

The Relevance of Sexually Transmitted Infections (STIs) in Relation to Access to Services in a Rural Area of New South Wales

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Purpose of the paper

This paper will present the findings from a qualitative study that explored the meaning and experiences of people in relation to sexually transmitted infections (STIs) and how such experiences influence access to relevant services in the region.

Methods

Participants for the study were recruited through the use of snowballing and self selection. Interviews were conducted with 24 participants aged between 19 and 65 years and living in rural communities. The interview data was transcribed and analysed using grounded theory methodological principles. The study is part of a larger project that includes quantitative data from NSW Health Notifiable Diseases Database on syphilis notifications for the Hunter New England Area Health, Northern region.

Results

Findings from this study indicate individuals engage in a process of regulating the flow of private information about STIs. The paper describes conditions that influence an individual's capacity to identify, seek and utilise the most appropriate service. It becomes apparent that close connections with other people is particularly relevant when accessing services within a rural town.

Findings

The implications of this study for policy and practice highlight the need to reconsider the current conceptualisation of STIs, particularly in relation to the complex social ties that exist in rural communities. Anonymity and confidentiality are important aspects for influencing the way in which people make decisions when seeking health care for STIs.

Introduction

Failure to seek timely testing and treatment for STIs may result in substantial health conditions. The silent nature of many STIs causes significant morbidity and mortality and if left untreated can increase the pool of infection within the population (World Health Organisation 2005). The asymptomatic nature of STIs coupled

with the stigma attached to STIs, (Cunningham et al. 2002; Fortenberry et al. 2002; Goffman 1963; Nack 2002; Newton & McCabe 2005) influence the way in which people access or do not access services.

In light of the recent increase in the incidence of certain STIs in Australia, the detection and treatment of infection is fundamental to the control of STIs. While a substantial body of knowledge exists on health seeking behaviour (Darroch et al. 2003; Dixon-Woods et al. 2001; Klausner et al. 2001; Plummer & Forrest 1999; Ward et al. 1997), screening and management of STIs (Cassell et al. 2006; Johnston et al. 2004; Skov 2002), surveillance and epidemiology (National Centre in HIV Epidemiology and Clinical Research 2005; Wright et al. 2005), there has been less attention given to understanding issues in STIs from a rural context.

Within rural communities, complex social relations exist as a network of multiple social ties among community members (Dempsey 1990). Subsequently, anonymity and privacy are difficult to maintain in rural communities where people are familiar and are known to most of the community members (Thomas et al. 1999). Access to services for the treatment and care of STIs in rural areas of Australia occurs through a number of avenues. These include general practitioners, sexual health clinics, emergency departments and Aboriginal medical services. Characteristics that are involved in influencing access to services include the model of service delivery, and the geographic dispersion of the population (Castaneda 2000). Furthermore, the shortage and inequitable distribution of general practitioners in rural areas (Humphreys et al. 2002; Humphreys et al. 1997; Strasser et al. 2000) and a delay in consultation with medical practitioners increases the complexity of medical care in rural areas (Humphreys et al. 2003). In addition, transport in rural areas tends to be unavailable or limited thus there may be a reliance on others with motor vehicles for transportation (Australian Institute Health and Welfare 2004). Moreover, the degree to which the service is culturally appropriate has an effect on accessibility particularly the convenience of access to health services and the quality of the relationship with medical staff (Australian Institute of Health and Welfare 2004; Ban 2004).

Complexities surrounding the multidimensionality of gender and sexuality have been a matter for continued exploration and debate in the transmission of STIs (Cheek & Rudge 1996). Health related gender differences are reflected in the notion that women appear to be more concerned about health issues than men are, and tend to seek help for medical conditions before they become serious (Najman 2000). Men's ability to recognise and act on sexual health problems is based on the aspect of a mechanistic approach to health, that is, they must perceive that there is both a visual and physically difference in their body before seeking help (Pitts et al. 2005). Although some men and women prefer same sex general practitioners, communication skills, experience and quality of care of medical practitioners were more important than the age or sex (Bourke 2002).

This paper presents findings from a qualitative study that aimed to determine the factors involved in accessing services for sexual health in a rural area. The study also aimed to describe the experiences of people when accessing, using and obtaining treatment for STIs in a rural area. It addresses the following questions: What are the factors that influence access to services in a rural context for STIs? How do the experiences of individuals influence access to services? How does the meaning of their experience affect their perceptions, interactions and negotiations when accessing services for STIs?

Methods

A qualitative research design that utilised grounded theory methodological principles was used for this study. Interviews were conducted with rural residents between 2004 and 2006 at venues mutually agreed on by the researcher and informants. The sample of informants provided contrasts based on the following categories: age, sex, type of contact with an STI, place of residence, education level, employment level, indigenous status, socio-economic status and relationship status. Informants were aged between 18 and 60 years and all informants identified themselves as Australian and as heterosexuals. The majority of the sample was obtained by snowball sampling. One informant responded from radio interviews and one informant responded from a pamphlet advertising the study. As a point of comparison, the inclusion criteria for the study broadened as the research progressed and included individuals who may not have had any contact with an STI.

The interviews varied in length between 30 minutes and two hours and when face-to-face interviews were not practical, telephone interviews were conducted. All interviews were recorded using a digital voice recorder, except one interview when it was not practicable to record information over the telephone. Written notes were made as the informant spoke. All informants were given the opportunity to turn the recording off when sensitive information was revealed. No informants took up that opportunity.

A semi-structured interview format was utilised with all of the informants. Topics included in the interview guide included: descriptions of sexual risk, what factors were important when they accessed services, what strategies were used, what was known about STIs, what factors were important to understanding the link between sex and STIs, and its effect on understanding of the informants and their sexuality, culture, and the way health care was approached.

Issues in Data Analysis

Analysis of data was undertaken using the grounded theory approach. Using constant comparison, coding of words sentences or paragraphs were subsequently organised into concepts and categories. NVivo software and manual methods were used in the transposition of the raw transcript data.

The researcher, with assistance from an administration officer, transcribed data word for word. Privacy and anonymity of the informants was maintained by numbering transcripts and strict security measures was maintained for the storage of data.

On reflection, a number of tensions caused some difficulties with the use of grounded theory. These included assumptions between practical knowledge of the area compared with the theoretical knowledge and deficiencies identified in skills and knowledge. The first author is a practitioner working in the area of public health within the field of sexually transmitted infections. In her role as Public Health Officer she undertook surveillance of STIs as well as ensured resources for sexual health services across the health area were equitable and distributed according to Department of Health Guidelines. Given this background, assumptions were made about the informants experiences and knowledge in relation to access to services. These assumptions were based on information from both the literature as well as anecdotal information obtained in her position as Public Health Officer. This created tension when undertaking interviews because in-depth probing of the informant's views was not attended to as well as could have been due to the underlying assumptions. To overcome these problems during the analysis, the data was examined more closely, specifically the various codes that were developed. For each code, a large number of questions were generated based on how, what, when, what if, and where. This method of questioning opened up aspects of the data that were initially not well understood.

Other aspects of skill deficiencies were located in the area of software use for qualitative research. Use of manual methods of analysis, led to inconsistency in the development of codes and as analysis progressed, the amount of data became overwhelming. It was decided by the author that the use of qualitative software could help with the management of the data. However the considerable effort and time required to learn the software and become proficient was underestimated. The use of grounded theory is a creative and complex process and while its use presents a number of challenges in the analysis of data, the learning curve associated with initial use of NVivo was significant. Developing mastery of NVivo was a time consuming and distracting issue. The more routine and mechanistic procedures of NVivo took over the creative and interpretive analysis process and the meaning of the data was in a sense lost in the initial analyses phase. Nonetheless, NVivo offered a way for successful management and analysis of the data.

Results

The resulting analysis relates to regulating the flow of private information about STIs. The context in which individuals regulate the flow of private information for STIs in a rural area is based on the private and public world of rural life. Factors that shape social life in rural communities such as the social bonds that are present, the relationships that develop, and the way in which behaviour influences the public and private aspects of rural life. Containing the spread of information involves a number of strategies that aim to prevent

the public exposure of private information. In order to contain information, the issue for the individual is who to tell, if to tell at all, how, when and why. These strategies include concealing shame and deceiving others while disclosing STI information to others. For the purposes of this paper, a discussion of one dimension that involves influencing informants' capacity to identify the most appropriate service is described.

Identifying, seeking and utilising services

In identifying, seeking and utilising services for STIs, there are two key issues that influence an individual's capacity to identify the most appropriate service. In seeking and utilising services for STIs an individual's experience includes reacting in response to an STI diagnosis in the medical encounter, interacting with the medical practitioner, interacting in public spaces and visibility.

Reacting in the medical encounter

Reacting in the medical encounter reflects an individual's feeling of shame and stigma, which they associate, with a diagnosis of an STI. The decisions that are made within the medical encounter are based on their previous experiences with medical practitioners. The importance that individuals place on professional and personal attributes of medical practitioners influences their interactions particularly when revealing 'secrets'. Within the medical encounter, 'secrets' can be revealed through a physical examination as well as questioning by the doctor. For the person to be able to allow an exposition of their 'secrets' to their doctor they would need to have a trusting relationship.

Trust was an important component that influenced an individual's decision to disclose private information. When the person perceives that, the relationship is not as trustworthy as what they would expect then concealment of information may occur. As the following informant says:

Well I think I'd be less inclined to go to a doctor that I didn't have a good relationship with. I wouldn't want to open up as much, which could cover a hell of a lot of the story if I didn't tell them it all and they mightn't find out what's wrong with me or anything like that because I'm covering 90 percent of the story up.

(Informant 17, female 24 years)

Not only was trust an important influence, but the gender dynamics of medical practitioners can influence perceptions about the self and the future disclosure of private information. The following informant was in a situation whereby he preferred to have the privacy of a sexual health service to his usual doctor but had very little choice over the gender of the medical practitioner. During the consultation, intimate questions were asked about sexual activities, which was confronting for the informant.

... it is a little bit more disconcerting when you are dealing with a female nurse or a doctor. Well when it comes to the examination side of the treatment you probably feel more self conscious than if you were talking to a male. Like you don't have a choice you know what I mean. You are

there to see the doctor and that is it and it sort of gives you more an impression that it is the way of the clinic, like female patients more so than it is for men.

(Informant 20, male 45 years)

The gender differences that are present in the above situation can influence the amount of information that is disclosed. The increased level of comfortableness with a male practitioner potentially can improve disclosure of intimate information for some men.

Interacting with the doctor

The frameworks, that individuals use to make choices shape individuals interactions with the doctor and can influence the decisions individuals make about seeking and accessing services. For example, some doctors who work in a rural area may have the dual role of being a family friend as well as a medical practitioner. The following informant explains:

... the family doctor was also a personal friend of our family. He would always come and see us when we were sick with flus and things. You know the usual childhood diseases. I got to know (Dr) very well and therefore his judgment was undoubted. He always seemed to know what was wrong with you and was able to fix it. So from the early days I always had this strong trust and confidence in the doctor .

(Informant 1, male 61 years)

Having a personal relationship with the medical practitioner meant that they knew them either on a personal level or they were the family doctor. This meant that the doctor had a level of intimate knowledge of family members, therefore adding extra assurance that medical practitioners generally could fix the problem. Knowing the medical practitioner had such a level of knowledge, made decisions about access easier as it is based on a positive experience. Having a personal relationship with a general practitioner made it easier to have an open conversation as the following informant shows:

My particular one [GP] now and she it's a woman and that makes me more comfortable about talking sexual things and I guess I would trust her based on a relationship that has built up over more than 10 years.

(Informant 24, female 59 years)

Having a medical practitioner of the same gender, as identified previously, encouraged open communication.

However, privacy to some individuals meant anonymity particularly when the individual believed that they may have an STI. Subsequently, having close connections with medical practitioners means that choice of access is based on the preference for anonymity. The strong sense to protect private information from becoming public knowledge is an impetus for individuals to go elsewhere. As the medical practitioner knows the family history, there is perception by the individual that somehow the doctor may not keep the information

confidential. The tension between wanting privacy and confidentiality and wanting to go to a known and trusted medical practitioner creates a complex situation for individuals as the following informant explains:

Well the doctor at the clinic, you go there to be tested. You don't have a problem. Well you don't have to go back and see them and talk to them about whatever. But if you have a regular GP then you are going to have to go back and deal with them all the time on a regular basis. But if you just go to the clinic you don't have a problem or you do have a problem. Well they can hopefully teach you one way or the other but if you go to a GP then you know it sort of it sits on their cards and it is on their memory bank and you don't want to talk to them about it. Well you don't have to because you have dealt with and it's fixed and they don't really need to know sort of thing. Usually GP's often know your sisters and you mother and brother and whatever and they sort of just more connected.

(Informant 20, male 45 years).

Concerns about exposure of private issues can influence an individual to opt on the side of privacy and confidentiality, thus helping to conceal the shame that may occur if others knew of their STI. The sense of 'blame' and irresponsibility associated with STIs increases the potential that individuals will remain silent about their infection.

Interacting in public spaces

Interacting inside and outside public spaces refers to the condition that influences an individual's thought processes when making decisions about access. Regulating private information occurs in places where there is a gathering of more than two people. Within these places, the social interaction may be incidental to the individual's activities such as within medical waiting rooms. In situations where individuals are in the presence of others, there are social rules that guide their conduct. The following informant explains how sexual health clinics can become public meeting places.

... the other day I met a girl up there and we were having a mad conversation. I got her number so I've made a few friends through the clinic.

(Informant 7, female 19 years)

Within the waiting room at the sexual health clinic, some non-verbal interaction occurs. The public exposure of individuals at specialised sexual health clinics suggest that behaviours are aimed at minimising that visual exposure. There is a brief acknowledgment of the other person and then attention is withdrawn as the following informant reveals:

... sometimes you have got to wait for a considerable time to get in for the appointment and then you will get other people, sort of young girls in the waiting room. ...everyone sort of looks in the different corners of the room trying to avoid each other and I think that makes you uncomfortable and you sort of feel uncomfortable.

(Informant 20, male 45 years)

The rules of conduct such as above involve the avoidance of eye contact to prevent a focus on the other person. The fear of being recognised by others in specific situations is extended to public places. Places such as sexual health clinics are highly visible sometimes because of the location of the service and the public recognition for the treatment of STIs. The following informant recalls:

... I was teaching at [school] and someone had to go to the clinic. It was a big joke about 'I saw you coming out of the clinic'. 'What were you doing there'? Obviously, he was there about a student and once again, it was sort of that joke type thing. ... And I must admit, it didn't enter my head for one minute that they were being serious. You know I knew it was light hearted and I assumed if he had been there it would have been for a student. I mean well who cares. ... but I think there's still a lot of you know hush, hush don't let anyone know. That type of attitude still.

(Informant 9, female 54 years)

The exposed and visible nature of the service can have implications for individuals. Private information may become public. Loss of control of private information disseminated through gossip means that individuals may be careful as to how they access services.

In contrast, the visibility of individuals at general practitioner surgeries did not raise the same sense of fear due to the non-specialised nature and the privacy of the medical encounter. A sense of shame and stigma was not as evident as the following informant suggests:

In a city that's less likely to happen so going to the chemist, the odds are here I would know somebody else who was in the chemist at the same time. So I would feel more constrained than I would making an appointment and talking to my doctor. ... I'm not saying the pharmacist wouldn't be confidential it is just the nature and having lived here I know a lot of people in the town. Partly from my work so the chemist isn't as confidential environment as the doctors. Who knows what you are in to see the doctor about?

(Informant 24, female 59 years)

Some informants felt privacy and confidentiality at the medical practitioner's surgery was acceptable. Although the following informant felt uncomfortable at having to verbalise her problem in the presence of others in the waiting room who potentially may know her, she felt confident in the knowledge that the information disclosed in a public situation would remain confidential.

... when I went to the doctors, I could tell from the reception lady, 'cause it's my family GP. I need to have a blood test, and she said what do you need it for. I said I have had unprotected sex, so I'd like to get checked out and symptoms and I want to be 100% safe. To me like I even

felt a bit funny about saying that to them because there was somebody else in the waiting room.

But, it didn't really worry me all that much because I know its confidential.

(Informant 12, female 23 years)

Influences that alter an individual's decision about access to services are expressed in a number of conditions that explore interactions with medical practitioners and the dichotomy between public and private aspects of an individual's private information. Such issues of privacy raise all kinds of intimacy issues and relationship obligations. Informants chose whom out of their social network they could tell, what they could tell and how they would tell it.

Conclusion

The condition of identifying, seeking and utilising services may influence an individual's control or lack of control in the regulation of private information. Control of private information was important to prevent stigma and shame that is associated with STIs. Balancing the need for privacy with a known and trusted medical practitioner is a delicate and complex process that involves strategic decision making about access to services. Knowing that the relationship a person has with their doctor is an intimate one is relevant for influencing the way in which people make choices about access to services, particularly for those individuals who have knowledge or perceive they may have contracted an STI. However, this study did not explore the quality of the care provided.

The affect of close relationships in rural areas on access to services are consistent with studies that showed continuity of care and being comfortable is important to rural residents (Dixon-Woods et al. 2001; Humphreys et al. 1997). The visibility and complex social ties that exist within rural towns has been identified by Dempsey (1990) who suggests that because of these aspects an individual's privacy and confidentiality are compromised. The tension that surrounds the issues of anonymity and confidentiality have important implications for seeking health care for STIs and supports previous evidence (Beck et al 2005; Warr & Hillier 1997).

The present research has implications for the gender and interaction theory. Interactions appeared to be a consequence of gender and findings from this study confirm that there are differences in the way men and women interact. This finding supports previous evidence that suggests that men find it easier to talk to men about sexual matters than to women (Swain 1989). In addition, preference for same sex medical practitioner has been identified previously (Bourke 2002) and appears to be important for a number of individuals.

Strategies directed at rural individuals to encourage individuals to seek healthcare for STIs will need to address the social interactions that occur in public and private situations and the nature of close relationships with health practitioners. When allocating resources, taking into consideration the preferences of individuals for close relationships versus anonymity could help to overcome some of factors that influence access to

services. For example, support for medical practitioners in testing and treatment of STIs is an important aspect for secondary prevention as well as a support mechanism for individuals to maintain a continuity of health service with a trusted professional. Specialised services need to have a broad network of access points to capture those individuals who prefer anonymity.

The consequences of stigma and shame associated with STIs in relation to access to services influences the way in which individuals seek health care. Challenging views held by the general population particularly in relation to how they perceive STIs can shape the way in which 'normalising' STIs could occur. Removing labels such as 'sexual health clinics' could help to reframe social views associated with STIs.

Individuals interviewed for this study were limited to one predominately rural health area, therefore a comparison with a metropolitan area could provide a more comprehensive study. Further research that explores the differences that occur between levels of socioeconomic status and by gender could add extra insight into the dynamics underpinning interactions for STIs in a rural area.

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