Knowledge of genital Chlamydia trachomatis infection in family planning clinic attenders

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Summary
The purpose of this study was to determine the level of awareness of genital Chlamydia infection and level of knowledge related to this infection in family planning (FP) clinic attenders. Clients attending FP clinics during a 3 month study period were invited to complete an anonymous self-administered questionnaire. Five hundred and sixteen questionnaires from female attenders were analysed. Results showed that 54% of respondents had heard of Chlamydia. Subjective knowledge assessment for Chlamydia was low compared to that for other infections. Mean knowledge scores relating to genital chlamydial infection were low. There was no significant age-related trend in knowledge scores. The implications of these findings are discussed in relation to increased Chlamydia screening activity in FP clinics.

Key words
genic chlamydial infection, knowledge levels

Key message points
• This population of family planning clinic attenders demonstrated a low level of awareness of genital tract chlamydial infection relative to other genital infections.
• The study indicated a low knowledge level of genital tract chlamydial infection.
• There was no significant age-related trend in knowledge levels.

Introduction
Chlamydia trachomatis is a common sexually transmitted disease. In Great Britain estimates of prevalence vary between 4.9% and 8% among the 16-25 year olds in the general population,1,2 whilst Hay et al found the level to be 29% in those attending genitourinary medicine (GUM) clinics.3 The infection has serious potential sequelae. In women, infection may cause cervicitis, endometritis, salpingitis and pelvic inflammatory disease with the associated risk of reduced fertility and ectopic pregnancy. The costs associated with this infection were conservatively estimated at £50 million per year in 1994.4

Early sexual experience and multiple partners have been shown to be independent risk factors for chlamydial infection.5 The incidence of chlamydial infection is highest among women under 25 years of age who have had more than five partners in the past year.6,7

A characteristic feature of chlamydial infection is the high number of asymptomatic infections in women which has been estimated to be as high as 70%8. The majority of men with genital chlamydial infection do have symptoms,9 although the proportion of asymptomatic men has been estimated to be as high as 25%.9

In view of the above, widespread screening is generally considered to play an important role in reducing prevalence when used in conjunction with contact tracing and treatment. Selective screening of those identified as being at high risk has been recommended.1,9,10 One problem with selective screening is the low sensitivity of a risk assessment tool. In an adolescent population no single risk factor or combination of risk factors could identify more than 42% of chlamydial infections.11 Others suggest that universal screening is more cost effective than selective screening in FP clinics if prevalence is greater than 3.1%.12 Screening and treatment have been demonstrated to reduce incidence of chlamydial infection,4 ectopic pregnancy13 and pelvic inflammatory disease.14

Education of the public with respect to the importance of genital tract chlamydial infection is imperative. Improved education has a key role in primary prevention and is also essential in screening and secondary prevention methods if the detection of asymptomatic infection is to be correctly managed. There are few data available on the public level of knowledge relating to Chlamydia, although the indications from a limited range of studies15-19 are that knowledge of sexually transmitted diseases in general, and specifically of genital tract chlamydial infection, is very limited.

The aims of our study were:
1. To determine the level of awareness of genital tract chlamydial infection in FP clinic attenders relative to their awareness of other genital infections.
2. To determine the level of knowledge related to genital tract chlamydial infection in FP clinic attenders.

Respondents were asked about their awareness of certain sexually transmitted/genital infections. The four most heard of infections were thrush (99%, n = 507), HIV/AIDS (98%, n = 501), genital warts (94%, n = 468) and hepatitis B (94%, n = 470) (Table 2). The three least heard of infections were trichomoniasis (21%, n = 86), bacterial vaginosis (42%, n = 186) and Chlamydia (54%, n = 240). Age breakdown indicated a general increase in awareness with increasing age. The youngest age group recorded lowest levels of awareness with respect to all infections apart from trichomonas, bacterial vaginosis and genital warts. With respect to Chlamydia there was a steady increase in awareness with increasing age (group 1 = 43.6%, group 2 = 57.8%, group 3 = 58.4%, group 4 = 60.6%).

<table>
<thead>
<tr>
<th>Infection</th>
<th>Total response</th>
<th>Positive response</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thrush</td>
<td>547</td>
<td>542</td>
<td>99%</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>549</td>
<td>535</td>
<td>97%</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>534</td>
<td>500</td>
<td>97%</td>
</tr>
<tr>
<td>Genital warts</td>
<td>531</td>
<td>499</td>
<td>94%</td>
</tr>
<tr>
<td>Genital herpes</td>
<td>532</td>
<td>491</td>
<td>92%</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>530</td>
<td>473</td>
<td>89%</td>
</tr>
<tr>
<td>Syphilis</td>
<td>527</td>
<td>451</td>
<td>80%</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>475</td>
<td>252</td>
<td>53%</td>
</tr>
<tr>
<td>Bacterial vaginosis</td>
<td>470</td>
<td>196</td>
<td>42%</td>
</tr>
<tr>
<td>Trichomonas</td>
<td>444</td>
<td>89</td>
<td>20%</td>
</tr>
</tbody>
</table>

There were highly significant differences between age groups for awareness of gonorrhoea (p < 0.001), syphilis (p < 0.001) hepatitis B (p = 0.004) and trichomonas (p = 0.006). Age-related awareness of Chlamydia was not significant (p = 0.06).

It is possible to have heard of an infection and yet know nothing about it. A Likert scale was used to ascertain the individuals self-perception of their knowledge of Chlamydia and other genital infections. As this is a subjective assessment there is no comparability between one person’s scores and that of another person. Consistency lies in the responses that one person gives to each of the questions, enabling comparison of the range of self-assessed knowledge of the sample between each of the infections. There was a wide variation in the average score of self-assessed knowledge. The lowest were trichomonas (mean = 1.1, mode = 0.0) and Chlamydia (mean = 1.6, mode = 0.0) and the highest were thrush (mean = 6.0, mode = 5.0) and HIV/AIDS (mean = 6.4, mode = 8.0). Standard deviations were similar for all the score ranges (range 2.17 - 3.69), consequentially the levels of knowledge reflect the trend that was apparent in levels of awareness. Not only do more people know about HIV/AIDS and thrush, but they also consistently assess themselves as knowing more about them.

Respondents were asked to complete a series of 23 questions related to chlamydial infection. Each question was phrased as a statement with three answer options of ‘true’, ‘false’ and ‘don’t know’. Eighty-six percent of the respondents (n = 445) answered all the questions whilst 4% (n = 21) answered none of the questions and 94% (n = 488) answered 22 or 23 questions.

The mean scores were calculated on the basis of the number of correct answers in relation to the number of questions attempted by each respondent to exclude error caused by non-completion. Generally the mean scores were very low. No one scored more than 70% correct answers;
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90% of the sample scored 40% correct answers or less and 37.2% of the respondents did not score any correct responses (valid cases = 506, missing cases = 8). The mean score for the whole sample was 17%. Breakdown of mean score by age group was as follows: age group 1 = 13%, age group 2 = 18%, age group 3 = 19%, age group 4 = 18%. The youngest age group had the poorest mean score. However, a single regression calculation of mean score against age group is not statistically significant (p = 0.15) indicating that there is no significant age-related trend in percentage correct scores.

The low levels of correct response were reflected across all the questions, with the highest score for any one question being 54.9% (Table 3).

Information sources
The most commonly cited information sources were magazines and books (61%, n = 174), FP clinics (33%, n = 80) television (31%, n = 76) and family and friends (31%, n = 77). The average number of sources listed was 1.5 (n = 209, missing cases = 307).

Results were similar for each age group, with magazines and books most commonly cited. School was recorded as an information source by 38% (n = 31) of the youngest age group. Fifty-five percent (n = 170) of respondents stated that they had never had any information. The high number of missing cases probably reflects the high percentage who stated that they had not heard of Chlamydia.

Thirty-one respondents (6.7%) felt that they were at risk of infection whilst 159 (34.6%) felt they were not at risk and 269 (58.7%) did not know. There were differences in responses between the age groups, with the highest perception of risk among age group 2, but no age related trend.

Discussion
General and relative awareness
The data indicate that this population have a low level of awareness of chlamydial infections both in absolute terms and in relation to their awareness of other genital infections. Caution should be exercised in applying these results to the normal clinic population, and a bias in favour of females. Possible explanations are the high attendance rates within youth clinics and consequent difficulties in distributing questionnaires. Also, clinic attendance in this age group is commonly a group activity and is not readily compatible with solitary activities such as questionnaire completion. The majority of male attenders are also among the younger age groups and attend youth clinics. It seems likely, therefore, that the two are related.

Opportunistic sampling leads to some degree of self-selection. However, if there is a skew in the findings it is likely to be in favour of those who had some awareness of STI's and would produce an over estimation of the knowledge levels of the underlying population.

Many of the findings are not surprising - HIV has had a vast amount of publicity whilst thrush is common, often readily detectable, and does not carry the stigma of STIs. Syphilis and gonorrhoea are traditional venereal infections but decreasing prevalence, particularly for syphilis, may account for a declining level of public awareness, particularly in view of the age-related statistically significant differences in awareness levels of these infections.

Knowledge levels
Among the respondents there was a low level of correct responses. Ninety percent of the respondents scored 40% or less, and 37% did not give any correct answers. For all but three of the questions less than 50% of the respondents gave the correct answer. If the questions are categorised as dealing with four areas: acquisition, symptoms, treatment and sequelae, the indication is that the level of Chlamydia-specific knowledge is lower than the raw figures suggest. Those related to acquisition (1,2,4,5,7 and 11) are not specific to chlamydial infection, but relate to transmission of STIs in general. Scores were highest for this category, providing four out of the top five scores, and it could be that respondents were drawing predominantly on general STI knowledge to answer these questions.

Questions specifically related to Chlamydia produced poor scores indicating that this population knows very little about chlamydial infection. Incorrect responses include both those who don’t know and those who give an incorrect

Table 3 Percentage correct answers (descending order) (numbers are added for convenience and do not reflect order within the questionnaire)

<table>
<thead>
<tr>
<th>Question</th>
<th>% correct</th>
</tr>
</thead>
<tbody>
<tr>
<td>1   Chlamydia infection can be caught by having sex with someone whom already has the infection</td>
<td>55.0</td>
</tr>
<tr>
<td>2   Chlamydia infection does not need to be treated</td>
<td>52.0</td>
</tr>
<tr>
<td>3   Chlamydia infection can be avoided by using a condom during sex</td>
<td>51.3</td>
</tr>
<tr>
<td>4   Chlamydia infection can be caught in swimming baths</td>
<td>49.0</td>
</tr>
<tr>
<td>5   Chlamydia infection can be caught from toilet seats</td>
<td>48.6</td>
</tr>
<tr>
<td>6   Chlamydia infection can be treated with antibiotics</td>
<td>46.4</td>
</tr>
<tr>
<td>7   If someone has had a chlamydia infection once they cannot catch it again</td>
<td>42.4</td>
</tr>
<tr>
<td>8   Chlamydia infection is caused by bacteria</td>
<td>39.0</td>
</tr>
<tr>
<td>9   Women can have chlamydia infection without knowing it</td>
<td>33.7</td>
</tr>
<tr>
<td>10  Chlamydia infection can cause long-term health problems</td>
<td>31.2</td>
</tr>
<tr>
<td>11  If women have chlamydia infection they usually have symptoms</td>
<td>30.9</td>
</tr>
<tr>
<td>12  Men can have chlamydia infection without knowing it</td>
<td>27.4</td>
</tr>
<tr>
<td>13  Chlamydia infection can make women infertile</td>
<td>27.4</td>
</tr>
<tr>
<td>14  Chlamydia infection can make it painful for a woman to pass urine</td>
<td>22.6</td>
</tr>
<tr>
<td>15  Chlamydia infection can cause a heavy white discharge in women</td>
<td>21.6</td>
</tr>
<tr>
<td>16  If women have chlamydia infection they usually have symptoms</td>
<td>17.7</td>
</tr>
<tr>
<td>17  If men have chlamydia infection they usually have symptoms</td>
<td>15.4</td>
</tr>
<tr>
<td>18  Chlamydia infection produces ulcers (sores) in the genital area in women</td>
<td>15.3</td>
</tr>
<tr>
<td>19  Chlamydia infections can cause ectopic pregnancies (pregnancy in your tubes)</td>
<td>10.2</td>
</tr>
<tr>
<td>20  Chlamydia infection can cause fibroids</td>
<td>9.0</td>
</tr>
<tr>
<td>21  Chlamydia infection causes a smelly green discharge in women</td>
<td>8.9</td>
</tr>
<tr>
<td>22  Chlamydia infection makes women feel sore and itchy around the vagina</td>
<td>8.0</td>
</tr>
<tr>
<td>23  Chlamydia infection can cause cancer of the cervix</td>
<td>6.0</td>
</tr>
</tbody>
</table>
response. It is important to note that there is a considerable level of misinformation within this category.

The use of closed questions and self-completion questionnaires carries its own limitations, although inclusion of the ‘don’t know’ category reduces the likelihood of resorting to guess work. Self-completion questionnaires can adversely affect the accuracy of responses, as they are dependent upon adequate understanding and interpretation of the questions. In order to increase the accuracy of the questions the word ‘can’ was incorporated in those statements which described possible Chlamydia-related symptoms. Questions therefore require careful reading and interpretation, a factor that may have affected to accuracy of responses. However, the sensitive nature of the information precludes the use of any other method, an approach that is supported in the literature.20, 21

The most commonly quoted information source was magazines and books which clearly play a highly influential role in public awareness and the dissemination of health messages. The variation in responses to key messages may be due in part to the emphasis given to them in magazine articles, for example there appears to be a greater awareness of infertility than ectopic pregnancy as a consequence of chlamydial infection. One problem of this selective presentation of material is the variation in the importance and personal relevance of any piece of information for individuals.

The proportion of younger respondents who cited school as an information source is encouraging. In the area in which the study was conducted there is a commitment to effective collaboration of health professionals with the education service on provision of sex education. These findings may indicate the value of such an approach.

Health promotion activities to raise levels of awareness are imperative at all levels if we are to attempt to reduce the prevalence of Chlamydia and the associated morbidity and health cost implications. If primary prevention is to be effective, individuals need accurate and relevant information on which to make decisions. Individuals can make decisions about personal risk of unsafe sex and their consequent use of barrier protection on the basis of cognitive errors, often based on social comparisons.22 Evidence suggests that this has occurred in association with HIV where assessment of low personal risk does improve knowledge. A similar study conducted with GUM clinic attenders, representing a highly selected at-risk population, demonstrated higher mean knowledge scores with an identical questionnaire.16

Much attention is currently being focused on the role of screening programs in the management of chlamydial infection, particularly in view of the pilot projects currently underway. If widespread screening becomes a reality, large scale awareness campaigns will be necessary to inform the public, a view supported by CMO’s expert advisory committee. The scale of the task is clearly considerable. In the interim, the debate is serving to maintain a high profile of this infection in the professional arena and a steady increase in the level of Chlamydia screening is to be expected. Our findings indicate that for many clients deemed to warrant screening there will be the necessity to educate the client first in order to obtain informed consent.

It would seem appropriate to tackle the educational activities prior to, rather than as a consequence of, any screening programme using as wide a range of information sources as possible.

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**References**


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**Original Article**

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