

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

McDonald MA, Thomas JC, Eng E. *When is sex safe? Insiders' views on sexually transmitted disease prevention and treatment.* *Health Educ Behav* 2001 Oct;28:624-42.

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 audiotaped 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.

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COMMENTARY

The qualitative study by McDonald *et al* provides important insight into the complex sociocultural phenomena of sexual risk assessment and decision making in a sociocultural group that is disproportionately affected by STDs.¹ Consistent with studies of "lay" beliefs and health practices in various health fields,² the study by McDonald *et al* shows how the health values, attitudes, and behaviour of a particular group can diverge markedly from "official" prevention strategies.

The strength of this study lies in its qualitative exploratory approach and its use of purposeful sampling to include participants at apparently high risk of STDs. This increases the likelihood of gaining an accurate account of the issues of interest. One limitation is that respondents were volunteers within the settings chosen and thus may not be representative of this particular group. A second limitation is the use of interviews as the sole method of data collection, which may, for example, result in respondents reconstructing idealised accounts of their actions. An illustration of this is the recognition by the authors that although respondents stated that it was not possible to know whether someone had an STD by the way they looked, this was the basis of "lay" prevention strategies that they used.

There is increased recognition of the importance of social and cultural variables in explaining the adoption of new behaviours and lifestyles. Culturally constructed health and social beliefs result in a wide range of unique patterns of health seeking and maintenance behaviours in different sociocultural groups.³ Practitioners could use the results of this study as a basis for reflecting upon the values and beliefs that underpin the prevention strategies that they encourage their clients to adopt. As McDonald *et al* acknowledge, it is important to avoid adopting stereotypical views of any individual or group. Instead, practitioners could view these findings as one of a range of probable socioculturally influenced strategies for the prevention of STDs.

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- 2 Borrayo EA, Jenkins SR. Feeling healthy: so why should Mexican-descent women screen for breast cancer? *Qual Health Res* 2001;11:812-23.
- 3 Bell DL, Ragin DF, Cohall A. Cross-cultural issues in prevention, health promotion, and risk reduction in adolescence. *Adolesc Med*. 1999;10:57-69.