People at high risk for STDs used a variety of primary and secondary prevention strategies


QUESTION: How do people at high risk for sexually transmitted diseases (STDs) understand and practice STD prevention?

Design
Ethnography.

Setting
A rural county in North Carolina, USA.

Participants
38 low income people ≥ 18 years of age (20 men, 33 African-American) were identified from an STD clinic and a county jail, and by social service professionals. 24 of the participants reported having had ≥ 1 STD.

Methods
Indepth interviews of 1–2 hours were held with each participant. Questions focused on sexual behaviour and condom use, drug use, STD care seeking and self treatment, and sexual risk taking in relation to curable STDs such as gonorrhoea, chlamydia, and syphilis. Interviews were audi-taped and transcribed. Codes, common patterns, and emergent themes were identified. Sections of 4 interviews were excluded because of data contamination by an inexperienced interviewer.

Main findings
The findings reflect an insider’s (emic) view of how to protect oneself from STDs and why. Primary and secondary prevention strategies were identified. The most common primary prevention strategy was partner selection based on familiarity, appearance, and reputation. Familiarity was equated with safety. The extended friendship and kinship networks of rural life provided a way to know something about potential partners, which provided a (sometimes false) sense of safety. Participants also judged a potential partner’s appearance to determine if he or she was “clean” (disease free) or “dirty” (diseased), terms that also seemed to have connotations of morality and immorality, respectively. Reputation was another criterion for partner selection. Many respondents referred to the active gossip network as a way that men passed the word when they thought a woman was infected or “burning” and should be avoided. Most respondents seldom used condoms, explaining that they simply did not like them. They did, however, use condoms selectively, usually with partners they perceived to be risky. Partners were characterised as “street” (risky partners related to life on the street) and “home” (safe partners at home). Many did not use condoms regularly with their main partners because they assumed (sometimes mistakenly) fidelity within this relationship. Other primary prevention strategies included washing after sex and having oral rather than penile/vaginal sex.

Participants also used secondary prevention strategies when they believed they had been exposed to an STD or noticed symptoms. The most common practice used by women was to visit the health department regularly to get checked out for STDs, even if they had no symptoms. Another strategy used by women was to ask trusted friends or family members for advice about suspected STDs. Many men reported asking for advice or immediately seeking treatment when they suspected an STD. They also self treated, before symptoms appeared, using antibiotics obtained without a prescription (ie, either prescribed but not taken for previous infections, obtained from friends, or purchased on the street). Reasons for obtaining antibiotics from the street rather than the health department included embarrassment and fear of injections. Although non-compliance with prescribed treatment was a common problem, several respondents reported complying with treatment.

Conclusion
People at high risk for sexually transmitted diseases used primary prevention strategies including partner selection based on appearance, familiarity, and reputation and selective condom use, as well as secondary prevention strategies including regular health department visits for screening, asking friends and relatives for advice, and self treatment with antibiotics.