

**ASSESSMENT OF KNOWLEDGE, ATTITUDE AND PRACTISES ON SEXUALLY  
TRANSMITTED DISEASES/INFECTIONS AMONG THE YOUTHS IN BUGOLOBI  
TOWN, JANUARY 2018.**

**BY  
MWANGI ESTHER MUTHONI  
BMS/0094/133/DF**

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## TABLE OF CONTENTS

|  |      |
|--|------|
| TABLE OF CONTENTS.....                                 | i    |
| LIST OF FIGURES .....                                  | iv   |
| LIST OF TABLES.....                                    | v    |
| DECLARATION .....                                      | vi   |
| APPROVAL .....   | vii  |
| LIST OF ABBREVIATIONS AND ACRONYMS .....               | viii |
| OPERATIONAL DEFINITIONS.....                           | ix   |
| ABSTRACT.....  | x    |
| CHAPTER ONE.....                                       | 1    |
| 1.0. INTRODUCTION .....                                | 1    |
| 1.1. BACKGROUND .....                                  | 1    |
| 1.2. PROBLEM STATEMENT.....                            | 3    |
| 1.3. STUDY OBJECTIVES.....                             | 4    |
| 1.3.1. BROAD OBJECTIVE.....                            | 4    |
| 1.3.2. SPECIFIC OBJECTIVES.....                        | 4    |
| 1.4. RESEARCH QUESTIONS .....                          | 4    |
| 1.5. JUSTIFICATION OF THE STUDY .....                  | 4    |
| 1.6. STUDY SCOPE.....                                  | 5    |
| 1.6.1. GEOGRAPHICAL SCOPE.....                         | 5    |
| 1.6.2. CONTENT SCOPE .....                             | 5    |
| 1.6.3. TIME SCOPE.....                                 | 5    |
| 1.7. CONCEPTUAL FRAMEWORK .....                        | 5    |
| CHAPTER TWO: LITERATURE REVIEW .....                   | 7    |
| 2.0. INTRODUCTION .....                                | 7    |
| 2.1. KNOWLEDGE CONCERNING STIs/STDs.....               | 7    |
| 2.2. ATTITUDES AND PRACTICES CONCERNING STIs/STDs..... | 9    |
| CHAPTER THREE: METHODOLOGY .....                       | 11   |
| 3.0. INTRODUCTION.....                                 | 11   |
| 3.1. STUDY DESIGN.....                                 | 11   |

|  |  |    |
|--|--|----|
| 3.2.   | STUDY AREA.....  | 11 |
| 3.3.   | TARGET POPULATION.....   | 11 |
| 3.4.   | STUDY POPULATION.....  | 11 |
| 3.5.   | SELECTION CRITERIA.....  | 11 |
| 3.5.1.   | INCLUSION CRITERIA.....  | 11 |
| 3.5.2.   | EXCLUSION CRITERIA.....  | 11 |
| 3.6.   | SAMPLING TECHNIQUE.....  | 11 |
| 3.7.   | SAMPLE SIZE DETERMINATION.....   | 11 |
| 3.8.   | DATA COLLECTION METHODS & TOOLS.....   | 12 |
| 3.9.   | QUALITY CONTROL.....   | 12 |
| 3.10.  | LIMITATIONS & DELIMITATIONS OF THE STUDY.....                                    | 12 |
| 3.11.  | ETHICAL CONSIDERATIONS.....  | 12 |
| CHAPTER FOUR: STUDY FINDINGS.....                              |  | 13 |
| 4.0.   | INTRODUCTION.....  | 13 |
| 4.1.   | Sociodemographic Characteristics of the Respondents.....                         | 13 |
| 4.2.   | Knowledge of Bugolobi Youth.....   | 14 |
| 4.3.   | Attitude of Bugolobi youth towards STIs/STDs.....                                | 15 |
| 4.4.   | Practice of Bugolobi youth pertaining STIs.....                                  | 16 |
| CHAPTER FIVE: DISCUSSIONS OF THE STUDY FINDINGS.....           |  | 19 |
| 5.0.   | INTRODUCTION.....  | 19 |
| 5.1.   | DISCUSSIONS.....   | 19 |
| CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS OF THE STUDY..... |  | 21 |
| 6.0.   | INTRODUCTION.....  | 21 |
| 6.1.   | CONCLUSIONS.....   | 21 |
| 6.2.   | RECOMMENDATIONS.....   | 21 |
| 6.2.1.   | To the Youth of Bugolobi.....  | 21 |
| 6.2.2.   | To the Health Care Providers and other Players in the Reproductive Health Sector | 21 |
| 6.2.3.   | To the governing Authorities and Ministry of Health.....                         | 22 |
| REFERENCES.....  |  | 23 |
| APPENDICES.....  |  | 26 |

|   |    |
|---|----|
| APPENDIX ONE: WORK PLAN.....                                | 26 |
| APPENDIX TWO: BUDGET .....                                  | 27 |
| APPENDIX THREE: MAP OF UGANDA.....                          | 28 |
| APPENDIX FOUR: MAP OF THE DIFFERENT REGIONS OF UGANDA ..... | 29 |
| APPENDIX FIVE: MAP OF KAMPALA .....                         | 30 |
| APPENDIX SIX: MAP SHOWING BUGOLOBI TOWN .....               | 31 |
| APPENDIX SEVEN: CONSENT FORM .....                          | 32 |
| APPENDIX EIGHT: STUDY QUESTIONNAIRE .....                   | 33 |

## **LIST OF FIGURES**

|  |    |
|--|----|
| Figure 1: Conceptual Framework n Knowledge Attitudes & Practice on STIs/STDs ..... | 5  |
| Figure 2: STIs Mentioned by Youth in Bugologi, 2018 (N=112) .....                  | 14 |
| Figure 3: STI Prevention methods known by Bugolobi youth, 2018 (N=112)) .....      | 16 |
| Figure 4: Bugologi Youth's Thoughts on STI infection and risk of HIV/AIDS .....    | 16 |

## **LIST OF TABLES**

|  |    |
|--|----|
| Table 1: Socio-demographic Characteristics of the Youth of Bugolobi, 2018 (N=114) .....  | 14 |
| Table 2: Signs and Symptoms of STIs/STDs Mentioned by Bugolobi Youth, 2018 (N=106) ..... | 15 |
| Table 3: Practice of Bugolobi youth concerning STIs .....                                | 18 |

**DECLARATION**

I, **Mwangi Esther Muthoni**, do hereby declare that this research dissertation is the product of my own efforts and to the best of my knowledge and conviction, has never been presented to any institution for any award or qualification whatsoever. Wherever the works of other people have been included, due acknowledgement to this has been made in accordance with the appropriate referencing and citations. The findings and the analysis that resulted from this research project are my original information.

Researcher .....

Signature .....

Date .....

**APPROVAL**

This work is hereby submitted to University examiners with my approval as University supervisor.

.....

**SOLOMON A. MBINA**

B.Sc. Biochem(ABU), PGDE (UDU), MPH (CUU), M.Sc Biochem (in-view)

School of Allied Health Sciences,

Department of Public Health.

Kampala International University-WC



## **LIST OF ABBREVIATIONS AND ACRONYMS**

|                |   |   |
|----------------|---|---|
| <b>AIDS</b>    | : | Acquired Immunodeficiency syndrome                              |
| <b>AMREF</b>   | : | African Medical and Research Foundation                         |
| <b>AOR</b>     | : | Adjusted Odds Ratio   |
| <b>HIV</b>     | : | Human Immunodeficiency Virus                                    |
| <b>IREC</b>    | : | Institutional Research and Ethics Committee                     |
| <b>KIU-TRH</b> | : | Kampala International University Teaching and Research Hospital |
| <b>STD</b>     | : | Sexually Transmitted Disease                                    |
| <b>STI</b>     | : | Sexually Transmitted Infection                                  |
| <b>TASO</b>    | : | The Aids Support Organization                                   |
| <b>UNAIDS</b>  | : | United Nations Programme on HIV/AIDS                            |
| <b>UNICEF</b>  | : | United Nations International Children's Emergency Fund          |
| <b>WHO</b>     | : | World Health Organization                                       |
| <b>NCI</b>     | : | National Cancer Institute                                       |

## **OPERATIONAL DEFINITIONS**

**Contraception:** Against conception. Device or practice that prevents a fertile woman from becoming pregnant (conceiving).

**Morbidity** : (mor-BIH-dih-tee) Refers to having a disease or a symptom of disease, or to the amount of disease within a population. Morbidity also refers to medical problems caused by a treatment. (NCI Dictionary of Cancer Terms, 2017)

**Mortality** : (mor-TA-lih-tee) Refers to the state of being mortal (destined to die). In medicine, a term also used for death rate, or the number of deaths in a certain group of people in a certain period of time. Mortality may be reported for people who have a certain disease, live in one area of the country, or who are of a certain gender, age, or ethnic group. (NCI Dictionary of Cancer Terms, 2017).

**Sero-status:** Serological status in blood being positive or negative for antibodies against an infective agent e.g. HIV virus.

**Youth** : Persons between the ages of 15 – 35 years as per the African Youth Charter, 2006 African Union Reference.

## **ABSTRACT**

**Introduction:** STIs/STDs are becoming neglected despite their contribution in morbidity and mortality. This could have resulted from the fact that most of them have become treatable since the discovery of effective antibiotics. This neglect has led to them creeping back with development of resistant strains that are hard to eradicate. The most affected group is the sexually active, highly experimental and naïve youth whose knowledge influences their attitudes and practice concerning STIs/STDs. Of more importance is the fact that most STIs are gateway infections to contraction of the deadly HIV and if STIs can be put on check, HIV spread can be stalled.

Given the public health importance, morbidity and mortality burden, plus the cost implications of neglecting STIs/STDs and their complications, plus the fact that neglecting them bears the risk of curtailing the HIV/AIDS scourge, a study into the knowledge, attitude and practice of the youth (most vulnerable) was conducted.

**Objective:** To assess the knowledge, attitude and practices on sexually transmitted diseases among the youths in Bugolobi Town in January 2018.

**Method:** A descriptive study design was used which applied both qualitative and quantitative approaches in data collection and involved 114 study participants from Bugolobi.

**Results:** The knowledge level of Bugolobi youth on STIs/STDs was high (98.25%) but their attitude was negative and practice poor as far as STI/STD prevention was concerned. Risky sexual practice e.g. with strangers (sex workers and for material gain) was rampant.

**Conclusion:** Despite the youth of Bugolobi having satisfactory knowledge level concerning STIs/STDs, their attitude, and consequently practices, are wanting. Still a lot needs to be done to convert the knowledge into attitude change and appropriate practices.

**Recommendations:** The youth need to change their attitudes and practices, refrain from early sexual debut and embrace condom use at every sexual contact. More funds and efforts needed in awareness creation as pertains to STIs/STDs.

## **CHAPTER ONE**

### **1.0.INTRODUCTION**

This chapter dealt with the background, objectives, problem statement, justification, conceptual framework, and scope of the study.

#### **1.1. BACKGROUND**

The knowledge of STD/STIs has existed within local communities of the world and in Uganda for over a century. Different perceptions about STDs have been around for a very long time. “In the latter half of the 20th century when new STDs emerged, perceptions also changed”(Irene O. Chiringa, 2016).

The emergence and spread of HIV/AIDS in Africa, especially among the youth, has been devastating. The epidemic reached pandemic proportions in most parts of Africa and by the end of 1997 an estimated 30.6 million adults and children were living with HIV/AIDS of which 68% were from sub Saharan Africa. Today the figure stands at a staggering 54 million cases in Africa alone (UNAIDS, 2016b).

“In Uganda the fight against STD/STIs became even ominous with the emergence of HIV/AIDS”. The first AIDs case was reported among the lakeside traders in Rakai district in 1981. By mid-1991, Uganda had an estimated 1.5 million people infected with the disease. Today the HIV/AIDS infection rates are high especially in Kampala and other urban centers”(Uganda Bureau of Statistics (UBOS), 2016).

“When scientists and health workers, both in Uganda and the world over, realized that one was most vulnerable to contract HIV/AIDS if he/she was infected with other STD/STI's, the government of Uganda on their advice established programs like condoms social marketing for change (SOMARC) and voluntary counselling and testing campaigns”. There are also a number of community-based programs that are involved in sexual and reproductive education for youths. These programs include religious based organizations like the church and Islamic Medical Association of Uganda, which are addressing STD/STIs among the youths. There is also save the youth from AIDs, which is a youth live program that targets mainly out of school youths. The program believes that sex is a deliberate choice. UNPF supported programs for enhancing adolescent productive life in Uganda, also targets the youth with the aim of enhancing the youth's reproductive health. (UNAIDS, 2016a)(UNAIDS, 2017).

The African medical research foundation (AMREF) runs sexual reproductive health programs for adolescents in Entebe, Luweero and Kabala. All the above programs talk about sexual and reproductive health concerns especially among the youth in Uganda to fight against all forms of STD/STIs. The youth are expected to utilize the services provided for them for their own benefits. The contraction, spread and prevalence of STIs, HIV/AIDS included, are a factor of the knowledge, attitudes and practices of the people at risk, and any efforts at intervention should be tailored to affect these three. It is with this in mind that the study aims to assess the knowledge, attitudes and practices on sexually transmitted diseases/infections among the youth of Bugolobi Town, Uganda in January 2018.

Sexually transmitted diseases/infections are diseases/infections that have a significant probability of transmission between humans by means of sexual contact: vaginal intercourse, oral sex or anal sex (WHO, 2016).

Despite the fact that several people are living with these infections, the causative agents of these diseases cannot be seen with our naked eyes which are then presumed to be the basic reasons leading to the spread of these diseases/infections.

This concept of STD/STI's has existed within the local community in Uganda for over a century. For example, in Buganda a man that contracted an STD especially gonorrhoea, that was most prevalent at that time, was considered to be brave in regards to courting women. STD still remains a great public health problem of major significance in most part of the world. Incidence of acute STD is believed to be high among adolescents worldwide due to changes and development in their lives (Uganda Ministry of Health, 2015).

Failure to diagnose and treat STD's at an early stage may result in serious complications and sequelae; including infertility, ectopic pregnancy, neonatal infection, ano-genital cancer, infant infections and death. STD's also account for massive expenditure in terms of treatment of the infected individuals (CDC, 2013).

STD's are also common in adults, but they are always hidden for the fear of opinion of others thus, self-medication is common and when sought, treatment is often obtained from; private practitioners, pharmacists, nurses and traditional healers (CDC, 2013).

The emergence and spread of HIV/AIDS have had a major impact on the management and control of other STD's. For example, antimicrobial resistance of several sexually transmitted pathogens is increasingly rendering some low-cost regimes ineffective. Not only that, the treatment of

infections such as, chancroid may have become increasingly difficult because of immunosuppression caused by co-infection with HIV. These leave management of STD's with very expensive drugs like; third generation cephalosporins. Due to unaffordability of these expensive treatments of choice, low cost drugs are still in use which lead to inadequate therapy, which may lead to complications, relapse, further spread and antimicrobial resistance (CDC, 2013).(Chimoyi et al., 2014). Given the significant contribution of knowledge in as far as influence on attitude and practice on STIs/STDs the research aims to assess the knowledge, attitude and practice of the youth (most relevant group in as far as STIs/STDs are concerned). In so doing, the researcher hopes to recommend interventions towards awareness creation, attitude change and appropriate practice.

## **1.2.PROBLEM STATEMENT.**

Globally, sexually transmitted diseases/infections cause nearly a half of the deaths among the youth under 34 years of age, and continue to be the leading cause of morbidity and mortality among all the preventive diseases (WHO, 2016).

Almost every youth has ever heard of STD/STI's, yet most of them feel that they are at little or no risks of contracting these infections. This presents a problem for behaviour change strategies targeting young people (Rashwan, Saat, & Abd Manan, 2012).

Despite the fact that there are quite a number of STDs/STIs that can equally cause significant morbidity and mortality, the commonly known ones include syphilis, gonorrhoea and HIV/AIDS. This paucity of knowledge among the youth as pertains the other STDs/STIs breeds challenges as far as prevention, diagnosis and treatment are concerned. Furthermore, the youth is the most experimental, most naïve, and most productive and reproductive portion of the population and thus mostly at risk and highly affected by STDs/STIs. Their naiveté and financial incapacities expose them to predators commonly euphemized as “sugar daddies”, “sugar Mommies” or lately “sponsors”(WHO, 2016). Bugolobi's youth are faced with these challenges given the low socio-economic status they are faced with. Their low earning potential makes them vulnerable to be enticed and tempted to indulge in sexual behaviors that put them at risk of contracting STIs/STDs. Although there is vast coverage of awareness campaigns concerning STIs/STDs, the laissez faire attitude among these youths, confounded by peer pressure to partake in vices such as alcohol, drug abuse and extra-marital high risk sexual behaviors puts them further at risk. Most life decisions and actions that affect one's life occur at the youth bracket. Being at this high energy, high paced

and highly impressionable age bracket makes the youth highly receptive and ripe for interventions of either healthy living or a doomed future!(Maina, Kimani, & Anzala, 2016). As far as the researcher is concerned, no such study has been conducted within the study area.

### **1.3.STUDY OBJECTIVES**

#### **1.3.1. BROAD OBJECTIVE**

The study aims to assess the knowledge, attitude and practices on sexually transmitted diseases among the youths in Bugolobi Town in January 2018.

#### **1.3.2. SPECIFIC OBJECTIVES**

1. To assess the level of knowledge on STD/STIs and their prevention/control among the youths of Bugolobi Town in January 2018.
2. To assess the general attitudes of youths of Bugolobi Town towards STD/STIs in January 2018.
3. To determine the practice of Bugolobi youth concerning STIs/STDs in January 2018.

### **1.4.RESEARCH QUESTIONS**

1. What knowledge do the youths of Bugolobi have about STDs / STI's?
2. What is the attitude of the youths of Bugolobi towards STDs / STI's?
3. What is the practice of Bugolobi youth towards STDs/STIs?

### **1.5. JUSTIFICATION OF THE STUDY**

Sexually transmitted diseases/infections, HIV/AIDS included, continue to devastate communities, especially in sub-Saharan Africa. The study will enable the researcher make recommendations that will help include, but are not limited to, influencing behavior change among the youth of Bugolobi. Statistics from the study will contribute to the knowledge pool that can be used by individual, local, institutional, regional and global organizations in planning, decision making and furthering more research. The Bugolobi community will benefit through a reduction of morbidity and mortality caused by STIs/STDs, HIV/AIDS included. Policy makers will find the information obtained through this study useful in formulation of intervention programs such as awareness-creation campaigns and outreaches concerning STIs/STDS and also help guide prioritizing reproductive health needs of the community and fund allocation for intervention. Information from this study will also fuel more research on related subjects within the study population or elsewhere. For instance, further research can be conducted on the prevalence of STIs/STDs in Bugolobi.

## **1.6. STUDY SCOPE**

### **1.6.1. GEOGRAPHICAL SCOPE**

The study was conducted in Bugolobi town in Kampala. It is approximately 4km from Kampala town the capital city of Uganda. It is a residential area situated in a typical urban centre and is also part of an industrial area. Bugolobi is a location in Kampala, Uganda's capital and largest city. The road distance between Bugolobi and the central business district of Kampala is approximately 7 kilometres (4.3 mi). The coordinates of Bugolobi are:0°18'36.0"N, 32°37'30.0"E (Latitude:0.3100; Longitude:32.6250).

### **1.6.2. CONTENT SCOPE**

The study was about assessment of knowledge, attitude and practices on sexually transmitted diseases/infections among youths of Bugolobi Town.

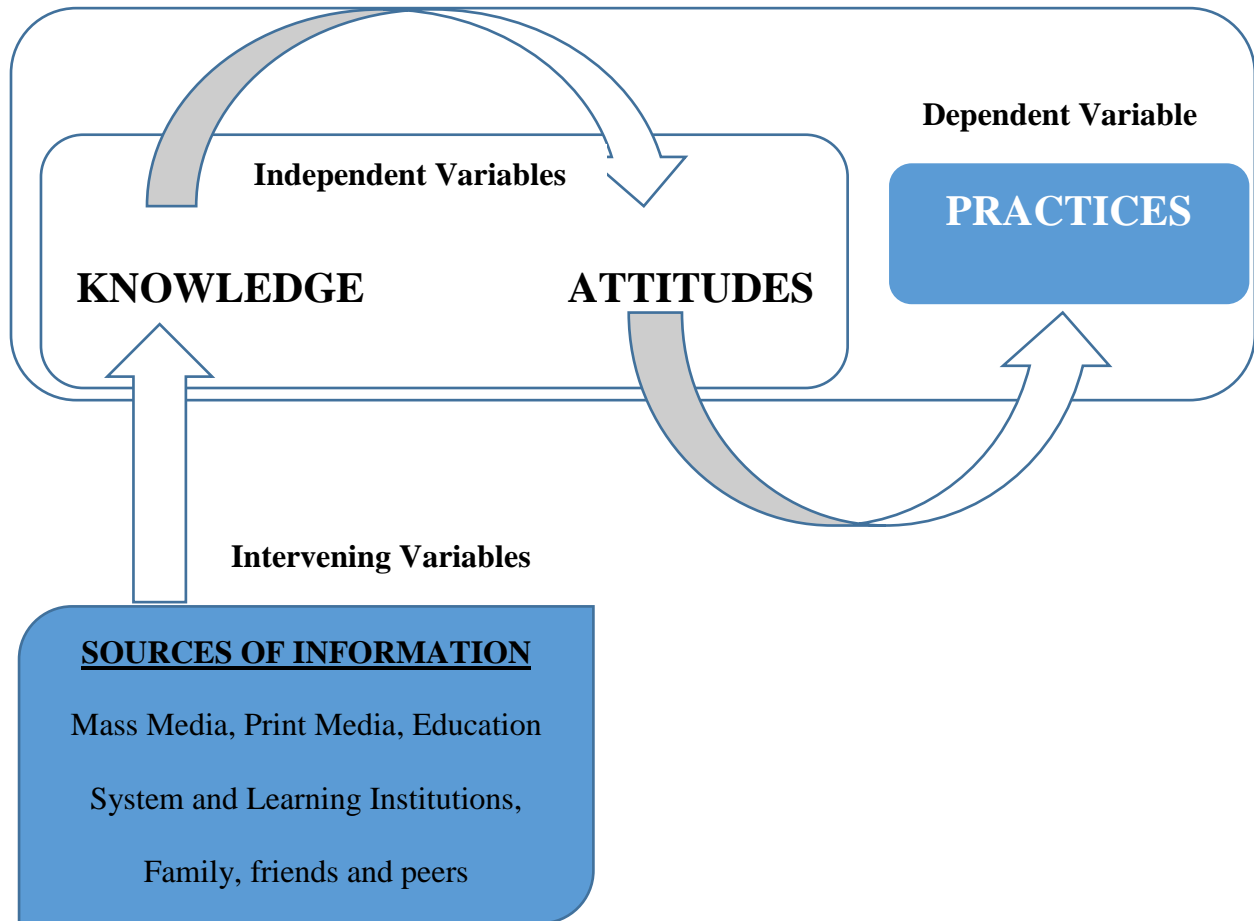
### **1.6.3. TIME SCOPE**

The study was conducted in January 2018.

## **1.7. CONCEPTUAL FRAMEWORK**

The attitude and practice of youths concerning STIs/STDs and HIV/AIDS are affected mainly by the knowledge they possess about the subject matter. The dependent variable for the case of this study will be taken as the practice concerning STIs/STDs while knowledge and attitudes will be considered as modifiable / independent variables that are in turn influenced by so many factors (intervening variables).





## **CHAPTER TWO: LITERATURE REVIEW**

### **2.0. INTRODUCTION**

This chapter dealt with various literature reviewed on the knowledge, attitude and practice towards sexually transmitted diseases/infections.

#### **2.1.KNOWLEDGE CONCERNING STIs/STDs**

Given the health significance of STDs/STIs and HIV/AIDS, efforts have been done world over assessing the knowledge level of different categories pertaining these. In China for instance, such a study conducted among medical students just a year ago in 2016 found out that despite there being no difference in knowledge as per participants' education level, a huge difference existed in STI knowledge between Chinese and foreign students. As a whole, Chinese students were more knowledgeable compared with their counterparts in many aspects. For example, only 49.68% of foreign students compared to 95.67% of Chinese provided the right answer related to the nature of pathogen. In addition, 34.39% of foreigners versus 90.97% of local students agreed that condom makes sexual intercourse safe in HIV acquisition. Contrary to Chinese students, whose source of information was mainly from school education, foreign medical students were more likely to use Internet; the majority of students reported an extracurricular training in HIV/STIs and almost all had wished to know more about HIV/AIDS. Confusions existed on route of transmission and risk factors of HIV transmission were found in both groups. It was showed that medical student knowledge remained inconsistent. Many students cited oral sex, mosquito-bites, saliva, sweat, urine, tears, public health facilities, and physical contact as route of transmission of HIV. Many also perceived students, healthcare providers, or migrants as high-risk populations of HIV acquisition (Figure 1(b)); meanwhile despite the conventional known factors (blood manipulation, acquisition of STI, illicit drug addiction, etc.) which may increase HIV transmission, poverty or tobacco consumption was also enumerated to increasing HIV transmission (Kuete et al., 2016). Studies concerning STIs and HIV/AIDS have not been confined to youth or medical students only. In 2017, a related study was conducted among 50 truck drivers of Punjab Pakistan where twenty drivers (40%) reported burning micturition but only two (four percent) knew the real cause of it. Thirty-two (64%) of them were well aware of the use of condoms. Thirty-eight (76%) truck drivers had the knowledge about the adverse effects of multiple sex partners (Ishtiaq, Asif, Jamil, Irfan, & Ishtiaq, 2017). A Mumbai study among college students published that the majority of

undergraduates had a low to moderate level of STI knowledge while HIV related knowledge was found to be much better (Ha, 2013).

An awareness study was conducted among students of Pulau Pinang in Malaysia in the year 2010. The study involved 1,139 students and it aimed at assessing the awareness of the students as concerns STDs/STIs out of whom 121 (10.6%) claimed that they had never heard about STIs (Anwar, Sulaiman, Ahmadi, & Khan, 2010). Three years later, in 2013, Kunzang Norbu and colleagues conducted an almost similar study in two rural districts in Bhutan: Gasa and Zhemgang. From this study, the average score was 61.6%. Respondents had highest knowledge about prevention and lowest about disease and complications (Norbu, Mukhia, & Tshokey, 2013).

In Ado Ekiti, South Western Nigeria in 2015, Amu and Adagun conducted a study assessing the awareness and knowledge of STIs among secondary school adolescents. From the study, they found that out of a study population of 550 adolescents, four hundred and ninety-nine (92.4%) had ever heard about STIs before, the three most important sources of information were electronic media (68.7%); teachers (68.1%); and print media (44.9%). Eighty percent of the respondents knew only a single STI and the two most commonly mentioned STIs were HIV/AIDS (78.0%) and gonorrhoea (23.0%). More than 75% of the respondents knew the modes of transmission of STIs while the rest had misconceptions. The most important symptoms mentioned were weight loss (77.4%), painful micturition (68.9%), and genital ulcer (54.1%). Overall, only 6.9% of the respondents had good knowledge of STIs; the rest had fair and poor knowledge (Amu, Adegun, Amu, & Adegun, 2015).

In a study conducted among 347 students of Haile Mariam Mamo Preparatory School in Debre Birhan Ethiopia in 2013 assessing the knowledge, attitude and practice on sexually transmitted infections, two hundred and sixty (74.9%) had heard about STIs and their prevention. Of these, fourteen (17.5%) came rural and two hundred forty-six (82.5%) were from urban areas. Most of the respondents (76%) cited the radio and television as the source of information followed by school (43.9%), parents (17.95%) and others (2.2%) (Adera, 2015). Still in Ethiopia, Shone Preparatory School study findings of 2014 were as follows; almost all respondents had heard about STIs before the interview. They had good knowledge concerning transmission mode and methods of prevention methods (Gemechu Kejela, 2015). The most recent Ethiopian study was in 2017 at Seto Semero high school. Out of three hundred and twenty-four students that took part in the study,

most (88.5%) had ever heard about STIs. Radio/TV was the most frequently source of information for STIs (Asmamaw, Addis, & Destaw, 2017).

In Katanga slum of Kampala Uganda, results from a cross-sectional study conducted among women of reproductive age in 2014 showed that, of the STI symptoms, the most commonly known were genital itching (60%) and genital rash (14.5%). Most mentioned multiple partners (63.7%) and unprotected sex (50.7%) as predisposing factors to STIs. Knowledge on methods of prevention was found to be high (92.3%) (Nawagi, 2014).

## **2.2. ATTITUDES AND PRACTICES CONCERNING STIs/STDS**

Knowledge concerning sexually transmitted infections will, in one way or another, influence the attitudes and practices of those who have it. This is not always so, since in some instances, despite the knowledge level being high, attitudes and consequently practices are not reflective.

Major concerns arose from the study among undergraduate students of a Mumbai college in 2013 where students' preventive sexual practices were found to be worrying. HIV-AIDS campaigns and other STIs seem to have been neglected (Ha, 2013).

In the Bhutan study for instance, despite the average knowledge score being at 61.6%, nearly one-third of the study population was practicing risky sexual behavior with 31.2% having sexual relationships with non-regular partners and 10.9% had extramarital sexual contacts. Regular use of condoms with non-regular partners was 49.1%. The most common reason for not using condom was unavailability during the sexual encounter. The study showed that despite increasing knowledge there was no reduction in risky sexual behavior ( $p > 0.05$ ) (Norbu et al., 2013). Similar trends can be witnessed in the Chinese study among medical students where it was observed that apart from knowledge, other factors such as sociodemographic characteristics, sexual behavior, HIV/AIDS, and STIs related patterns play a key role in medical student attitude and behavior towards HIV/AIDS, STIs and people affected by these diseases (Kuate et al., 2016). The Debre Birhan study also agrees with this trend of events as seen in the conclusion that even though most of the respondents had knowledge about STIs, still there were misconceptions and their practice remained quit low (Adera, 2015).

It is not all gloom as far as attitude and practice towards STIs are concerned. In the Shone study of 2014, only 15.18% had a negative attitude towards STIs. About 42.20% of the respondents did not agree with the idea that having a history of STIs increases risk of acquiring HIV/AIDS and 27.70% had not agreed with the fact that condom use can prevent STIs. About 41.25% had

practiced sexual intercourse, 1.60% of them had practiced with commercial sex workers, and only 71.2% of these used a condom. Sexually transmitted infections prevention practice was higher among respondents who had good sexually transmitted infections knowledge (AOR [95%CI] =1.76[1.74, 4.21]) and those who had positive attitude towards sexually transmitted infection (AOR [95%CI] =2.91[2.48, 5.72]) (Gemechu Kejela, 2015).

The Katanga slum study in Kampala, Uganda by Nawagi in 2014 concluded that; most of the respondents did not follow the appropriate behavior patterns despite being knowledgeable about the various methods of prevention of STIs (Nawagi, 2014).

## **CHAPTER THREE: METHODOLOGY**

### **3.0. INTRODUCTION**

This chapter dealt with the different tools used in population selection and sampling, study design, data handling and all the determinants of study feasibility. The study design, study area, study population, selection criteria, sampling technique, sample size determination, data collection and ethical considerations were dealt with here.

#### **3.1.STUDY DESIGN**

A descriptive study design was used which applied both qualitative and quantitative approaches in data collection.

#### **3.2.STUDY AREA**

The study area was Bugolobi Town in Uganda.

#### **3.3.TARGET POPULATION**

Youths (Persons between the ages of 15 – 35 years as per the African Youth Charter, 2006 African Union Reference).

#### **3.4.STUDY POPULATION**

All youth (both male and female) of Bugolobi Town in Uganda.

#### **3.5. SELECTION CRITERIA**

##### **3.5.1. INCLUSION CRITERIA**

- All youths of Bugolobi Town who were willing and who gave their consent took part in the study.

##### **3.5.2. EXCLUSION CRITERIA**

- Any youth who refused to offer consent were excluded.

#### **3.6.SAMPLING TECHNIQUE**

Consecutive enrollment technique was used whereby study subjects were recruited as they were met, consented and as they met the inclusion criteria.

#### **3.7.SAMPLE SIZE DETERMINATION**

The sample size was determined using Fishers et al., 2006 formula i.e.  $N=Z^2PQ/D^2$ :

Where;

N is the desired sample size

Z is the standard normal deviation taken as 2.0 at a confidence interval of 95%.

P is the proportion of the study population possessing good knowledge on STIs/STDs = 92.3% (as per Nawagi et, al, 2014)

D is the degree of accuracy= 0.05.

Q= (1-P) which is the population without the desired characteristics.

Therefore,  $N= \frac{2^2 \times 0.923 (1-0.923)}{(0.05)^2} = 113.71$

**One hundred and fourteen (114) respondents will be a representative of the study population.**

### **3.8. DATA COLLECTION METHODS & TOOLS**

Data was collected using a questionnaire and entered into Microsoft excel 2016 spreadsheets and analyzed using SPSS version 17.0. Descriptive statistics were performed using absolute numbers, percentages, ranges and measures of central tendency accordingly. Data was presented in tables, graphs and charts using MS PowerPoint.

### **3.9. QUALITY CONTROL**

The questionnaire was pretested in a population with similar properties to the population under study. The researcher employed the services of two research assistants conversant to the study subject and knowledgeable of the local language to obtain as accurate information as possible.

### **3.10. LIMITATIONS & DELIMITATIONS OF THE STUDY**

The researcher tackled time and financial constraints through a rigorously followed work plan and budget. Funds were outsourced from family, friends and well-wishers.

### **3.11. ETHICAL CONSIDERATIONS**

Written approval from KIU-TRH and IREC was obtained. The purpose of study was clearly explained to the participants after which the respondents were consented both verbally and in writing and assured that all data and information obtained would be treated with utmost confidentiality and would not be used for purposes other than those approved for the research. The respondents reserved the right to participate or not to participate.

## CHAPTER FOUR: STUDY FINDINGS

### 4.0.INTRODUCTION

This chapter dealt with the findings of the study. Sociodemographic characteristics, knowledge, attitudes and practice of Bugolobi youth pertaining to STIs/STDs were tackled here.

#### 4.1.Sociodemographic Characteristics of the Respondents

Necessary information on the study was given to the participants, including purposes and procedures. It was explained that participation was voluntary and that information given by the respondents would be protected. A total of 114 youths took part in the study making a response rate of 100%. Of these, 67(58.77%) were males and 47(41.23%) females giving a male to female ratio of 1.4:1. The age of the respondents ranged from 15 to 26 with mean of 18.61 and standard deviation of  $\pm 1.89$ . Majority 98 (85.97%) were single while the rest were married. Majority of the respondents 88(77.19%) were catholic, 12(10.53%) protestant and 4(2.28%) Muslim. 8 (7.02%) were still in primary school, 81 (71.05%) in secondary school, 12(10.53%) in post-secondary school. Only 3 (2.63%) had completed primary level, 7 (6.14%) had completed secondary level and 3(2.63%) post-secondary education. None hadn't gone to school completely. (Table 1)

|                   | <b>Variable</b>    | <b>Number (Percentage)</b> |
|-------------------|--------------------|----------------------------|
| Sex               | Male               | 67(58.77%)                 |
|                   | Female             | 47(41.23%)                 |
| Age (years)       | 15 – 19            | 84(73.68%)                 |
|                   | 20 – 24            | 29(25.44%)                 |
|                   | 25 – 29            | 1(0.88%)                   |
|                   | 30 – 34            | 0(0%)                      |
|                   | 35 and above       | 0(0%)                      |
| Religion          | Catholic           | 88(77.19%)                 |
|                   | Protestant         | 12(10.53%)                 |
|                   | Muslims            | 4(12.28%)                  |
|                   | Others             | 0(0%)                      |
| Marital Status    | Single             | 98(85.95%)                 |
|                   | Married            | 16(14.05%)                 |
| Educations Status | Still in Primary   | 8(7.02%)                   |
|                   | Still in Secondary | 81(71.05%)                 |



|  |                          |            |
|--|--------------------------|------------|
|  | Still in Post-secondary  | 12(10.53%) |
|  | Completed Primary        | 3(2.63%)   |
|  | Completed Secondary      | 7(6.14%)   |
|  | Completed Post-secondary | 3(2.63%)   |
|  | None                     | 0(0%)      |

Table 1: Socio-demographic Characteristics of the Youth of Bugolobi, 2018 (N=114)

**4.2. Knowledge of Bugolobi Youth**

Out of the total 114 youths 112 (98.25%) of them had heard about and were aware of STIs and the sources of their information were radio/TV 53(47.32%), school 44(39.47%), from both radio/TV and school 12(10.71%) and other source 3(2.68%). About 64(57.14%) of the respondents knew Gonorrhoea, 25(22.32%) knew syphilis, 6(5.36%) knew chancroid, 5(4.46%) knew Lymphogranuloma Venerum (LGV), 8(7.14%) mentioned all the above while 4(3.57%) mentioned others HIV/AIDS included.

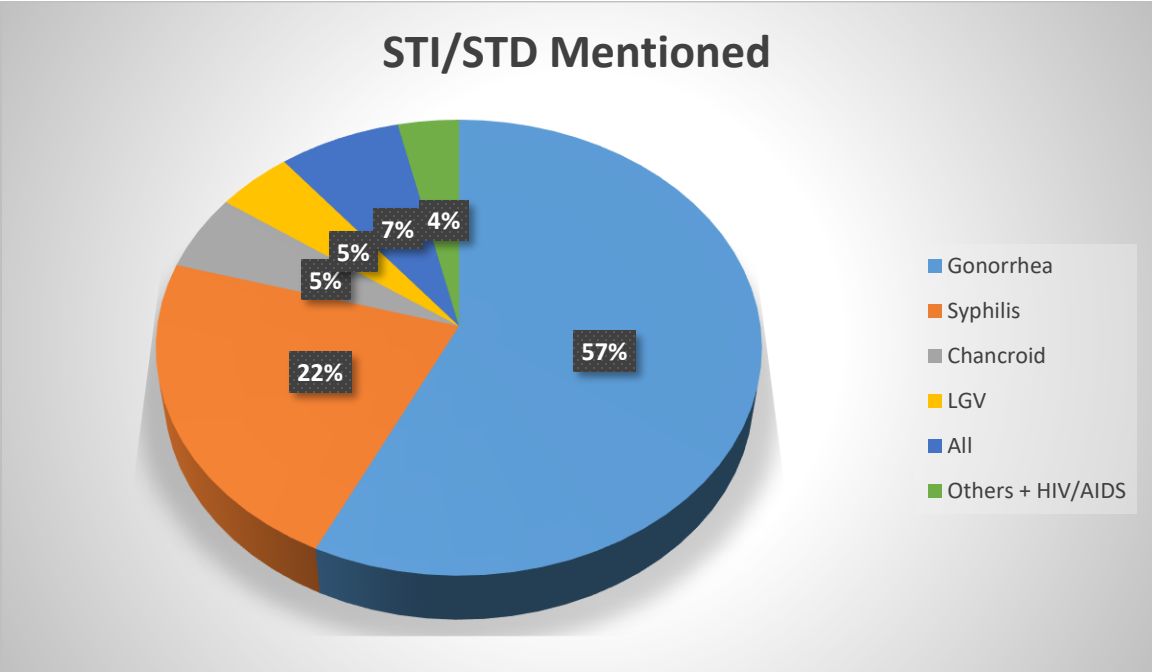


Figure 2: STIs Mentioned by Youth in Bugolobi, 2018 (N=112)

Of the 112 (98.25%) who had heard about STIs, 106(94.64 %) of them were aware of the signs and symptom of STIs. Among the signs and symptoms of STIs mentioned were; lower abdominal pain in females, burning sensation on urination, redness on genital area, discoloration of urine, Vaginal discharge in females, urethral discharge in males, menstrual abnormality in females,

impotence and scrotal swelling in males. Respondents were to mention as many signs and symptoms as they knew them (Table 2)

| <b>Sign &amp; Symptom</b>          | <b>Frequency</b> | <b>Percentage (%)</b> |
|------------------------------------|------------------|-----------------------|
| Lower Abdominal pain in Females    | 54               | 50.94                 |
| Burning sensation on urination     | 82               | 77.36                 |
| Redness & soreness of genitalia    | 17               | 16.04                 |
| Discoloration of urine             | 14               | 13.21                 |
| Vaginal/urethral discharge         | 102              | 96.23                 |
| Menstrual abnormalities in females | 25               | 23.59                 |
| Impotence in males                 | 4                | 3.77                  |
| Scrotal swelling in males          | 18               | 16.98                 |

*Table 2: Signs and Symptoms of STIs/STDs Mentioned by Bugolobi Youth, 2018 (N=106)*

#### **4.3. Attitude of Bugolobi youth towards STIs/STDs**

Despite unanimously agreeing that anyone could contract STIs, the attitude of the youth was negative in that none of them thought that they could contract STIs. The reasons for this erroneous assumption was that 112(100%) stated that STIs only afflicted sexually promiscuous individuals such as sex traders and truck drivers and they were none of those. None of them thought they were at any risk of contracting an STI despite a majority of them being sexually active.

On the different methods of prevention against STIs, 32(28.57%) mentioned abstinence, 30(26.79%) mentioned condoms, 45(40.18%) mentioned faithfulness to one partner while 7(6.25%) mentioned avoidance of contact with high risk individuals. (Figure 3)

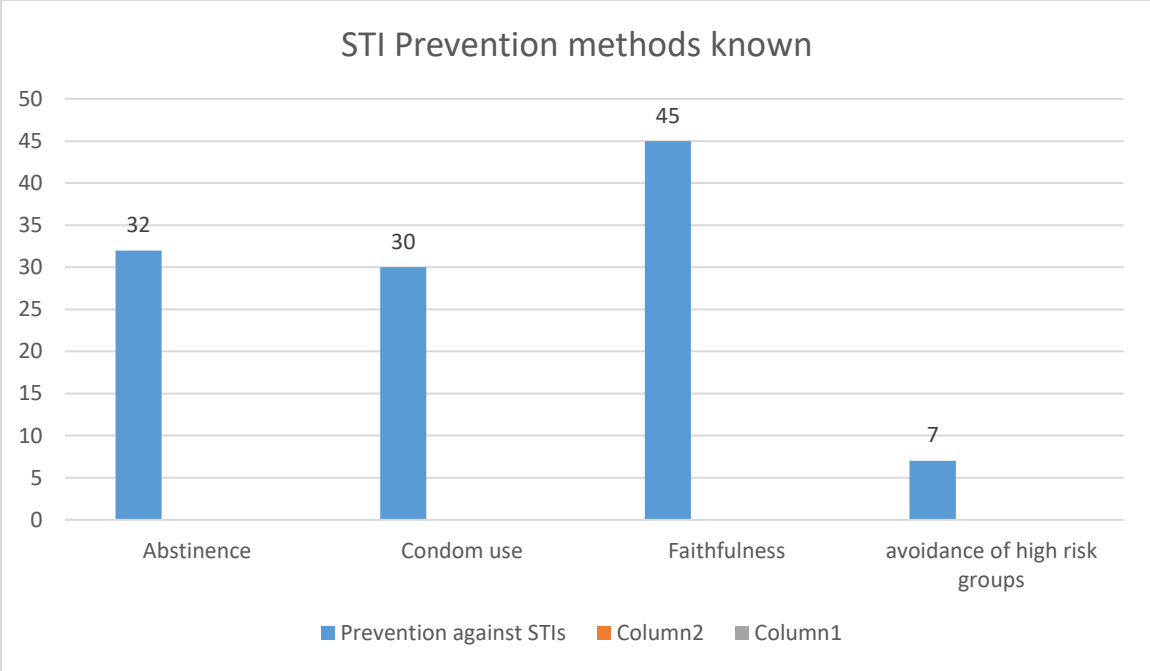


Figure 3: STI Prevention methods known by Bugolobi youth, 2018 (N=112)

On the question whether one with an STI/STD was at an increased risk of contracting HIV/AIDS, only 50(44.64%) agreed while the rest (55.36%) did not think so. (Figure 4)

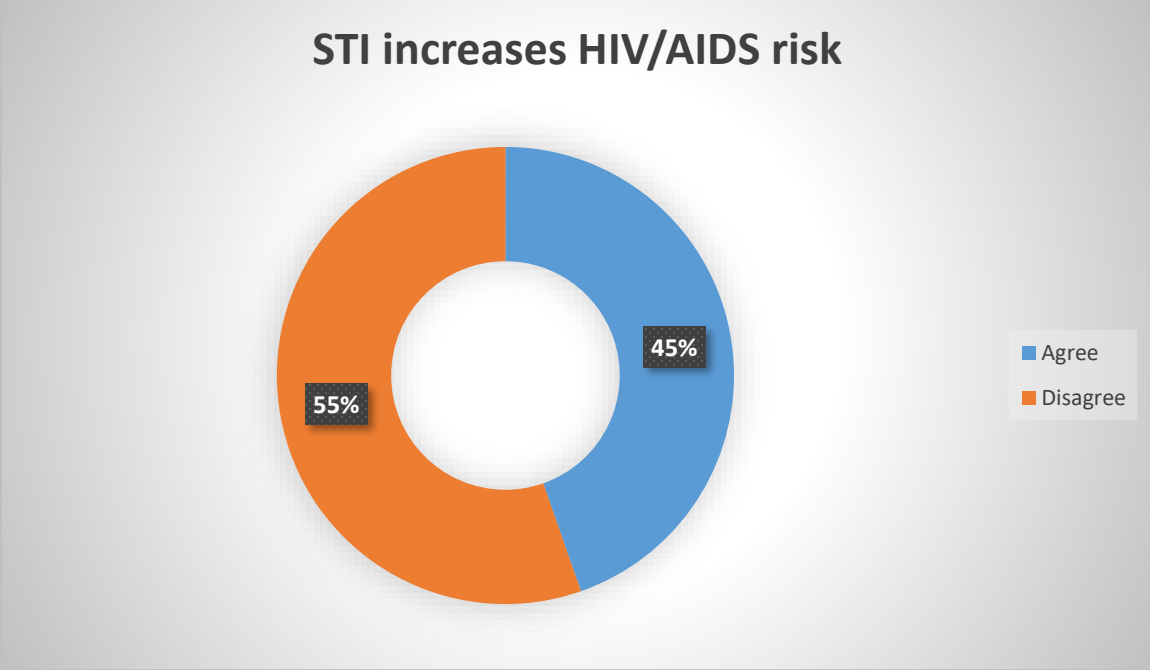


Figure 4: Bugolobi Youth's Thoughts on STI infection and risk of HIV/AIDS

**4.4.Practice of Bugolobi youth pertaining STIs**

Out of the 114 respondents 48(42.11%) had a history of sexual intercourse and the rest had none. All of those with a positive history had had their sexual debut before the age of 15 years, the

youngest being 9 and the oldest 14 years. 18(15.79%) stated having had sex with someone other than their main sexual partner and those who were still sexually active at the time of the study had had only one sexual partner in the last six months. 4(3.51%) of the respondents, who were all male, stated that they had ever had casual sexual intercourse with a stranger (sex worker) but stated that they all used protection at the time (condoms). 14(12.28%) of the respondents (2 males and 12 females) agreed to have had sexual intercourse for material gain. All the 2 males stated that they used a condom during the act whereas 8(66.67%) of the females who agreed to indulging in sexual intercourse for material gain stated that no protection was used leaving only 4(33.33%) of the females who had ensured that their male partner used protection (condom). None of those who had had sexual intercourse with strangers knew their or their partners' HIV sero-status.

Of the sexually active youth who had never had sexual interactions with strangers (30), 12(40%) stated that they long stopped using any protection with their partners but ensured that contraceptive measures were used. On the question on why this was so, all stated trusting their partners but only 8(66.67%) knew both the partners' and their own HIV sero-status. None of the remaining 18 knew their sero-status nor their partners'.

The 66(57.90%) who were not sexually active had chosen total abstinence, while of the sexually active, 28(58.33%) of the 48 all used condoms. None mentioned being faithful as a strategy for prevention of contracting STIs/STDs.

On what they would do if they noticed that they had developed signs and symptoms indicative of an STI/STD, all (100%) said that they would quickly seek medical assistance and thought it appropriate that their sexual partner(s) should also be treated. (Table 3)

|  | <b>Variable and frequency</b>  | <b>Percentage (%)</b>              |
|--|--|------------------------------------|
| History of sexual intercourse<br>(N=114) | YES: 48<br>NO: 66  | 42.11<br>57.89                     |
| Age at sexual debut (N=48)               | < 15 years: 48<br>>15 years: 0<br>Youngest: 9 years (3 respondents)<br>>9 but < 14 years: (37 respondents)<br>Oldest: 14 years (8 respondents) | 100<br>0<br>6.25<br>77.08<br>16.67 |
| Sex with strangers (N=48)                | With sex workers: 4 (all male)<br>For material gain: - 2 males   | 8.33<br>4.17                       |

|   |  |                    |
|---|--|--------------------|
|   | - 12 females                               | 25.0               |
| Protection use (N=48)   | With sex worker: 4 (all male)              | 8.33               |
|   | For material gain: 6 (2 males & 4 females) | 12.50(4.17 & 8.33) |
|   | With main partner: 18                      | 37.50              |
| Protection used (144)   | Total abstinence: 66                       | 57.90              |
|   | Condoms: 28                                | 24.56              |
|   | Being faithful:0                           | 0                  |
| Knowledge of HIV status (N=48)  | With sex worker: 0                         | 0                  |
|   | For material gain: 0                       | 0                  |
|   | With main partner: 8                       | 16.67              |
| If with signs & symptoms indicative of STI/STD, what would they do (N=48) | Seek medical advice: 48                    | 100                |
|   | Do nothing: 0                              | 0                  |
| What of the partner?  | Treated too: 48                            | 100                |

Table 3: Practice of Bugolobi youth concerning STIs

## **CHAPTER FIVE: DISCUSSIONS OF THE STUDY FINDINGS**

### **5.0. INTRODUCTION**

This chapter dealt with the discussions, conclusions and recommendations of the study findings.

#### **5.1. DISCUSSIONS**

In this study, knowledge towards STIs was good. 98.25% of the respondents had heard about STIs with knowledge on the most common causes of STIs being known. Their knowledge on the common signs and symptoms of STIs was adequate, with all mentioning correctly the signs and symptoms. Of concern though was the fact that most of the respondents did not view HIV/AIDS as common STI/STD. The knowledge level was impressively higher than most studies reviewed. For instance, it was higher than that found among Chinese medical students (95.67%) in 2016 (Kuate et al., 2016), truck drivers in Punjab Pakistan (76%) (Ishtiaq et al., 2017), and even higher than that among undergraduates in Mumbai (Ha, 2013). It was also better than that among students in Palau Pinang in Malaysia (Anwar, Sulaiman, & Khan, 2010), dwellers of rural Districts of Bhutan (Norbu et al., 2013), Ado Ekiti in Southwestern Nigeria (Amu et al., 2015). Of more importance, closer home, it was better than that among residents of Katanga slum in Kampala Uganda (Nawagi, 2014). This difference in knowledge level could be attributed to different population dynamics involved in the several populations studied, different interventional programs instituted in terms of STI/STD awareness creation through the various sources of information, or merely just from the passage of time. Of much emphasis, is the difference in socio-economic status and education level between the Bugolobi youth and the slum dwellers of Katanga. The hardships faced in a slum would make them not have access to the various sources of information on STIs/STDs such as radios, televisions, internet, newspapers among others.

Despite the impressive knowledge level, the youth of Bugolobi had a negative attitude which affected their practice towards STI/STD prevention. Most did not think they were at risk of contracting STIs/STDs since most thought that these were only afflictions of the sexually promiscuous! Of more concern was the fact that most (55.36%) did not think that STIs/STDs increased one's risk of contracting HIV/AIDS. For these reasons, their practices as pertains to STI prevention, leaves a lot to be desired.

Close to half (42.11%) of the youth of Bugolobi were sexually active, with ages of sexual debut below 15 years and with some as early as 9 years. 18 (15.79%) of the youth of Bugolobi had had sex with strangers (sex workers) and for material gain. This totals to about 37.55% of all the

sexually active (48). This a large proportion of youth indulging in risky sexual behavior. What makes it more alarming is the fact that 20 (41.67%) of the sexually active were not using any form of protection, including those females who had indulged in sexual intercourse for material gain. Compounding the problem even more is the fact that only 8 (16.67%) of all the sexually active youth were aware of their or their partners' HIV status. This kind risky behavior exposes them to contracting STIs/STDs, HIV included.

The negative attitude and poor practice is not isolated to the Bugolobi youth. The study findings mirror those found in several places where similar studies have been conducted. Among students in a Mumbai college in 2013 for instance, preventive sexual practices were found to be worrying. HIV/AIDS and other STIs/STDs campaigns seemed to have been neglected(Ha, 2013). In Bhutan, similar worrying trends were evident as evidenced by the fact that 33.33% of the population were practicing risky sexual behavior with 31,2% having had sexual relations with non-regular partners with less than regular (50.9%) use of condoms with these partners(Norbu et al., 2013). A similar alarming trend was also evident in the Debre Birhan study(Adera, 2015).

All is not gloom though. Encouraging findings have been gotten in places like Shone. In a study in Shone, 84.82% of the population had a positive attitude towards STIs despite a large portion (42.20%) disagreeing that STIs increased one's risk of contracting HIV(Gemechu Kejela, 2015). Still, the 41% of the sexually active in our study is almost equal to that of the Shone study (41.25%). This could reflect on the similarities in culture between the two populations as far as beliefs around sexual practices and ages at sexual debut. The difference comes in in the proportion of those who had had sexual relations with sexual workers. The Shone population's was lower (1.60%) compared to Bugolobi's 8.33%. This could be a reflector on the cultural and/or religious restrictions of the Shone people. Overall, Shone's prevention strategies were higher than in our study(Gemechu Kejela, 2015), maybe due to their higher level of knowledge on STIs/STDs.

The Katanga slum dwellers of Kampala were also found to have inappropriate behavior patterns as far as STIs/STDs and prevention(Nawagi, 2014). These results were similar to those in our study. This could be a reflection on regional and cultural similarities between the Katanga population and the Bugolobi population, both being from Uganda.

## **CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS OF THE STUDY**

### **6.0.INTRODUCTION**

This chapter deals with the conclusions derived from the study findings and recommendations made to the various stakeholders.

#### **6.1.CONCLUSIONS**

Despite the youth of Bugolobi having satisfactory knowledge level concerning STIs/STDs, their attitude, and consequently practices, are wanting. Still a lot needs to be done to convert the knowledge into attitude change and appropriate practices.

#### **6.2. RECOMMENDATIONS**

From the study findings and conclusions derived, the researcher recommends the following to the various stakeholders:

##### **6.2.1. To the Youth of Bugolobi**

1. Translate their impressive knowledge concerning STIs/STDs into attitude change and proper preventive practice.
2. Refrain from practices that encourage early sexual debut given the risks that come from their sexual naivety and inexperience.
3. Embrace protection use (condoms) during every sexual encounter despite familiarity with the sexual partner and ensure knowledge of both their HIV/AIDS sero-status.

##### **6.2.2. To the Health Care Providers and other Players in the Reproductive Health Sector**

1. Conduct more reproductive health outreaches, campaigns and seminars geared at influencing attitude change and practice improvement concerning STIs/STDs with special emphasis on the role played by STIs/STDs as gateway for contraction of HIV/AIDS.
2. Increase supply of free condoms particularly in hotspot areas such as institutions, bars and lodgings and brothels and encourage their use.
3. Step up free and voluntary HIV/AIDS screening drives and educate the youth on the importance of knowing one's and one's partner's status at all times.



### **6.2.3. To the governing Authorities and Ministry of Health**

1. Avail funds and resources towards step up of reproductive health campaigns with emphasis on STIs/STDs, and protective devices (condoms) supply.
2. Institute more awareness creation avenues such as adverts in the main media, print media, social platforms, posters, and banners by the Ministry of Health targeting specifically the youth and advocating behavior change.

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## APPENDICES

### APPENDIX ONE: WORK PLAN

| S/N | Activity                        | Months in the year 2017 & 2018 |                     |                     |             |                     |                       |             |
|-----|---------------------------------|--------------------------------|---------------------|---------------------|-------------|---------------------|-----------------------|-------------|
|     |                                 | Aug<br>2017                    | Sep-<br>Oct<br>2017 | Nov/<br>Dec<br>2017 | Jan<br>2018 | Feb/<br>Mar<br>2018 | Apr –<br>July<br>2018 | Aug<br>2018 |
| 1   | Identification of the proposals |                                |                     |                     |             |                     |                       |             |
| 2   | Proposal writing and approval   |                                |                     |                     |             |                     |                       |             |
| 3   | Data collection and analysis    |                                |                     |                     |             |                     |                       |             |
| 4   | Report writing and binding      |                                |                     |                     |             |                     |                       |             |
| 5   | Final report submission         |                                |                     |                     |             |                     |                       |             |

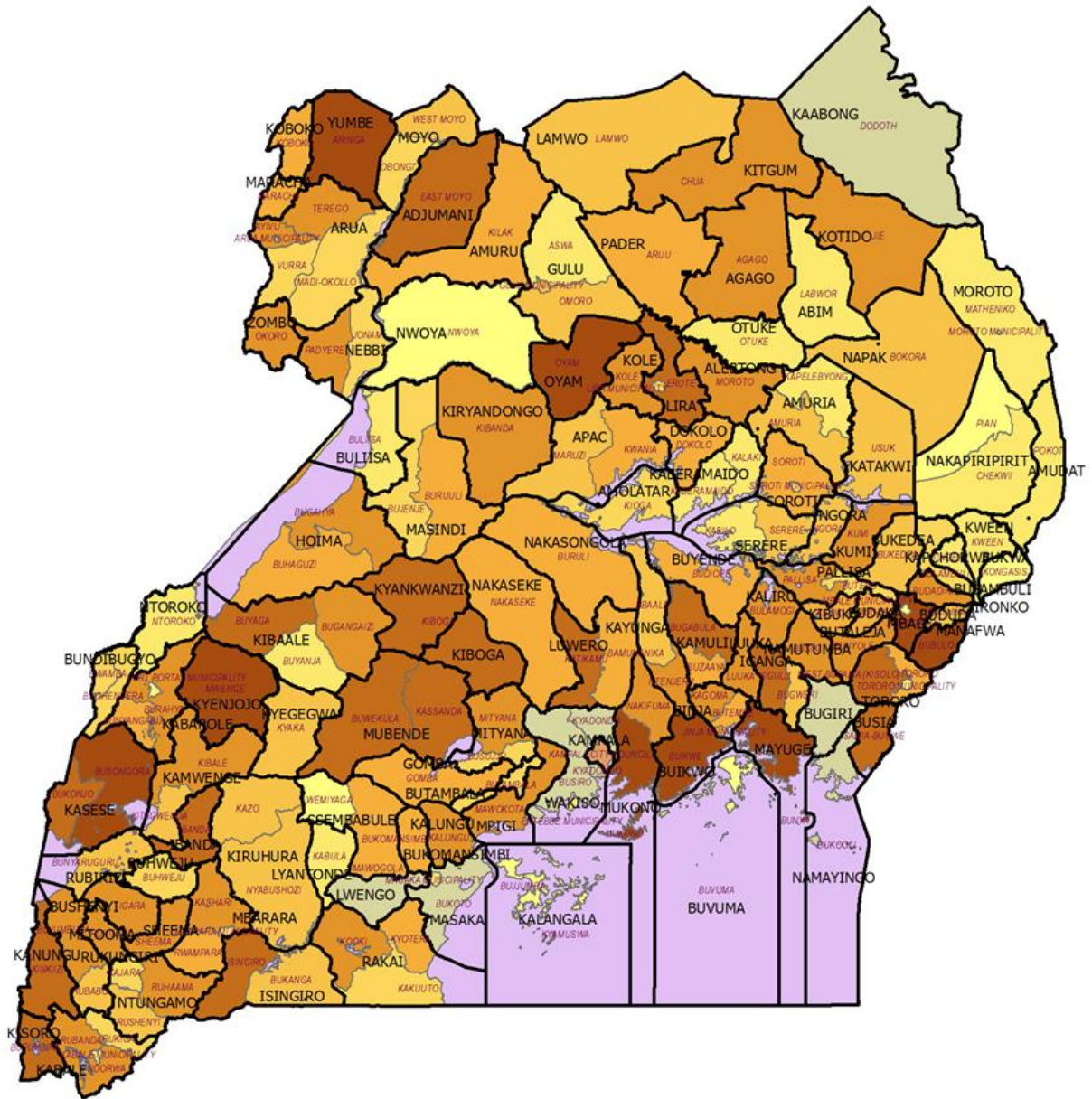
## APPENDIX TWO: BUDGET

| S/N      | Item                                    | Quantity | Unit price | Total cost     |
|----------|---|----------|------------|----------------|
| <b>1</b> | <b>Stationary</b>                       |          |            |                |
| A        | Photocopying Reams Paper                | 3        | 18000      | 54,000         |
| B        | File Folders Pieces                     | 2        | 2000       | 4,000          |
| C        | Flash disk                              | 1        | 40000      | 40,000         |
| D        | Pens                                    | 5        | 1000       | 5,000          |
|          | <b>Sub total</b>                        |          |            | <b>103,000</b> |
| <b>2</b> | <b>Typing Services</b>                  |          |            |                |
| A        | Questionnaire                           | 30       | 400/=      | 12,000         |
| B        | Proposal Copies                         | 3        | 20,000/=   | 60,000         |
| C        | Report Copies                           | 4        | 20,000/=   | 80,000         |
|          | <b>Sub total</b>                        |          |            | <b>152,000</b> |
| <b>3</b> | <b>Data Collection</b>                  |          |            |                |
| A        | Transport (To and from study area) Days | 3        | 120,000    | 120,000        |
| B        | Lunch Days                              | 3        | 20,000     | 20,000         |
| C        | Literature Search (Libraries, internet) | 5        | 150,000/=  | 300,000        |
|          | <b>Sub total</b>                        |          |            | <b>440,000</b> |
|          | <b>Grand Total</b>                      |          |            | <b>592,000</b> |

APPENDIX THREE: MAP OF UGANDA

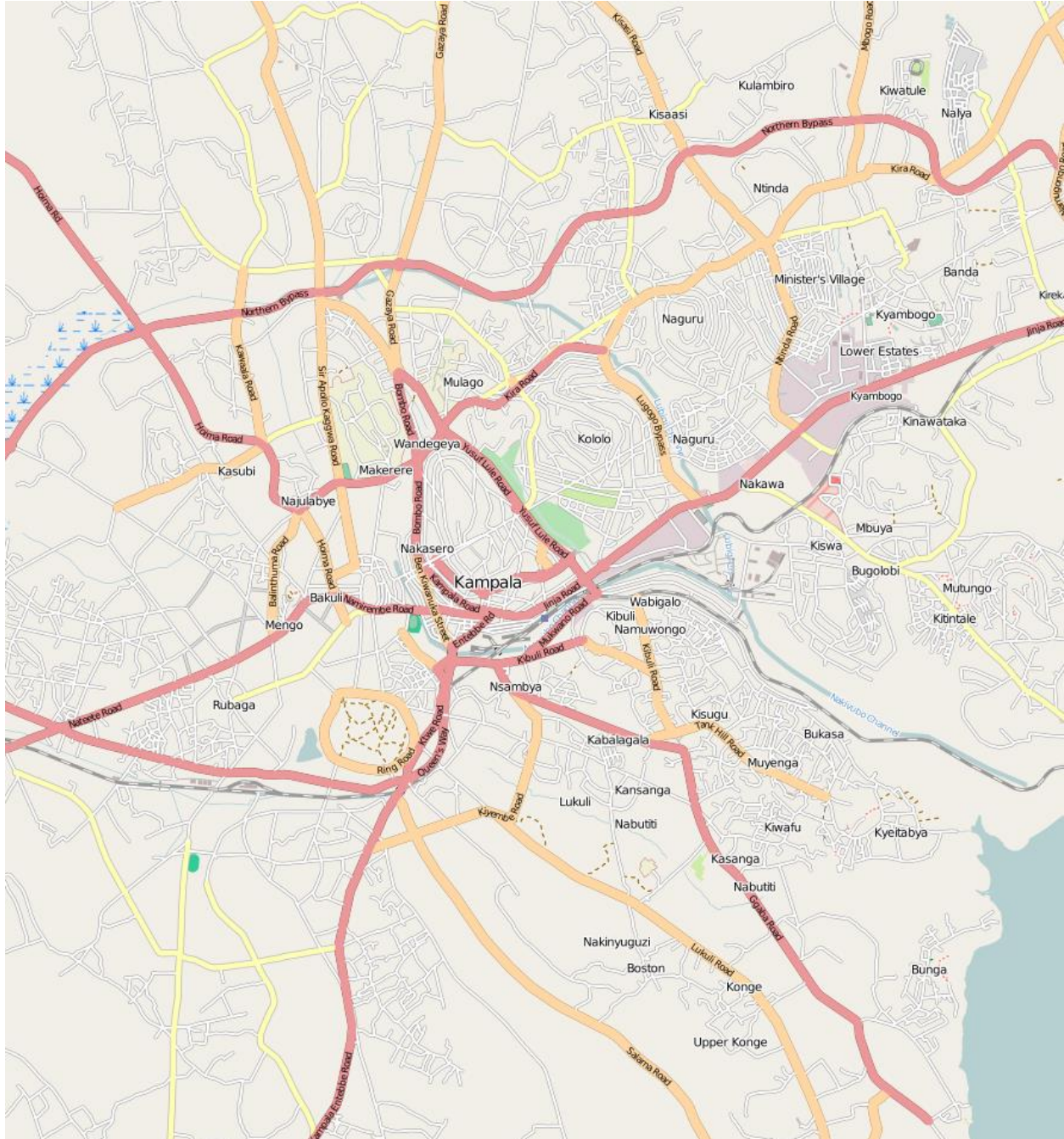


**APPENDIX FOUR: MAP OF THE DIFFERENT REGIONS OF UGANDA**





## APPENDIX FIVE: MAP OF KAMPALA



**APPENDIX SIX: MAP SHOWING BUGOLOBI TOWN**



**APPENDIX SEVEN: CONSENT FORM**

**CONSENT FORM**

**STUDY TITLE:** ASSESSMENT OF KNOWLEDGE, ATTITUDE AND PRACTISES ON SEXUALLY TRANSMITTED DISEASES/INFECTIONS AMONG THE YOUTHS IN BUGOLOBI TOWN, JANUARY 2018.

I do hereby willingly consent to take part in this study as explained to me by ..... (Name of interviewer).

Signature of respondent ..... Date .....



**MAIN SECTION**

**A. Knowledge**

1. Have you ever heard about STD/STIs?      YES                       NO

2. If yes (to 1 above), where did you hear about them from?

Television       Radio                       Newspapers       School

Friends

Others (specify) .....

3. Which STIs / STDs do you know (name as many as you know)

.....  
.....  
.....

4. What are the various symptoms of STIs / STDs? (mention as many as you know)

.....  
.....  
.....  
.....

**B. Attitude**

5. Who is most at risk of contracting STDs / STIs? .....,

.....  
.....  
.....

6. Do you think you are at risk of contracting an STI/STD?

YES                       NO

If no (to 5 above), why do you think not? .....

7. What can one / you do to avoid contracting sexually transmitted diseases?

Use of condoms

Be faithful

Abstinence

Others (specify) .....

8. What would you do if you found out that you have an STI/STD? .....

.....  
.....

9. Do you think that a person infected with an STI/STD is at a higher chance of contracting HIV/AIDS?

YES  NO

**C. Practice**

10. Have you ever had sexual intercourse? YES  NO

11. If yes (in 9 above), at what age was your first sexual intercourse? .....

12. Have you ever had sexual intercourse with other than your main sexual partner (e.g. boyfriend/girlfriend, spouse)? YES  NO

13. How many sexual partners have you ever had in the past 6 months? .....  
.....

14. Have you ever had sexual intercourse with a stranger?

YES  NO

If yes to 14. Above, did you use any sort of prevention?.....

15. Have you ever had sexual intercourse for any sort of gain, financial or otherwise?

YES  NO

If yes to 15. Above, was any protective measure used? .....

16. Do you think that infection with STIs/STDs increases one's risk of contracting HIV/AIDS? .....

17. What would you do if you developed signs and symptoms indicative of STI/STD?

.....  
.....  
.....

18. Do you think that your current sexual partner(s) need to be treated too if you had signs or symptoms of STI/STD? YES  NO

19. If yes (to 14 above), mention the ones you know .....  
.....  
.....

20. Have you ever used any?

YES  NO

21. If yes (to 16 above), which ones have you ever used?

Condoms

Faithfulness

Abstinence

Others (specify) .....

22. If no (to 16 above), why don't you use any of the preventive measures?

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.....  
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23. Do you have anything else you want to add, ask for clarification or add to what you have said?

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THANK YOU