of care giver	204	47.3
Religious reasons	143	33.2

**n=71

According to table 4, the most preferred source of treatment for STIs among most of the respondents were private hospitals (205; 47.6%) followed by government hospitals (191; 44.3%). Self-medication (18; 4.2%) was the least treatment option. Similarly, among discussants, private clinics were preferred to government clinics, while only a few mentioned family physicians and nurses as their most preferred source of care.

Table 4: Respondents preference for treatment

Where would you prefer to seek treatment if you had an STI?	Most Preferred	More Preferred	Least Preferred	Not at all
Private Hospital	205 (47.6%)	102 (23.7%)	39 (9.0%)	85 (19.7%)
Government Hospital	191 (44.3%)	107 (24.8%)	45 (10.4%)	88 (20.4%)
Traditional clinics	30 (7.0%)	33 (7.7%)	62 (14.4%)	306 (71.0%)
Chemist shops	19 (4.4%)	59 (13.7%)	127 (29.5%)	226 (52.4%)
Self-medication	18 (4.2%)	16 (3.7%)	59 (13.7%)	338 (78.4%)

**Multiple responses included*

Perceived risk of ill-health

In determining the respondent's perceived risk of ill health as a result of STIs, (table 5a); a twenty eight (28) point scale developed by the researcher was used. Question twenty (20) with 7 stems of questions that elicited feelings on how serious they think STIs could get were re-coded on the questionnaire.

Therefore, the total points obtainable by a respondent were twenty eight (28). Those who scored fourteen points or less (≤ 14) were considered as having a low perceived risk of ill-health as a result of STIs while those who scored fifteen points and above (≥ 15) were considered as having a high perceived risk of ill-health as a result of STIs.

Of the 431 respondents, 372 (86.5%) respondents recorded a high level of perceived risk of ill-health as a result of STIs while 59 (13.6%) respondents recorded a low perceived risk of ill-health. The mean score for PR was 19.75 which also show that generally, majority of the respondents were aware that STIs could be very dangerous to their health.

During the FGD initial reaction to contracting an STI was elicited. Generally fear was a first reaction amongst others. A discussant specifically responded,

"I will shout Ye! Mogbe!" [A Yoruba exclamation]*, while another discussant responded, *"At first I will be scared, then I'll get antibiotics."*

Table 5a Perceived Risk (PR) Score

Mean score = 19.75	Frequency n = 431	Percentage (%)
High perceived risk of ill-health	372	86.5
Low perceived risk of ill-health	59	13.6
Total	431	100

Bivariate analysis (table 5b) revealed a significant positive relationship between treatment options and perceived risk of ill-health. Thus, the higher the level of perceived risk of ill-health of respondents, the more they are likely to seek treatment for STIs. ($r = .318, p < .01$). Therefore the alternative hypothesis was accepted.

Table 5b Association between treatment options and perceived risk of ill-health

Correlations		Treatment options	Perceived risk of ill-health
Treatment options	Pearson Correlation	1	.318
	Sig. (2-tailed)		.000
	N	431	431
Perceived risk of ill-health	Pearson Correlation	.318	1
	Sig. (2-tailed)	.000	
	N	431	431

Discussion

Knowledge of STIs

More than half (74.2%) of all respondents had heard of STIs before. This finding is consistent with but higher than that of a study conducted in Northern Nigeria in which 67% of adolescents were aware of STIs (Aliyu, Dahiru, Ladan, Shehu, Abubakar, Oyefabi & Yahaya, 2013), and lower than that of a study conducted in Ado-Ekiti, western Nigeria in which 92.4% of respondents had high awareness of STIs (Amu & Adegun, 2015). These reveal some regional knowledge variations. The discussion also showed some level of knowledge but lacking in depth.

In this study, general knowledge on STIs was quite high. Regarding specific knowledge about STIs, findings were similar to those reported by studies carried out in Tanzania (Tengia-Kessy & Kamugisha, 2006) and Europe (Samkange-Zeeb et al, 2011) in which the most commonly known STI was also HIV.

Majority of the respondents knew that STIs could be transmitted through unprotected sex, sharing of unsterilized sharp objects and blood transfusion. This is in consonance with the reports of various other studies conducted within the country (Amu & Adegun, 2015; Mmari et al, 2010; Aliyu et al, 2013; Kadiri et al, 2014) though these studies focused mainly on HIV/AIDS.

The three most commonly mentioned symptoms of STI were abnormal discharge from penis/vagina, painful urination and weight loss. The least mentioned was body rash. This contrasts with that of a study conducted among youths in North Central Nigeria (Aliyu et al, 2013) in which the most popularly known symptoms of STIs were rash, painful urination, and painful intercourse.

The most common mode of prevention of STIs known by the respondents were condoms, avoiding contact with the blood of an infected person and staying faithful to one sex partner. Majority of the female discussants mentioned hospital check-ups, seminars on STIs, use of “protection” (condoms) as ways of preventing STIs whereas the male discussants mentioned use of condoms, abstinence and marriage as ways of preventing STIs. When asked what interventions would be best in preventing STIs, both groups mentioned health talks and hospital check-ups. This only buttresses the lack of adequate knowledge on issues concerning STIs and some level of gender differences still in existence.

There were equally misconceptions on the modes of prevention as a significant number of respondents incorrectly agreed that avoiding toilets used by infected people could prevent STIs. Misconceptions such as this need to be addressed to avoid stigma. These misconceptions were also repeated by discussants during the focus group discussion. Studies have established that respondents’ knowledge of STIs could be attributed to the widespread publicity and education on HIV/AIDS and not necessarily based on their specific knowledge of other STIs.

Based on other studies and findings from this study, the level of in-depth knowledge on STIs especially the four curable STIs is quite discouraging. These studies have shown that so much attention and publicity has been given to HIV/AIDS, whereas other STIs with serious complications which can also predispose to HIV/AIDS have been ignored. It is important that quality information about these other STIs should be publicised.

Source of information on STIs

The major sources of information were television, social media, the internet and school. This result is quite similar with that of a study carried out in South Western Nigeria where the major sources of STI information were the radio, television, teachers, and newspapers (Amu & Adegun, 2015).

The most likely reason why social media and internet were the major sources of information may be due to increased access to smart cell phones which enables them easy access to the internet and social media platforms which in turn gives them continuous access to various kinds of information.

Tertiary institutions are also playing increasing roles in the dissemination of information about STIs through health workers which could be internal or external, sign boards that convey information on STIs especially HIV/AIDS and some student groups/fellowships who take it upon themselves to educate their peers on STIs. Discussions also revealed mixed sources of information such as non-focused doctor’s appointment and church meetings. Although not synchronised, these indicate increased efforts by other sectors.

There were also differences in males and females responses regarding the existence of educational programs on STIs. Male participants agreed to have had one organised by a certain named group JCI (actual meaning wasn’t known at the time of discussion), while the

females were not aware of any such programs have existed before. Both groups however felt information on STIs was of importance due to low level of in-depth knowledge and high occurrence of co-habitation and HIV prevalence following random check-ups in that population

Health seeking behaviour

Very few respondents admitted to have contracted an STI before. All respondents who had contracted STIs sought at least one form of treatment with the majority seeking treatment from private hospitals. This finding contrasts with reports from a study carried out in South Africa where youths preferred to seek treatment in general hospitals compared to private ones (Otwombe et al 2015). The least place the respondents sought treatment was in traditional clinics. This also contrast with some studies carried out in western Nigeria where the reports show that youths preferred to seek treatment in traditional clinics or with herb dealers as a result of shame. They also preferred traditional clinics and herb dealers because of the privacy rendered in their services and reduced chances of running into someone familiar.

One of the challenges of this study is that very few participants admitted that they had contracted STIs at a particular point in their lives. No female discussant admitted to have contracted an STI before or admitted to knowing someone who had contracted a STI. Only one male discussant admitted to have contracted an STI at some point in his life. A study found gender differences in health seeking behaviour. Females had lower odds (odds ratio 0.6) than males of seeking treatment for STIs (Mmari et al). Few of the male discussants expressed that they had some friends who had been infected with STIs. Majority of the discussants both male and female mentioned that they would combine traditional medications with orthodox medications. Up to 80% of the Nigerian population still make use of traditional medicines (Ekeanyanwu, 2011). Therefore it is not surprising that some youths would also make use of this channel of care.

The participants generally agreed that most young adults with STIs symptoms sought care from government hospitals, private hospitals, self-medications or traditional healers/herbalists. Some of the medications mentioned by the participants were: *Jedi*, *Alabukun*, *Bicham*, *Kedy*, *Dr Oroki*, *Yemkem*, *Yoyo* bitters, Bitter leaf juice mixed with *ogogoro* (dry gin) and some GNLD products. This finding corroborates an earlier study where same treatment sites were suggested. (Adededimeji, 2005)

Factors influencing health seeking behaviour

Majority of the respondents in this study would be motivated to seek treatment if cost of treatment is low. High cost of treatment was a major discouraging factor from seeking treatment. This finding agrees with the report from a study carried out in Kwara State, Nigeria (Kadiri et al, 2014) where the high cost of treatment in some hospitals was noted as a major factor contributing to youths accessing road side pharmacies and herbs.

Also, the attitude of health workers was a major factor affecting health seeking behaviour. Various studies have shown that young people have zero tolerance for any form of stigmatisation from health workers.

Religious reasons were the least option that could either encourage or discourage respondents from seeking treatment. Very few studies mention religion as a source of treatment or factor in health seeking behaviour, however a study carried out in North Central Nigeria reports that an informant had to resort to prayers when STI symptoms were deteriorating (Kadiri et al, 2014).

Disclosure of status

Majority of the respondents in this study would feel free to discuss with someone if they had an STI. Health workers were the best people they would discuss their status with followed by parents and pharmacists. This finding is slightly consistent with reports from a study carried out in Western Nigeria in which majority of the female participants would rather

discuss their STI status with their mothers and female siblings. The least people they would discuss their status with were teachers and herbalists. This slightly contrasts with findings from the focus group discussions in which most female participants would rather not discuss their status with anyone or at most a health worker.

There were also slight gender differences in the disclosure of status. Most guys agreed they can talk to their friends about STIs and they also agreed that the least people they will speak to about STIs were their parents. Adedimeji, 2002 had earlier reported similar findings. Infection with an STI was reported by 27% of boys and 10% of girls and as much as 49% of participants reported knowing a young person infected with an STI.

Perceived risk of ill-health as a result of STIs

Most respondents recorded a high level perceived risk of ill-health as a result of STIs which shows that generally, majority of the respondents were aware that leaving STIs unattended for a long time or ignoring it totally could be very dangerous to their health and that of their partner.

Most participants did not show any special preference for a particular source of care as a result of their initial perception/reaction to symptoms. There were mixed reactions regarding sexual behaviour following the discovery of an STI. Half of the participants would stop having sex till they get treated for STIs, while the other half reported that they will keep having sex but with contraceptives most preferably condoms.

Conclusion

Youth in this tertiary institution have fair health seeking behaviour and applaudable knowledge about STIs but lacking in depth. There are gender differences in health seeking behaviour. Perceived risk of ill health following STI was high. Misconceptions still exist. Many still have disclosure difficulty. Young adulthood is a time of wild experimentation and a peak for information sharing especially in the modern technological world. Given the right information and channels for learning, positive behaviour change can be attained to protect the youth.

Recommendations

There is a need to establish a heart-to-heart youth friendly counselling and support center where students can freely walk in to discuss issues pertaining to health and sexuality. Furthermore, the workers in the health center should be adequately equipped to provide confidential and friendly services for STI treatment and counselling.

There's a need to intensify efforts to promoting knowledge on STIs among students by conducting periodic seminars and compulsory comprehensive sexuality education classes that will educate students on the dangers of risky sexual behaviors and STIs.

Frequent media features around STIs and youth sexuality need to be made on the internet and social media. These can serve as powerful channels for providing factual and scientific information on STIs for young people.

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