

ORIGINAL RESEARCH ARTICLE

Treatment seeking behaviours for sexually transmitted infections among young adults in Ekurhuleni East, Gauteng, South Africa: a qualitative study

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Abstract

This study explores the treatment-seeking behaviours for Sexually Transmitted Infections (STIs) among young adults in Ekurhuleni East, Gauteng, South Africa. Using qualitative methods, data was collected through in-depth interviews with 30 participants aged between 18-39 years who have been diagnosed with STIs. Data analysis was conducted using Braun and Clarke's six-step thematic analysis, identifying key barriers to treatment seeking such as stigma, employment-related constraints, financial dependency, and health literacy, as well as facilitators like social support, healthcare access during pregnancy, and personal health concerns. Participants' health-seeking experiences highlighted challenges in accessing health care, behavioural changes post-diagnosis, and varying adherence to prescribed treatments. While some completed treatment as instructed, others discontinued early due to symptom relief. The findings emphasize the need for improved health literacy, stigma reduction, and integrated STI care to enhance timely treatment-seeking and adherence. Strengthening community support and youth-friendly health services could further improve outcomes for STI management in this population. (*Afr J Reprod Health* 2026; 30 [7]: 15-28).

Keywords: sexually transmitted infections, treatment seeking behaviours, barriers, health

Résumé

Cette étude explore les comportements de recours aux soins pour les infections sexuellement transmissibles (IST) chez les jeunes adultes d'Ekurhuleni Est, dans la province du Gauteng, en Afrique du Sud. Une méthode qualitative a été employée pour recueillir des données auprès de 30 participants âgés de 18 à 39 ans ayant reçu un diagnostic d'IST, au moyen d'entretiens approfondis. L'analyse des données a été réalisée selon la méthode d'analyse thématique en six étapes de Braun et Clarke, identifiant les principaux obstacles au recours aux soins, tels que la stigmatisation, les contraintes liées à l'emploi, la dépendance financière et le niveau de connaissances en santé, ainsi que les facteurs facilitant le recours aux soins, comme le soutien social, l'accès aux soins pendant la grossesse et les préoccupations de santé personnelles. Les expériences de recours aux soins des participants ont mis en lumière les difficultés d'accès aux soins, les changements de comportement après le diagnostic et l'observance variable des traitements prescrits. Si certains ont suivi le traitement jusqu'au bout, d'autres l'ont interrompu prématurément en raison d'un soulagement des symptômes. Les résultats soulignent la nécessité d'améliorer les connaissances en santé, de réduire la stigmatisation et de mettre en place une prise en charge intégrée des IST afin de favoriser un recours aux soins plus rapide et une meilleure observance thérapeutique. Le renforcement du soutien communautaire et des services de santé adaptés aux jeunes pourrait améliorer davantage la prise en charge des IST au sein de cette population. (*Afr J Reprod Health* 2026; 30 [7]: 15-28).

Mots-clés: infections sexuellement transmissibles, recours aux soins, obstacles, santé

Introduction

Treatment seeking behaviours are decisions to take action or not by a person who believes they have a health issue. In general, treatment seeking behaviour refers to health behaviour demonstrated by actions performed to preserve health or stop

illness from developing.¹ Delayed or inappropriate treatment for STIs increases the risk of human immunodeficiency virus (HIV) acquisition and may cause other harmful outcomes.²

Many young people lack the knowledge they need about STIs and sexual health, and they also fail to seek prompt, official medical attention.³

This indicates that many young people continue to put off seeking urgent STI care. The study further states that young people consistently voiced a need for more comprehensive sexual health education while also highlighting significant barriers to accessing it. These obstacles often stemmed from parents and healthcare providers who feared the topic or viewed it as taboo, hindering open discussions. In addition, another study found a relatively low prevalence of self-reported STIs among adolescent girls and young women.⁴ Youth in low- and middle-income countries experience significant barriers in health seeking for STIs and often do not seek or postpone medical care. Improving the uptake may require addressing clinic systems, provider attitudes, confidentiality, and cultural norms related to youth sexuality.³ Treatment of those engaged in sexual interactions is crucial to breaking the cycle of STIs.⁵

Globally, more than a million STIs are acquired every day (World Health Organization).⁶ Individuals aged 15 to 49 have the highest rates of STI infection. In 2016, 127.2 million new cases of chlamydia, 86.9 million new cases of gonorrhoea, 156 million new cases of trichomoniasis, and 6.3 million new cases of syphilis were recorded.⁷ South Africa has the highest STI burden in the world. In 2017, an estimated 23,175 new cases of syphilis, 4.2 million instances of chlamydia, and 6.2 million cases of gonorrhoea were reported.⁸ At the same time, 8.5% of Uganda's key populations had syphilis.⁹ In the African region, 58% of women receiving antenatal care have their syphilis checked.¹⁰

STIs are a variety of clinical diseases brought on by microorganisms that are acquired and transmitted through sexual contact.¹¹⁻¹² The chance of contracting HIV is increased by STIs such as herpes, gonorrhoea, and syphilis.¹³ Pregnant women who have STIs run the risk of major complications such as stillbirth, neonatal mortality, low birth weight, preterm, sepsis, newborn conjunctivitis, and congenital malformations. STIs can lead to major morbidity, such as cancer, infertility, pregnancy problems, and accelerated HIV transmission.¹⁴⁻¹⁵ If STI testing and treatment are introduced, many of these problems can be avoided.¹⁶ In both urban areas and rural or underserved areas, STIs can increase prenatal,

delivery, or postnatal sickness and death.¹⁷ Furthermore, absolute incident cases grew between 1990 and 2019, although most nations had declines in age-standardised incidence rates for STIs. STIs are a global public health concern that needs greater attention and health prevention services, particularly in sub-Saharan Africa (SSA) and Latin America.¹⁸

Stigma and the fear of being judged are obstacles that prevent females from telling their partners about their condition.¹⁹ It has been noted that this significantly contributes to the burden of death and illness, as STIs have significant psychosocial repercussions for both the individual and the community.²⁰ STIs continue to be a severe societal disease that has a considerable influence on people's attitudes. In most communities, STIs are viewed as a source of shame and stigma. Most studies are focused on STIs, little is known about treatment seeking behaviours for STI in young adults; hence, this study aimed at exploring treatment seeking behaviours for STI in young adults in Ekurhuleni East sub-district. The findings of this study hope to contribute to the body of knowledge at large and influence the policy makers regarding the treatment seeking behaviours thus, improving the health of young adults.

Methods

Study design and setting

In this study, a qualitative research approach was employed, using an exploratory and descriptive design. This methodological choice was made to enable the researcher to gain a deeper understanding and obtain rich, detailed information on the topic under investigation. The study was conducted at five public healthcare facilities in the Ekurhuleni East sub-district, Gauteng Province, South Africa, comprising four community health centres and one primary healthcare clinic. All Ekurhuleni's healthcare facilities offer integrated services, allowing a patient to be treated for HIV and other disorders by a single clinician, usually a nurse.²¹ Patient headcounts are 5,000 monthly at municipally run primary care clinics from 07H30am to 16H30pm. In contrast, headcounts are >5000 per month at larger provincially

administered community health centres (CHCs) that operate 24 hours and have a specialist family physician on-site to support health services delivery. Data saturation was achieved after 24 interviews, as participants provided similar responses with no new information emerging. However, the researcher conducted an additional six (6) interviews to confirm data saturation, resulting in a total sample size of 30 participants. The study population consisted of both male and female participants aged 18 to 39 years who had previously been diagnosed with STIs. Participants were required to have received healthcare services from the selected healthcare facilities.

Data collection

Data collection took place from July to August 2024. The researcher approached potential participants, provided a detailed explanation of the study's objectives, and obtained informed consent from those who agreed to participate. Prior to the main data collection process, a pilot study was conducted with four participants to refine the interview guide. Each interview lasted approximately 45 minutes. Purposive sampling was employed in this study. This approach was selected to investigate treatment-seeking behaviours for STIs among young adults in Ekurhuleni East. Semi-structured face-to-face interviews were utilized as the primary data collection method, guided by an interview schedule developed in alignment with the research questions and study objectives. All interviews were conducted in person at healthcare facilities for an average duration of 45 minutes.

The data collection tool was available in three (3) languages-English, IsiZulu, and Sepedi-which are the main languages spoken in the Ekurhuleni East sub-district, and the researcher was fluent in all three languages. Participants were informed and permitted to express themselves in any language of their choice during the interviews. The researcher used an audiotape recorder to ensure that all information shared during the interviews was accurately captured. All recorded responses were later transcribed, and those requiring translation were also translated. These processes were conducted by the principal researcher, Who has experience in qualitative data collection and transcription. Interviews were conducted in private

consultation rooms within the healthcare facilities to ensure privacy and minimise interruptions. Data collection occurred after participants had received STI-related services and were clinically stable. The interviews were conducted by the principal researcher under calm and confidential conditions, allowing participants to speak freely about their treatment-seeking experiences without fear of being overheard by healthcare staff or other patients. No prior relationship existed between the researcher and participants before the commencement of the study. Participants had no previous personal or professional interaction with the researcher. At recruitment, participants were informed that the interviewer was a postgraduate researcher conducting the study as part of academic research. The purpose of the study, the researcher's role, and the voluntary nature of participation were clearly explained before obtaining informed consent.

Data analysis

Thematic analysis, following Braun and Clarke's six-phase approach, was employed to analyse the data. This process involved six systematic steps: (1) familiarization with the data, (2) coding, (3) generating initial themes, (4) reviewing the themes, (5) defining and naming themes, and (6) writing up the analysis and generating a report.²² The transcribed data was labelled as Participant 1 to Participant 30; the transcripts were imported to NVivo 14 software. All transcripts were coded as they emerged and recorded as initial coding on NVivo 14. Once the coding was completed, the researcher began organising the codes into broader themes.

Trustworthiness

To assure trustworthiness, the researcher followed and used the criteria of credibility, dependability, confirmability, and transferability. The researcher gained confidence in the study phenomena through peer debriefing with the supervisors, and the researcher spent time engaging with the participants during the interviews to create trust and ensure that in-depth, quality data was acquired. Dependability was assured by maintaining an audit trail that included complete documentation of the methods and decisions made throughout the investigation.

The researcher established confirmability by using procedures to reduce personal bias and ensuring that the findings accurately reflected the participants' responses. The findings were directly related to the data by including direct participant quotes to support the themes. To ensure transferability, the researcher made sure that data analysis was done exactly, consistently, and comprehensively. The findings were directly related to the data by including direct participant quotes to support the themes. To ensure transferability, the researcher conducted data analysis precisely, consistently, and extensively, recording and systematizing everything so the reader could determine whether the method was legitimate.

Ethical considerations

This study was approved by Sefako Makgatho Health Sciences University Research Ethics Committee (SMUREC) (ref: SMUREC/H/474/2023:PG) as well as the Ekurhuleni Health District Research Committee (EHDRC) (ref: GP_202402_008). Participants gave written consent before participating in the study. All data from the database remained confidential as participants details were kept anonymous..

Results

Participants characteristics

The study consisted of 30 participants, both male and female, aged between 18 and 39 years. The mean age was 30, with a median of 32. The majority of participants were aged 30-34 years, followed by those aged 35-39 years, 25-29 years, and the least represented group was 18-24 years. In terms of gender distribution, 20 participants were female, while 10 were male. Most participants had completed Grade 12 (13 participants), followed by Grade 11 (8 participants). Additionally, four participants held a diploma, three had a degree, one had a certificate, and one participant had Grade 10. Employment status varied, with 14 participants being unemployed, 13 employed, and 3 self-employed. (Table 1)

Presentation of findings

This study identified key factors influencing treatment-seeking behaviours and health-seeking experiences among young adults diagnosed with STIs in the Ekurhuleni East sub-district. Two main themes emerged from the data analysis. The first theme, *factors influencing treatment-seeking behaviours*, highlighted both barriers and facilitators affecting participants' decisions to seek care. Barriers included stigma associated with STIs, employment-related constraints, financial dependency, and limited health literacy. Facilitators included social support from family and friends, access to healthcare during pregnancy, and personal concern for health and the wellbeing of loved ones. The second theme, *health-seeking experiences*, captured participants' encounters within healthcare facilities, behavioural changes following STI diagnosis, and treatment outcomes and adherence. Participants reported mixed healthcare experiences, ranging from pain and embarrassment to positive education and support from healthcare providers. Following diagnosis, many participants adopted safer sexual behaviours, improved communication with partners, and increased engagement in routine testing. However, while some participants adhered fully to treatment regimens, others discontinued treatment prematurely once symptoms subsided. (Table 2)

Theme 1: Barriers to seeking treatment

Participants discussed how different barriers influenced their motivation and ability to seek treatment. Their narratives indicated a similar thread of obstacles that hindered treatment-seeking, including stigma, employment, financial dependency as well as health literacy.

Sub-theme 1.1. Stigma

Participants expressed how stigma associated with STIs created feelings of shame, embarrassment, and fear of judgment, making it difficult for them to seek treatment. They felt that an STI diagnosis would label them as promiscuous or irresponsible, which hindered their willingness to visit health facilities.

Table 1: Displays the full demographic information of the 30-study participant

Participant number	Age	Gender	Highest level of education	Employment status	Relationship status	Relationship duration
Participant 1	32	Female	Grade 12	Employed	In a relationship	5 years
Participant 2	32	Female	Grade 12	Unemployed	In a relationship	5 years
Participant 3	35	Female	Grade 12	Self employed	In a relationship	1 year
Participant 4	35	Female	Grade 12	Unemployed	Married	9 years
Participant 5	31	Female	Grade 11	Self employed	Single	Not in a relationship
Participant 6	33	Female	Grade 12	Self employed	In a relationship	2 years
Participant 7	36	Male	Degree	Employed	In a relationship	10 months
Participant 8	35	Female	Grade 12	Unemployed	In a relationship	2 years
Participant 9	37	Female	Grade 11	Unemployed	Married	12 years
Participant 10	32	Female	Diploma	Employed	In a relationship	6 months
Participant 11	33	Female	Diploma	Employed	In a relationship	4 years
Participant 12	29	Female	Certificate	Unemployed	In a relationship	3 years
Participant 13	22	Female	Grade 12	Unemployed	In a relationship	2 years
Participant 14	32	Female	Grade 10	Unemployed	In a relationship	10 years
Participant 15	39	Male	Grade 11	Unemployed	Single	Not in a relationship
Participant 16	20	Male	Grade 12	Unemployed	Single	Not in a relationship
Participant 17	22	Male	Grade 11	Employed	In a relationship	5 years
Participant 18	32	Male	Grade 11	Employed	Single	Not in a relationship
Participant 19	19	Female	Grade 12	Unemployed	In a relationship	1 year, 6 months
Participant 20	22	Female	Grade 12	Unemployed	In a relationship	1 year
Participant 21	25	Female	Grade 11	Employed	In a relationship	2 years
Participant 22	36	Male	Degree	Employed	In a relationship	5 years
Participant 23	25	Male	Grade 12	Unemployed	In a relationship	1 year
Participant 24	39	Male	Diploma	Employed	In a relationship	3 years
Participant 25	31	Female	Grade 12	Employed	In a relationship	2 years
Participant 26	26	Male	Degree	Employed	In a relationship	3 years
Participant 27	29	Male	Grade 11	Employed	In a relationship	4 years
Participant 28	26	Female	Grade 12	Unemployed	In a relationship	3 years
Participant 29	35	Female	Diploma	Employed	In a relationship	2 months
Participant 30	31	Female	Grade 11	Unemployed	In a relationship	4 years

Table 2: Summary of emerged main themes and related sub-themes

Main themes	Sub-themes
1. Barriers to treatment-seeking	1.1. Stigma 1.2. Employment-related constrains, 1.3. Financial dependency, 1.4. Health literacy
2. Facilitators for treatment-seeking	2.1. Social support, 2.2. Healthcare access during pregnancy, 2.3. Concern for health
3. Health-seeking experiences	3.1. Experiences during health care access 3.2. Behavioural changes after STI diagnosis
4. Treatment outcomes and adherence after seeking health care	

Their responses went like this:

“What I can talk about is that when you have an STI, you become uncomfortable; even when you are sitting with people, you think everyone knows that

you are sick. It is like everyone can see that you are sick.” (Participant 21, 25-year-old female)

“I was ashamed because I am married. When you are married, you expect that all things to go well.

It's not easy to have conversations about STIs because...you are seen differently when you have STI." (Participant 9, 37-year-old female)

"I felt bad because the diagnosis with STI is like it indicates promiscuity, that you are an irresponsible person." (Participant 22, 36-year-old male)

Sub-theme 1.2. Employment

Some participants indicated that work obligations and the fear of missing work to attend healthcare facility appointments also posed challenges to their partners seeking treatment. Participants' partners faced difficulties balancing work responsibilities with healthcare facility visits. Their responses went like this:

"He promised to come with me when he is off on my next visit. He doesn't get time off right now, but maybe on my follow-up date, he will be available." (Participant 25, 31-year-old female)

"When he doesn't go to work, because his problem was to miss work, I assured him that when he visits the clinic, they will write him a sick note to submit at work, as proof he was at the clinic." (Participant 6, 33-year-old female).

Sub-theme 1.3. Financial dependency

Participants indicated financial constraints, including dependence on partners or lack of funds for transportation, were also barriers. In cases of reliance on their partners, participants felt restricted in their options and often faced threats or intimidation. Participants said:

"I was injected 2 times and skipped the 3rd one because I did not have taxi fare" (Participant 14, 32-year-old female).

"Because as I am not working, I am depending on him....if I insist on other things, you find that he threatens me that I will go and stay at home in the rural areas." (Participant 9, 37-year-old female).

Sub-theme 1.4. Health literacy

Participants indicated how health literacy about STIs contributed to their reluctance to seek treatment. Some initially misunderstood their symptoms for other conditions, while others lacked basic knowledge of how STIs are transmitted or treated. Participants said:

"Firstly, I thought it was something that would stop soon; I didn't think it was STI." (Participant 16, 20-year-old male).

"The thing is that they did not explain to me how I got syphilis. If they told me how you get it. I would know and be careful next time, and not do the wrong thing." (Participant 19, 19-year-old female).

"The day I got STI, I was not sure what it is. For me, I did not have a clue how one gets it." (Participant 17, 22-year-old male).

In addition, some participants indicated that they thought STI was HIV. The participants said:

"Eish! STIs, especially when you do not have much information..., I thought it was HIV." (Participant 12, 29-year-old female).

"The first thing I thought was HIV! It's HIV." (Participant 13, 22-year-old female).

"I don't know what STI is, but I know HIV." (Participant 14, 32-year-old female).

Theme 2: Facilitators for treatment-seeking

Participants also indicated different facilitators that influenced them to seek treatment, which included support from family or friends, healthcare access during pregnancy, and personal health concerns for their health and that of their loved ones.

Sub-theme 2.1. Social support

Social support from family and friends provided emotional support, encouraging participants to seek treatment despite initial hesitation or fear. Below are responses made by the participants:

"I felt lonely. It was difficult to tell my parents, but I told them, and I did not know that someone would support me the way they did." (Participant 19, 19-year-old female).

"My sister said no, it does not kill, and I was relieved. It's the same even if I were to get HIV. I was going to treat it because my mother told me that when you are dating, you face things like that, and partners do not talk, so don't be shocked when you get a disease like this, you must attend clinic" (Participant 20, 22-year-old female).

"I never share with anyone. I shared with my uncle as a man, because I never share with anyone" (Participant 22, 36-year-old male).

Sub-theme 2.2. Healthcare access during pregnancy

Several participants discovered their STIs during pregnancy check-ups, which then motivated them to seek consistent treatment to protect their babies. Pregnancy served as an opportunity for healthcare providers to identify and address STIs, encouraging participants to seek treatment for their health and the health of their unborn children. Below are the responses made by the participants:

"I never had any symptoms, and I just heard when they told me at the clinic." (Participant 14, 32-year-old female).

"At the clinic, they said it would affect the baby. I was worried when I did not take the injections because I injected 2 times and skipped the 3rd one because I did not have a taxi fare. They restarted me with treatment and said the child can be sick." (Participant 14, 32-year-old female).

"I was not aware that I have STI. I was only made aware when they took my blood; there was not even a sign that there was something. Yhoo! My heart was broken because this was my first child. I did not expect anything about STI, and I thought I would do follow-up visits normally. Hence, I decided to take treatment so that it can be treated and not affect the baby." (Participant 19, 19-year-old female).

"I did not even see anything. I come here, and the nurses took blood. I did not even know. I was here for pregnancy, nothing else." (Participant 4, 35-year-old female).

"I did not know. I heard from the nurses when I visited the clinic, as you can see, I am pregnant. I heard nurses telling me that I have this type of STI I have; they said it syphilis." (Participant 6, 33-year-old female).

"I explained to him that we both need to be treated so that our baby comes out fine." (Participant 6, 33-year-old female).

Sub-theme 2.3. Concern for health

Apart from accessing healthcare during pregnancy, participants indicated that they wanted treatment due to symptoms or concerns about how their condition might affect them or their relationships. Below are responses from participants:

"I went to the clinic, and when I got to the clinic, I was even spotting blood. At the clinic, they saw that

I was pregnant, and I did not know I was pregnant." (Participant 5, 31-year-old female).

"I told him it was itching when I go to pee. The discomfort; I asked him if he felt the same way. He said no. OK, when I started seeing the colour changing on my discharge, and now even the smell was off, I also told him and asked if he saw anything. He said no. I decided to go to the clinic." (Participant 10, 32-year-old female).

"I was not sure what it was, but because I know my body. When I went to the toilet, the urine took a long time to come out, so when I checked, I saw that something yellowish was coming out. I concluded that this indicates something wrong in my body" (Participant 17, 22-year-old male).

"I told her that this thing is back, and she also said that her periods seem not to be normal; I said we should go to the clinic because this thing may end up killing us because STI comes in many ways." (Participant 17, 22-year-old male).

"If one doesn't complete the journey of the treatment, that will mean you are not fully healed, and you are at great chances of like the STI being resistant to antibiotics." (Participant 26, 26-year-old male).

Theme 3: Health-seeking experiences

This theme emerged when participants were asked about their experiences at the healthcare facility, treatment outcomes, and adherence to treatment after seeking treatment for an STI. Participants reflected on various experiences during healthcare access and the behavioural changes they adopted post-diagnosis. These experiences influenced participants' overall perception of the healthcare process, impacting their health-seeking behaviours and adherence to treatment.

Sub theme 3.1: Experiences during healthcare access

This sub-theme emerged as participants recounted the various steps involved in their clinic visits, from initial testing and diagnosis to the administration of treatment and emotional responses. These elements highlighted both positive and negative encounters, shaping their perceptions of the healthcare experience and influencing their attitudes toward seeking treatment in the future.

Participants often mentioned that their healthcare visits began with routine tests, including HIV tests. The sequence of events leading to their STI diagnosis was memorable for many. Below are their responses:

“They start by testing you for HIV. Then they gave me tablets that I have to take. I think there were six or seven, if I'm not mistaken, then the injection and they offered me a condom.” (Participant 1, 32-year-old female).

“When I got to the clinic, they told me to go to the toilet to take a urine sample; I did, they tested it. They asked me what brought me to the clinic, and I told them something was coming out. They said, “OK, here the test says you have an STI.” (Participant 17, 22-year-old male).

“When you are pregnant, there are many tests that are done on you throughout the pregnancy. One of the tests came back saying I have syphilis.” (Participant 6, 33-year-old female).

Moreover, another memorable aspect of the healthcare experience was the treatment administration and the effectiveness of the treatment. Participants intensely described the tablets and injections they received; the injection, in particular, was often mentioned as painful, and they further reported rapid symptom relief, making it a noteworthy part of their healthcare experience. Below are their responses:

“After getting that injection and drinking pills, the following day, it was no longer burning. The major thing was burning urine, but after getting that injection and pills after 30 or 40 minutes when I was urinating, it was getting better. The following day, when I woke up, that discharge was no longer coming out.” (Participant 15, 39-year-old male).

“You know if I were to have it again, I wouldn't go back to the clinic. Yhoo! You see that injection! That injection is painful, and I would never, I did not feel right. They gave me tablets as well, a lot of tablets, about six tablets to drink at the same time. They also tested me for HIV.” (Participant 16, 20-year-old male).

“They gave me the thing that I won't forget. ... we don't like injections. Actually, it's very painful, but yeah, they gave me some tablets as well, yeah, a few tablets that were different.” (Participant 23, 25-year-old male).

Furthermore, to the physical aspects, emotional responses also emerged as participants described feelings of embarrassment, particularly during physical examinations or sensitive questioning. Below are responses participants presented:

“I told the sister that is burning inside, and she said she wanted to see it, and I was so embarrassed. I was so embarrassed, but I showed her.” (Participant 7, 36-year-old male).

“I went to the clinic for a check-up of blood pressure; then the nurse requested that I go do a pep smear; she checked me and said there was something that she was seeing that she did not like, she injected me. I asked what it was, and she said something like STI. She did not say STI; she said something like STI. She injected me with a hot and painful injection.” (Participant 29, 35-year-old female).

Some participants noted positive experiences with healthcare providers who took the time to educate them on STI prevention and safe practices, which left a lasting impression. Below are their responses:

“The sister was very good; she helped him, she explained, showed him pictures from charts, how STI looks on men, everything about STI. Then he was very afraid. Even now, he's scared of STIs. He was very afraid. There is also that injection; I think it helped me” (Participant 2, 32-year-old female).

“At the clinic, they sat me down and educated me on how I should take care of myself so that I do not get an STI again; every time I am having sex with my partner, I should use a condom so that I don't find myself being infected with HIV. So, I also saw it important to take this message and tell my partner.” (Participant 3, 35-year-old female).

Sub-theme 3.2. Behavioural changes after STI diagnosis

Many participants reported behavioural changes following their diagnosis. This sub-theme emerged when participants were asked about their efforts or steps to prevent reinfection following their STI diagnoses; many participants reported adopting behavioural changes to avoid reinfection and safeguard their health. These changes encompassed increased use of condoms, heightened awareness of partner testing, routine health checks, improved

communication with partners, and commitments to monogamy. These shifts in behaviour reflect both a reaction to the physical discomfort of the STI and an increased understanding of the risks involved in unprotected sexual activities.

A primary behavioural change noted by participants was the consistent use of condoms during sexual activity. Many participants emphasised that the experience of contracting an STI encouraged them to adopt safer sexual practices. Below are their responses:

"When we had sex again, I told him that let us use a condom." (Participant 12, 29-year-old female).

"I am always using condoms. I do not want to experience that again. It's not nice. I condomise all the time." (Participant 17, 22-year-old male).

"We used a condom for some time because he says I have a disease, I will infect him." (Participant 12, 29-year-old female).

"I will have to use protection until we agree to get tested. That is what I am going to do from now on." (Participant 15, 39-year-old female).

"It was really difficult, after treatment, I am using a condom. I don't want to see myself there." (Participant 16, 20-year-old male).

"I must have one partner. I must use a condom. Yeah, yeah, yes. and be faithful. It's not a child play. It's painful, and yeah, someone must stick to one partner and must not share the partner with other people." (Participant 7, 36-year-old male).

Some participants reported increased communication with their partners, ensuring they understood the importance of using protection and undergoing regular testing. Below are their responses:

"I taught myself not to sleep without a condom, not to sleep when on periods." (Participant 20, 22-year-old female).

"I do communicate with partners; I highlight the clinical symptoms of different STIs because currently I do have some knowledge. So, before I engage in sexual activity with a partner, I communicate." (Participant 22, 36-year-old male).

"People just need to protect themselves and never judge someone by their looks." (Participant 23, 25-year-old male).

In addition, participants reported a greater emphasis on regular health screenings and STI testing. The diagnosis experience highlighted for many the

importance of monitoring their health. See their responses below:

"She advised us to do a frequent test like HIV testing. Every six weeks or six months." (Participant 1, 32-year-old female).

"I will keep coming to check if I still have it, and if it did not affect me or the baby, I will continue coming to see if I don't have infection/s." (Participant 19, 19-year-old female).

"Every time a mobile bus comes here, I test for everything." (Participant 20, 22-year-old female).

Lastly, some participants described taking proactive steps, such as carrying condoms and visually inspecting their partner for signs of STIs. See their responses below:

"When you have a boyfriend, you should always have condoms, buy them for yourself and go with them to your boyfriend. Don't say you are waiting for him to bring them." (Participant 5, 31-year-old female).

"I ask my partner, when he is naked, I ask to see his penis to see if nothing is coming out of it. I look at it and make sure he's fine because sometimes the condom breaks, so I make sure I check him..." (Participant 29, 35-year-old female).

Theme 4: Treatment outcomes and adherence after seeking health care

This theme emerged when participants were asked about the treatment outcomes and their adherence to prescribed STI treatment. Some participants were completing their medications as directed and experiencing successful outcomes, while others discontinued treatment prematurely.

Several participants reported adhering fully to their treatment, motivated by a desire for complete recovery and recognising the importance of following medical instructions. This group understood the potential consequences of incomplete treatment, such as antibiotic resistance, and highlighted their commitment to finishing the prescribed medication. See the participant's responses below:

"I finished the course even though the symptoms were gone. I finished them." (Participant 20, 22-year-old female).

"I should complete the course so that I avoid resistance to antibiotics in the future" (Participant 26, 26-year-old male).

"I did because the sister there told me that whatever I'm going through can be cured only if I follow her instruction." (Participant 23, 25-year-old male).

"I understand. I don't mind medication and pills. I like taking them. ...when I feel pain, I drink pills. They keep stopping me here. "Stop drinking pills" I love them; anything as long as it is going to help me, I drink, whether you inject or you give me a pill to drink, I do not have stress." (Participant 29, 35-year-old female).

"I completed my tablets because I care about my own health, and I wanted to be ok. It's not a nice feeling to have that itchy vulva and your vagina, it's smelling" (Participant 28, 26-year-old female).

Conversely, some participants reported failing to complete their medications once they began feeling better, reflecting a common misconception that symptom relief equates to full recovery. These individuals often stopped taking their medication prematurely, risking incomplete treatment and possible recurrence of the infection. Here are their responses below

"I did not even finish that medication; after seeing that I was fine after 3 days, I did not continue with it. I usually take medication and do not complete it. I told myself that it's fine because I am fine now. I will complete it when it comes back again." (Participant 12, 29-year-old female).

"Hahaha, I can't say that because I think in the packet when 4 tablets were left, and then I see myself as completely healed. Then I said no, it's fine, I'm healed, but all in all I got healed even though I never completed the course." (Participant 22, 36-year-old male).

"Immediately after feeling okay, I stopped the treatment." (Participant 25, 31-year-old female).

"It was difficult for my husband to finish; I had to always remind him to take his pills." (Participant 9, 37-year-old female)..

Discussion

Various factors, including stigma, employment constraints, financial dependency, and limited health literacy, influenced the treatment seeking behaviours of participants. Stigma was a prominent barrier, as participants frequently reported shame and fear of being judged. This aligns with the findings from¹⁹ on the cultural context of STI

diagnosis in marginalised areas, such as townships in RSA, where stigma and the fear of being judged are obstacles that prevent females from informing their partners about their condition. Employment constraints also influenced treatment-seeking behaviour, especially for participants who feared taking time off from work or jeopardising their job security. Research indicates that employment history, including periods of unemployment, correlates with perceived barriers to healthcare access, especially among disadvantaged populations.²³

Financial dependency on a partner was another barrier, particularly for female participants who relied on their partners for financial support. This dependency often created a power imbalance, limiting the autonomy of participants to seek care independently. This aligns with the concept of financial abuse in a relationship, which is a type of IPV that dramatically reduces a person's autonomy by encouraging economic reliance, which in turn limits access to needed healthcare. This abuse expresses itself as controlling behaviours that delay a partner's capacity to obtain and manage financial resources, making it difficult for victims to exit abusive relationships or seek critical medical care.^{24, 25}

Health literacy emerged as a constant issue, as participants commonly did not understand STIs, their symptoms, and treatments. This finding echoes²⁰ that the male gender, urban residence, and employment are significant determinants.

The findings of the study also revealed that several facilitators encouraged participants to seek STI treatment. Key motivators included social support, healthcare access during pregnancy and personal health concerns, consistent with existing literature on the factors promoting healthcare seeking behaviour. Social support emerged as a significant facilitator, with family and friends providing emotional encouragement and reducing feelings of isolation. Research indicates that social support is crucial in enhancing healthcare seeking behaviour.²⁶ It can diminish the stigma associated with STIs, encouraging individuals to seek care without fear of judgment. Participants in the study who confided in family members often received reassurance and practical advice, which helped them overcome reluctance to seek treatment. This

aligns with a study that found that social networks can buffer against the negative psychological impacts of STI related stigma.²⁷ Healthcare access during pregnancy served as another important facilitator, as pregnant participants were more likely to access STI testing and treatment as part of routine prenatal care. This finding is consistent with²⁸ that pregnancy can increase healthcare engagement, as individuals prioritise the health of their unborn children. The authors further states that maternal-fetal attachment significantly influences women's engagement with health advice during pregnancy, as concern for the fetus encourages adherence to healthy behaviours. In this study, many participants mentioned that their awareness of an STI diagnosis occurred during prenatal visits, often motivating them to initiate or continue treatment to protect their pregnancies. This supports previous findings from another study that maternal health concerns can override some of the usual barriers to treatment seeking, as pregnant individuals are generally more motivated to attend healthcare appointments.²⁸

Personal health concerns also encouraged participants to seek treatment, particularly when they experienced symptoms or worried about possible health consequences. Health behaviour theories, such as the HBM, suggest that perceived health threats are a primary motivator for health seeking actions.²⁹ In line with this, several participants described changes in bodily symptoms, such as itching, discomfort, burning urine or unusual discharge, which prompted them to visit the clinic. Studies have similarly shown that having multiple STI-related symptoms is positively associated with seeking treatment at a clinic, suggesting that symptom severity influences treatment seeking behaviour.^{30,31} In summary, facilitators for STI treatment seeking were primarily rooted in external support, pregnancy related care access, and self-motivation through health concerns. The participants' health seeking experiences demonstrate a wide range of reactions to STI care and treatments in healthcare settings, including both positive and negative encounters. Their experiences included initial testing procedures, treatments received, treatment reactions, STI education, and views about the

screening process; most participants indicated that healthcare facility visits involved an HIV test as a part of standard STI care, followed by urine or blood tests to confirm STI diagnoses. Furthermore, most participants said they had received antibiotic treatment for STIs, usually consisting of a single-dose injection and a combination of pills. One memorable feature of the treatment was the injection, which several participants found unpleasant and painful. However, participants also noted rapid symptom relief following treatment.

In addition to physical treatment, many participants highlighted the importance of healthcare professionals' education on STI prevention. This included information on condom use, personal hygiene and the risks of STIs, including HIV. Participants expressed particular appreciation for the educational component of the intervention, especially those who had limited knowledge about STIs before their clinic visits. This aligns with findings a study, where young people reported a strong desire for expanded sexual health education but noted barriers to accessing it, often due to apprehension or feelings of taboo associated with discussing such topics with parents or healthcare providers.³

After receiving an STI diagnosis, participants reported significant behavioural changes, primarily related to increased testing, relationship communication, safer sex behaviours, and higher personal health monitoring. These behavioural changes are a combination of more proactive and preventative tactics, including frequent testing and partner monitoring, as well as more immediate, practical ones, like persistent condom use. This aligns with finding from a study where participants' reported safer sexual behaviors after STI diagnosis, which include more frequent condom use.³² Participants' experiences with treatment adherence and outcomes differed, with some adhering to their prescribed medication and others discontinuing treatment prematurely once symptoms stopped. Similar patterns of incomplete adherence to STI treatment have been reported in recent research, where nonadherence was linked to perceived symptom improvement and limited understanding of the importance of completing treatment.³³

Strengths

The research utilizes comprehensive interviews to provide a detailed exploration of individual experiences, feelings, and behaviours associated with seeking treatment for STIs. The study includes participants of different ages, gender, educational backgrounds, and employment statuses, enhancing the diversity of perspectives. The study focuses on Ekurhuleni East, providing localized insights that can inform targeted public health interventions. Findings are relevant to similar urban and peri-urban communities in South Africa and other low- and middle-income countries.

Limitations

This study had several limitations that should be considered when interpreting the findings. Firstly, the study was conducted among young adults in the Ekurhuleni East sub-district, which may limit the generalization of the findings to other settings, including rural areas or broader South African settings. Secondly, the use of self-reported data may have introduced recall bias or social desirability bias, particularly given the sensitive nature of sexual and reproductive health topics. Thirdly, the gender distribution of participants was skewed towards females, which may have influenced the findings related to gender-specific barriers and facilitators to STI treatment-seeking behaviours. Lastly, while the study provides valuable insights into individual and social factors influencing treatment-seeking, it offers limited exploration of healthcare system-level factors such as facility constraints, healthcare provider attitudes, and medication availability, which may also play a significant role in shaping treatment-seeking experiences.

Conclusion

The findings highlighted critical factors influencing health-seeking behaviours and treatment outcomes. Barriers to effective treatment seeking included stigma, financial constraints, and a lack of health literacy. In contrast, facilitators such as social support, healthcare access, and personal health concerns significantly motivated individuals to seek

care. The study also revealed that while many participants adhered to treatment plans, others struggled with completing prescribed medications, indicating a need for better treatment adherence support. The study makes recommendations to facilitate regular treatment seeking, efforts should be made to improve health literacy and offer mobile health services, which should be taken to workplaces. Community support structures, including family and peer support, should be integrated into health campaigns to encourage treatment adherence. In addition, healthcare providers should be trained to offer compassionate, non-judgemental care, particularly to young adults facing stigmatisation. Services should be more youth-friendly, ensuring patients feel comfortable seeking treatment without fear of judgement. Additionally, integrating STI care with other health services, such as maternal care during pregnancy, could improve treatment seeking behaviours. Furthermore, health interventions should encourage sustained behavioural changes post-diagnosis, including consistent condom use and regular STI testing. Educational programs should emphasise the importance of completing the entire course of treatment, as early discontinuation may lead to drug resistance and reinfection.

Conflict of Interest

The authors declare no conflict of interest.

Contribution of authors

NM conceptualized the study, designed the methodology, secured ethical approvals, conducted data collection through in-depth interviews, performed thematic analysis, and drafted the manuscript. RJS and MMM provided supervision throughout the research process, contributed to refining the study design and analysis, and critically reviewed the manuscript for theoretical rigor, clarity, and coherence. All authors reviewed and approved the final version of the manuscript.

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Ethical approval and consent to participate

This study was approved by the Sefako Makgatho Health Sciences University Research Ethics Committee (SMUREC) (Ref: SMUREC/H/474/2023:PG) and the Ekurhuleni Health District Research Committee (EHDRC) (Ref: GP_202402_008). Written informed consent was obtained from all participants before participation, and confidentiality was maintained throughout the study.

Availability of data and materials

The data generated and analyzed during this study are not publicly available to maintain participant confidentiality but are available from the corresponding author upon reasonable request.

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