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‘It has to speak to people's everyday life...’: Qualitative Study of Men and Women’s Willingness to Participate in a Non-Medical Approach to Chlamydia trachomatis Screening

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'*It has to speak to people's everyday life…*': Qualitative Study of Men and Women's Willingness to Participate in a Non-Medical Approach to *Chlamydia trachomatis* Screening.

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Abstract

Objectives

To explore factors associated with men and women's willingness to provide a urine sample for *Chlamydia trachomatis* screening in various non-medical settings.

Methods

Men and women aged 16-24 years attending non-medical settings were invited to participate in urine-based screening and later participate in a follow-up in-depth interview. Participant observation techniques were also employed to collect data on young people's response to the offer of screening.

Results

The views of 24 men and women revealed three themes in relation to willingness to participate, particularly among men: their raised awareness of chlamydia, particularly its asymptomatic nature; the convenience of the offer; and the 'non-medical' nature of the screening. In contrast, women more often felt the public nature of the settings inhibited them from agreeing to take the test and thus acted as a barrier to their willingness to participate in screening.

Conclusions

The gender difference in willingness to participate in non-medical screening suggests that extending the reach of screening could certainly assist in bringing more young men into screening but may not necessarily destigmatise screening for women. As such, the potential benefits to men must be considered in the context of the potential psychosocial harms to women.

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INTRODUCTION

Chlamydia trachomatis infections are mostly diagnosed in specialist sexual health settings, with few at-risk young people in England reached via more innovative screening approaches, [1] despite the Chief Medical Officer's Expert Advisory Group advocating the extension of screening into non-medical settings.[2] In contrast with England, there is no national screening programme for chlamydia in Scotland; screening is based on Scottish Intercollegiate Guidelines Network (SIGN) (www.sign.ac.uk) recommendation to opportunistically screening women. Taking screening into non-medical settings could be one way to reach at-risk young people who may not use specialist sexual health services, and provide opportunities to reach young men. The feasibility of community-based approaches to chlamydia testing and screening has been demonstrated across a variety of non-medical settings, [3-9] as well as by postal methods. [10-13] However, screening needs also to be acceptable to the target screening population as there is little utility in offering screening in non-medical settings if there is unwillingness among this group to accept the offer. [14] Qualitative data on the acceptability of testing or screening have been obtained largely from women; [15-17] however, exploratory testing and screening work which includes men has been undertaken: with a clinic-based population,[18] within the National Survey of Sexual Attitudes and Lifestyles (Natsal 2000), [9] Chlamydia Screening Study (ClaSS) [20] and with men tested whilst in detention, [21] and so evidence on their willingness is emerging. Despite these contributions, there remains scant qualitative data on factors influencing men and women's willingness to be screened for chlamydia in non-medical settings and a lack of sufficient understanding on the acceptability of screening in other non-medical settings.

This paper reports the factors associated with men and women's willingness to be screened for chlamydia across a range of non-medical settings (education, health & fitness, and workplace) by urine sample. In-depth interviews were conducted with a sample of those willing to undergo the test and those who declined. Given we found a significant gender difference in willingness to provide a sample for testing (40.1% [61/152] *v* 26.8% [52/194], among men and women respectively; $P < 0.001$), [22] interviews focused on reasons for this gender difference.

METHODS

Men and women, aged 16-24 years, were approached and invited to participate in urine-based chlamydia screening in three non-medical settings in Glasgow, UK: Education (further education setting, attracting mostly 16-24 year olds); Health & Fitness (three local authority facilities); and Workplace (two call centres – office-type environments which handle incoming and/or outgoing calls to provide telephone customer service or sell goods). It is important to note that young people were being invited to participate in research rather than national screening, given there is no national screening programme for chlamydia in Scotland. A description of the recruitment process has been reported elsewhere. [22] In brief, young people using the settings were approached in communal areas [such as a canteen (education), main entrance foyers (health and fitness) and kitchen/'chill-out zones' (workplace)] and invited to participate in the study by completing a self-administered questionnaire, which asked about their knowledge of chlamydia and views towards screening. On returning the questionnaire, respondents were invited to provide a urine sample for chlamydia testing in a nearby toilet facility within the setting (although they were still included in the study if they declined the test). All respondents were verbally informed about the process of receiving the test result, including the need to consent to their contact details being passed to a Health Adviser at a local GUM clinic, for treatment. Respondents who were willing to provide a sample were asked to provide two methods of contact (choosing two of postal address, E-Mail, mobile [call or text message] or landline telephone). 'Privacy' levels for respondents varied across the study settings: there were times when no one was around in the main foyer of a health and fitness setting but there was always a large volume of young people using the canteen during lunch hour in the education setting. The sole researcher - a female, dressed informally - approached setting users and was perceived by respondents to be a similar age to older study respondents. The researcher's non-medical status was made clear to respondents and every attempt was made to ensure a consistent approach to recruitment. Nevertheless, there was a gendered response that in turn affected the way in which men and women were approached in the study settings, such as longer interactions with men, who were less familiar with chlamydia than women.

A sample of all study respondents who completed the questionnaire was later contacted (after test results were communicated – by text, email or post one week later) and invited to participate in an in-depth interview to explore their views on the screening process. A quota sampling approach was

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planned to recruit around ten percent of survey participants (purposively capturing those who provided a sample for testing and those who did not, and within the former group those who tested negative and those who tested positive). In practice, all 24 respondents who were willing to be interviewed were subsequently interviewed – with two of the five people testing positive willing to participate. Interviews took place either in a private area of the study setting or University. All interviews were tape recorded and transcribed verbatim and coded using Atlas.ti (Scientific Software Development, Berlin). Interview transcripts were read repeatedly and coded to identify emerging themes, within which 'willingness to test' became the organising theme of the analysis. [23] Recurring themes in relation to this topic were checked independently by MR and GH.

Ethical approval

Approval was granted by the University of Glasgow Faculty of Medicine Ethics Committee. Care was taken to ensure all respondents were no younger than 16 years in all settings. The confidentiality of the test result was emphasised to respondents, except in the event of a positive result when a health adviser from a local genitourinary medicine (GUM) clinic would be informed. All respondents who provided a sample of urine had previously given their written consent for their contact details to be passed to a health adviser in the event of a positive test result.

RESULTS

In all, 24 people (10 women and 14 men, aged 17-24 years) participated in a depth interview; 18 interviewees had agreed to be tested and gave a sample of urine for testing, whereas 6 had not.

Barriers to willingness to be screened

Low perceived risk

We have reported elsewhere perception of being at risk of having chlamydia was a strong predictor of being willing to provide a urine sample for testing. [22] Conversations in the settings as well as the in-depth interviews revealed some young women declined screening as they were in a monogamous relationship and therefore felt they could not be at risk of having chlamydia:

- I: I wasn't bothered about the fact that he wasn't using them [condoms] because I was on the pill…and I knew who he'd been with
  R: He wasn't a stranger to you?
  I: Uh-huh. Uh-huh. It wasn't an issue, really.
  (#309, Female, Age 20, Workplace).

When then asked if her low perceived risk was her reason for declining the test she commented: "yeah well it's [chlamydia] just not something I think I'm at risk of".

Some young men commented that they did not have sex with 'dirty girls' therefore they too could not be at risk of having chlamydia, and so declined the offer of screening. This view contrasts with the knowledge all except one main study respondent (99.2%) had that chlamydia is transmitted via unprotected sex. Indeed, in-depth interviews revealed this knowledge when discussing 'others', such as school pupils and college or university students, who most interviewees believed to be an 'at-risk' group based on their perceived promiscuous sexual lifestyles.

- "I think students are probably the higher risk than anybody else… some of the students have slept with three people in one night and all different people." (#181, Female, Age 23, Health & Fitness – declined screening).

Embarrassment

Both men and women described feelings of embarrassment towards being approached and offered screening in view of others. Men, however, often downplayed their feelings of embarrassment by emphasising their preference towards non-medical screening as "the lesser of two evils" (in comparison with clinic-based screening, particularly GUM settings); men preferred to be embarrassed in the company of their friends or colleagues than in 'a clinic full of strangers'.

- "For me personally I think some medical places can be quite off putting, they're quite daunting…whereas in your workplace, you're in your own safe environment, you know

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everyone in here, you kinda trust everybody a bit I suppose 'cos you're working with then all day." (#311, Male, Age 20, Workplace)

In each study setting women were observed producing their samples from within their jacket pockets, or even from their bags, in an attempt to conceal the kit from public view. No male was observed doing this; in contrast, when returning their sample some held it aloft (particularly men who were participating with a group of male friends) to examine the colour and compare it with their friends' sample. One man, when later asked about this behaviour, during his follow-up interview, described the 'male bravado' element of such behaviour (#258, Male, Age 22, Health & Fitness).

Stigma

Women often described a 'type' of women who contracts STIs, or requires a STI test; consequently, women's unwillingness to accept the offer of screening stemmed from their desire to avoid being seen by 'others' in the public setting as 'that sort of person'. The potential for women to experience stigma in these non-medical setting was a barrier to their willingness to provide a sample for testing. One woman, who did not wish to be tested, explained:

- "It's the associations that come with STI's. I think there's a sort of stigma around them, like if you might have an STI, it means that you've slept with a lot of people. I don't want to look like I'm that sort of person." (#352, Female, Age 21, Workplace).

No male interviewee discussed this kind of stigma during discussions of willingness to accept the offer of screening in these non-medical settings.

Supporting factors to willingness to be screened

Raised awareness

Most men commented on their newly raised awareness of key features of chlamydia – the largely asymptomatic nature of chlamydia infection, the higher prevalence of infection among young people and the ease with which it could be tested for using urine - as being a support to their willingness to be screened.

- "I've heard of chlamydia, but I didn't know what it was really…but I know now because of you. I guess knowing how common it is, jeez! …that's really why I thought about getting tested…" (#77, Male, Age 20, Education).

Men's enthusiasm to gain knowledge about chlamydia, other STIs and related matters was evident in various, often lively, exchanges with the researcher. Whilst men considered the non-medical approach acceptable because they welcomed the opportunity to gain knowledge about chlamydia, women also found the approach acceptable for 'others' to gain knowledge about chlamydia.

Convenience

The convenience of the offer of screening, in settings these men were already using, was another key support to men's willingness to be screened.

- "I like the fact that I come here [gym] quite a lot, y'know a couple of times a week and if you hadn't been here I probably wouldn't have done it …but because you came up to me in here well that made it easy just to go actually." (#258, Male, Age 22, Health & Fitness)

The 'easiness' of the test, or 'while it's here' and 'it's no effort to do it' were frequent comments from men within each of the settings. Young women also spoke positively of the convenience of non-medical screening, but more in relation to 'others', rather than themselves:

- "I think if it was made more available in places like this and schools and stuff then it's made easier for people y'know, it's easier for them to get tested" (#309, Female, Age 20, Workplace).

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Non-medical nature of the screening settings

Whilst men spoke of their reluctance to access dedicated sexual health services, or general practice - for the purpose of seeking testing - female respondents only referred to this in relation to their perceptions of men's willingness to participate in non-medical screening. Men often discussed their apprehensions about attending a GUM clinic seeking screening and explained their preference for non-medical screening approaches because it enabled them to avoid attending a GUM clinic:

- You know, a lot, a lot of people don't like going to the doctor full stop… I think it's more men who are afraid of going to the doctor…I wouldn't go to a clinic but I did it [screening] here" (#308, Male, Age 22, Workplace).

- "Because everybody sits and looks at you [in a GUM clinic]. 'Like that what are you here for?' 'Nothing, eh sore finger.' Sore finger, eh, in a sexual health clinic? Has it got chlamydia?" (#311, Male, Age 20, Workplace).

Many men made positive comments about the setting being non-medical. Factors such as the (informal) appearance and age of the researcher, as well as the fact that the screening was offered in 'less formal settings' - foyers, canteens and 'chill-out zones' – were reported as contributing to their perceptions that the screening was non-medical:

- *"…*'cos you're [the researcher] just like us. You're not trying to be like above us or anything, which a lot of, I suppose doctors and whatever, what have you, **do**…" [*Respondents' emphasis*] (#311, Male, Age 20, Workplace).

In contrast, few female interview respondents expressed this particular opinion although one female respondent felt that sexually transmitted infections were not solely an issue for the medical profession:

- "…making people familiar with medical issues like STIs has to get out of medical settings, has to speak to people's everyday life…" (#370, Female, Age 24, Workplace).

Within each of the settings men often responded more positively to an informal approach. The more matter-of-fact manner in which women tended to discuss their awareness of chlamydia, for example by saying 'Oh yes I've heard of it; I was offered screening at my last smear test' (Fieldnote diary entry, Education setting) suggested women appeared to know more about chlamydia. Women were often at ease completing the self-administered questionnaire but during screening discussions became increasingly embarrassed, which neither humour nor a continued formal manner eased. In comparison, young men often appeared to relax when the researcher adopted a more informal approach, which encouraged screening discussions.

DISCUSSION

This study offered young people chlamydia screening in various non-medical settings, including education, health and fitness, and workplace, and sought the reasons for their willingness, or otherwise, to be screened. There are few qualitative studies investigating women and particularly men's willingness to participate in chlamydia screening. Research, more broadly, has explored women's attitudes towards their diagnosis of chlamydia and their motivation for accepting the offer of chlamydia screening; [24] however, the focus has largely been on clinical populations and on uptake rates, although more recently people's willingness to participate in non-clinical screening and their views towards screening has been explored qualitatively. [19; 20] Gathering information on men and women's reasons for participating, or otherwise, in non-medical screening is important given that 'innovative approaches' to extend screening to 'hard-to-reach' young people [25] and greater opportunities for men are being advocated. [26] Given this, and the paucity of qualitative studies on non-clinical populations, this study adds important and novel information.

The willingness of men in this study to accept the offer of screening in less than private circumstances, challenges notions that men are difficult to engage in sexual health screening or hold negative or neutral attitudes towards their sexual health.[19] As in other work, the screening was well received, with many men enthusiastic to learn more about chlamydia and often engaged the researcher in lively conversation to obtain information. [27] For young men, the screening offered in

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these settings was easy and convenient for them. Many more men spoke of appreciating the non-medical nature of the screening and being approached by and entering a discussion with a non-medical professional. This finding contrasts with the views of respondents to the chlamydia testing component of Natsal 2000: many preferred to be asked for a urine sample by a medical professional. [9] However, their finding that the professionalism of the interviewers helped assuage embarrassment and uncertainty reflects the views of men and women participating in this non-medical screening.

However, contrasting responses from women suggests there were clear gender differences in barriers and supports to willingness to participate in screening. Barriers for women included beliefs regarding stigma, a similar finding to research with women screened in clinical settings. [16;19] Thus this non-medical approach to screening was less successful in reaching young women, with fewer providing a urine sample compared with men; however, it is important to note that the recommendations of the SIGN guidelines in Scotland enable women (but not men) to have alternative screening opportunities.[29]

A barrier for both sexes was their perception of being at risk of having chlamydia. That many respondents who considered themselves to be at risk of having chlamydia were then willing to provide a sample of urine when approached in these non-medical settings is a positive finding. This suggests convergence between medical advice and lay responses; in other words, the advice for young people is to be tested for chlamydia if there are risk factors or a perception of risk, and many young people who considered themselves at risk adhered to this general view and were tested. However, many who considered themselves at risk did not accept testing in these non-medical settings. In-depth interviews revealed the complexity in many of the narratives about risk of having chlamydia, which were often predicated on the perceived risk-status of their current or recent sexual partners; as noted by others, this has implications for the coverage of screening. [30] As such, it is a limitation of this screening approach that is still fails to reach at-risk groups, including those who declined the test and more obviously those who did not attend the screening venues. A further limitation is the low number of people who declined the offer of a test being willing to participate in an interview; their views may not be representative of all those who declined the offer of screening, and so the results have to be considered in that context.

The ability to reach young men could be a benefit of non-medical approaches to screening. [1 31] At the end of the third year of the NCSP in England, 18% of tests came from men; 15% of tests provided as part of Healthy Respect (a Scottish Executive funded demonstration project available in the Lothian NHS board area) were from men. [1;32] However, the potential for women to experience increased stigma from non-medical approaches might reduce the benefits of non-clinical approaches to screening unless the increased numbers of men being seen to engage with screening affects the de-stigmatisation of screening for women. Further research to identify differences in willingness to screen by class, age and ethnicity is required. Additionally, the context, gender and access to non-medical settings to establish screening (including management willingness to allow screening opportunities in settings), requires further investigation to strengthen our understanding of how effective non-medical screening is as part of control strategies to reduce the prevalence of chlamydia infection in the population.

CONCLUSIONS

Reaching at-risk groups and engaging them in testing or screening is vital to be in a position to reduce morbidity or transmission; however, it is important to collect information on why people are willing, or otherwise, to be screened for chlamydia in non-medical settings so as to begin to understand the potential such approaches to screening may have to the broader goal of reducing prevalence in the population. The gender differences in reasons for being willing to be screened for chlamydia in non-medical settings reveals the important benefit of such an innovative approach to reach young men, but that should be balanced by the potential this approach has to cause psychosocial harms to women.

KEY MESSAGES

- Barriers to screening for Chlamydia in non-medical settings varied by gender.
- Women’s felt stigma was a barrier to testing but men did not report stigma as a concern.

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- Men's increased awareness of Chlamydia, knowledge of the ease of being tested by urine sample and convenience of the test encouraged uptake of testing.
- Improving levels of screening for Chlamydia requires better engagement with young people, to increase awareness of the link between sexual risk and acquisition of infection.

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CONTRIBUTORS

MER and GH had the original idea for the study, designed the study with KL, and were involved in the drafting of the paper. KL carried out all the fieldwork described in the paper, carried out primary data analysis, and wrote the first draft of the paper.

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