Insights into the Barriers and Motivators Impacting Chlamydia Screening Rates amongst Male Students

Julie Fowlie, University of Brighton, J.Fowlie@bton.ac.uk
Matthew Wood, University of Brighton, Matthew.wood@bton.ac.uk
Julian Reuter, University of Brighton, Socko454@hotmail.com

Abstract

The National Health Service (NHS) for England and Wales states that the number of confirmed Chlamydia cases is growing. Individuals within the 16-24 years age range account for 65% of new cases and these are almost equally split between males and females. However, of the 1.3 million individuals who attended NHS contraceptive clinics in 2009 only 140,000 were men. This suggests that the rates amongst men may be even higher and that males in particular are not accessing available services. This paper explores the attitudes and behaviour of British male university undergraduate students to sexual health and outlines recommendations to increase Chlamydia screening rates. 147 questionnaires, 58 depth interviews and three focus groups were used to generate the consumer insight required by the National Social Marketing Centre's "benchmark criteria". Several key issues have been identified as a result of the research. Current Chlamydia screening information and advertising is having little or no impact on the behaviour of most male students. There is a perception that their peers view visiting a clinic negatively and this can be a major barrier to Chlamydia screening. Screening should be normalised amongst students' social groups and services made more convenient and accessible to improve participation rates.

Keywords: Social marketing, sexual health, Chlamydia, students

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Background

Whilst just one in eight of the population in the UK are aged between 16 and 24 years this group accounts for about half of newly diagnosed STIs (sexually transmitted infections): 65% of all chlamydia (79,557 of 121,986), 55% of all genital warts (49,250 of 89,838) and 50% of gonorrhoea (9,410 of 18,710) infections diagnosed in GUM (genitourinary medicine) clinics last year (Pharmaceutical Services Negotiating Committee [PSNC], 2009). Recent research conducted by the BBC (2009) suggests rates of chlamydia could be as much as 1:10 in the under 25's. It is not surprising that The British Association of Sexual health and HIV (BASHH, 2010a) in its Standards for the Management of STIs has identified sexual health as one of the six key goals for which primary care trusts must commission comprehensive wellbeing and prevention services. However, surgeries and planning facilities are predominantly accessed by women (BASHH, 2010b) and only a few projects have attempted to proactively reach out to men in places such as colleges, factories and prisons. About 1 in 10 individuals tested through the NHS Chlamydia Screening Programme are men and males tend to be less well informed about STIs (Men's Health Forum, 2006). This paper aims to explore the exchange process (Bagozzi, 1978) impacting young males' attitudes and behaviour towards screening and at the heart of the social marketing approach (Andreasen, 2000).

Recent Chlamydia Screening Initiatives

The NHS is currently running a campaign labelled "Sex Worth Talking About" (NHS, 2009). The campaign aims to help young people (although not specifically students) make more informed choices about contraception, look after their sexual health and avoid unwanted pregnancies. It is based on the claim that it is "easy, everyday and normal to have discussions about contraception between partners, parents and health care professionals" (ibid, 2009). It aims to increase awareness of sexual health, as well as encouraging open, honest discussions and a culture that frames sexual behaviour among young people as a normal part of their development (ibid, 2009). There was little or no awareness of this campaign amongst our particular sample or respondents, who are also unresponsive to more local campaigns – this is discussed further in the results section. Under The National Chlamydia Screening Programme 270,729 screens were conducted in 2007, a 93% increase on 2006 (PSNC, 2009). This shows that proactive attempts to screen more young people have been successful; however, screening rates amongst males remain relatively low.

The Chlamydia Outreach Advice Screening Treatment (COAST) scheme in Lincolnshire is part the government's plan to ensure 35% of all 15-24 year-olds are screened for Chlamydia by 2011 (NMSC, 2010). Research identified key insights, for example young people want one point of contact for advice, screening and treatment. Text messaging is the preferred way of receiving test results. A majority of young people preferred screening services to be nurse-led. The worry of how to inform previous sexual partners is a major barrier to screening and young people wanted support in this area. On the basis of this insight COAST developed a strong marketing mix and service design, which included free screening at 109 venues that young people use; outreach activities and tutorials conducted with groups of students in local colleges; results provided quickly via text, email or mail; COAST will trace and inform sexual partners if there is a positive result; free treatment is provided when and where users choose; targeted promotions, communications and branding which were co-produced and

tested with audience. In the first year-ending 31st March 2008 N.E. Lincolnshire had screened 7.5% of the 15-14-year-old population, compared with 4.9% for all England. However, this campaign targets all young people and results for males are not available, making its success with men difficult to determine.

Social Marketing and Behaviour Change

This paper uses exchange theory (Bagozzi, 1978: Maibach, Kreps & Bonaguro, 1993), stages of change model (Prochaska & DiClemente, 1982), social cognitive theory (Bandura, 1986; Maibach & Cotton, 1995; Hastings, G., MacFadyen, L. & Anderson, S. (2000) and core social marketing concepts (Wood, 2008; Andreasen, 2003;1994; Kotler & Zaltman, 1971). It is based on the principle that people generally change for emotional rather than rational reasons, they are influenced by a range of factors and individuals and usually require personal support (Fowlie & Wood, 2008; 2009; Wood & Fowlie, 2009). Before developing social marketing interventions and campaigns it is essential to gather meaningful insights into the attitudes, emotions and behaviours of the target audience. COAST identified key perceived costs and barriers preventing young people from undertaking Chlamydia screening (NSMC, 2010). This paper discusses exploratory research which should help in the development and delivery of appropriate interventions to improve screening rates specifically amongst male students.

Exchange Theory

In order to increase consumers' (male university students) readiness to change social marketers must provide them with something beneficial in exchange. In this sense, exchange involves "the transfer of tangible or intangible items between two or more social actors" (Bagozzi, 1978). It is important to note that the exchanges must be mutually beneficial, where the perceived benefits outweigh the perceived costs, voluntary adoption by the consumer is most likely (Maibach, Kreps & Bonaguro, 1993). In other words, positive exchange occurs when the motivators are less than the perceived barriers and the resulting social price is then seen as "affordable" (Andreasen, 2000). On the other hand, if the perceived cost of adopting a new behaviour outweighs the perceived benefit in the exchange process, the target population will not adopt the desired behaviour; that is, to increase the frequency of Chlamydia screenings. It is also useful to note that people often respond to incentives to change their behaviour (Hastings, 2007). Exchange theory is a core principle of marketing and academics have argued that the target audience's perception of the benefits they will receive through the adoption of a certain behaviour is the key motivation that marketers must understand and use to achieve change (Andreasen, 2000).

Stages of Change Model

Developed by Prochaska and DiClemente (1982) this model analyses the target audience's actual readiness to change, and states that "behaviour change is a process rather than an on/off switch, and it is a good idea for those interested in enacting change to start by finding out how far people have progressed along this process" (Hasting, 2007, p 27). According to this model male university students may progress through five stages: 1: *Precontemplation* – aware of chalmydia screenings, but disinterested; 2: *Contemplation* – consciously evaluating the personal relevance of screenings, and how increasing their frequency would affect their lives; 3: *Preparation* – they decide to act and attempt to put in place steps needed to carry out the new behaviour; 4: *Action* – they receive regular chalymidia screenings; 5: *Confirmation*

(maintenance) – they are committed to the behaviour and have no desire or intention to regress to previous behaviour patterns.

Social Cognitive Theory

Human behaviour is reciprocally determined by internal personal factors (such as knowledge and self-efficacy) and environmental factors (such as levels of deprivation or availability of facilities in the local community) (Bandura, 1986; Maibach & Cotton, 1995). Hastings, MacFadyen and Anderson (2000) argue that from a social marketing aspect health behaviour takes into account the influence of the individual and also that of the direct surrounding environment. As a result our behaviours are directly influenced by friends, family and the local community, known as the 'immediate environment'. Also, human behaviour is influenced by "social mores, economic conditions and cultural norms", in other words the 'wider social context' (Hastings, 2007). This research demonstrates that social influences, in particular from peers, have a critical impact on male students' screening behaviour.

Research Methods

Using a random sampling approach (Saunders, Lewis & Thornhill, 2007; Kish, 1995) 147 male university undergraduate students (aged 20-24) at various campus locations were surveyed using a structured questionnaire (Salant & Dillman, 2007) to acquire some preliminary insights into their behaviour. It included questions on existing sexual activity; history of STIs, if any; frequency of GUM clinic visits and reasons behind these visits, if any; rating of experience of services offered; and any other issues related to visiting GUM clinics. In addition to the survey fifty-eight depth interviews and three focus groups were held with the same segment to provide qualitative data (Mariampolski, 2001). The interviews aimed to determine the factors that influenced particular individuals in making choices around sexual health (Bandura, 1986). The focus groups were carried out to generate deep insights into the attitudes and behaviour of the target audience (Ritchie & Spencer, 1994). Interviews were also conducted with four nurses at a local GUM clinic to gain insights into target audience behaviour from the perspective of professional service providers.

Results

Of the 147 males students who answered the questionnaire the vast majority (96% [n=141]) stated that they were sexually active, of which 30% (n=29) replied that they had had an STI in the past. Exploring these 29 positive responses further the majority (62% [n=18]) said that they had found out about their infections through previous sexual partners, rather than home tests (21% [n=6]) or sexual health clinics (17% [n=5]). This supports evidence from menshealthforum.org.uk (2009). Over half of the respondents (51% [n=72]) are screened less than once a year and 16% (n=23) had never been screened. 12% (n=17) are screened at least once a year with the remainder (n=29 [21%]) claiming to have screening more frequently than once a year. Only a minority of students appear to be following the national guidelines for the frequency of sexual health screening for Chlamydia amongst under-25s, which is at least annually, or after a change of sexual partner (BASHH, 2010a). Over half (52% [n=77]) of the sample responded to the question *"what was the reason behind your last visit to a sexual health clinic?"*: 36% (n=28) stated unprotected sex, 26% (n=20) a regular check-up, 18% (n=14) because of symptoms, and 10% (n=8) for other reasons. Only 9% (n=7) gave advertising (health promotion) as the reason and 71% (n=105) of students are unaware the university offers free Chlamydia screenings. This supports previous research which shows that male students perceive university posters advertising Chlamydia screening on campus as

boring and that posters in general are not read by men unless they contain drink or food offers (Chaudhary, et al 2008). It is apparent that simple flyers and posters are not sufficient to encourage males to participate in free screenings and to move from precontemplation/contemplation to take action Prochaska and DiClemente (1982). Respondents were asked about perceived barriers and costs preventing them from undertaking screening. 61% (n=87) stated that the operating hours of GUM clinics were insufficient. 37% (n=52) answered that the main reason for non-screening is peer perception and pressure. Lack of available information was perceived as an issue by 35% (n=49) while17% (n=24) stated that the waiting times were a barrier. The interviews provided further insight regarding the perceptions of screenings and GUM clinics and some indicative quotes are provided below:

- "I am unsure as to where the clinics are. But then again, even if I did know, I have no real means of transport to get there as I don't drive."
- "I have heard that they literally stick something down you, and it kills. Why on Earth would I go through that?
- "You tell your mates you're going to the clinic and you're known as 'AIDS boy'"
- "You sit there, and quite frankly, you feel quite dirty".
- "I do go every month. This is simply because my father took me to a clinic when I became sexually active. Ever since then I've gone regularly".

Results from Focus Groups

The focus groups delivered similar results to the interviews and questionnaires. This qualitative research highlighted and discussed the key issues in regards to sexual health clinics. Deutschman (2007) demonstrates that fear and facts do not create change and this supports the arguments of social marketers (Hastings & Stead, 2004). The health aspect is not a big enough benefit in the exchange process (Maibach, Kreps & Bonaguro, 1993) to adopt social marketing behaviour:

Barriers to adopting the desired behaviour are:

- Peer perception; "Every time I go to get screened, the girls always laugh and ask what I've caught now. So I try to keep my visits quiet. But then if they find out I went, they definitely think I have something."
- Operating hours: "Try doing third year pharmacy, then try and find time to go during the times they give you."
- No weekend screening times
- Lack of information and advertising impact: "They're all the same, and none of them have made me interested in screening"
- Embarrassment when calling the clinics, and when waiting for appointments
- Afraid of results

Motivators to adopt the desired behaviour are:

- A sufficient exchange
- Parental and peer advice and encouragement
- Being able to openly discuss sexual issues within the community
- Requirement to adopt behaviour as a result of societies, course, enrolment, etc.
- Would go more often if they were in a group

Male students may increase the frequency of Chlamydia screenings if there were convenient ways of doing so, or if they were required to do so. The interviews with GUM nurses established that the current ratio of male to female patients seeking screenings is around 1-3 (although better than national statistics for this age group). It was also noted that most men

visit clinics alone, rather than in groups, and they often wish to remain anonymous or use fictional names. Clearly, perceived stigma around STIs and screening within individual young males' reference groups causes embarrassment. This acts as a barrier, particularly in the absence of motivators and perceived benefits, preventing the adoption of "healthy" behaviours, in other words regular Chlamydia screening. This shows the value of applying social cognitive theory in this situation (Hastings, MacFadyen and Anderson (2000).

Conclusions and Recommendations

Several key issues have been identified as a result of the research. Current Chlamydia screening information and advertising is having little or no impact on the behaviour of most male students. Relationships with peers and reference groups are critical. Because there is a perception that their peers view visiting a GUM clinic negatively (with various negative associations) male students may not readily participate in Chlamydia screening. There are negative (and often inaccurate) myths surrounding the procedures at GUMs. Also, perceived logistical problems, for example restrictive operating hours and long waiting times for an examination, act as costs and barriers which may prevent the adoption of screening behaviour. Currently many male students do not feel there is enough a reward or benefit in the "exchange" process to outweigh the perceived costs and barriers in taking part in Chlamydia screening. To influence a positive transition in the stages of change model (Prochaska & DiClemente, 1982) social marketing interventions and campaigns should be developed to specifically address the concerns of male students. Many students appear to be "stuck in the precontemplation/contemplation stages and more targeted research and interventions are required to address this issue. It is evident that the adoption and frequency of Chlamydia screenings is impeded by peer pressure and perception. Male students are uncomfortable because they are very concerned about what their peers and friends may say or think. Sexual health screenings should be part of societal norms (Bandura, 1986; Maibach & Cotton, 1995) and build on positive relationships (Wood & Fowlie, 2009). To support the current NHS campaign "Sex Worth Talking About" university societies and groups (for example, sports teams, drama groups, etc) should be encouraged to undertake regular Chlamydia screenings. It is important to reinforce that testing for STIs is "normal" and of benefit to the social group as well as the individual. The free university Chlamydia screenings service suffers from a lack of awareness and/or perceived inconvenience. Flexible hours/locations and an on-line booking facility would be helpful. In conjunction automated e-mails/SMS messages should be used as reminders for screening and appointments times and new media used as communication channels (NSMC, 2010). More generally this research supports the social marketing approach, which recognises that facts and information (creating awareness) are not sufficient to motivate behaviour change and more targeted interventions are required which take into account exchange processes and social/environmental influences (Andreason, A. 1994; Wood, M. 2008).

Limitations and Further Research

This exploratory study involved a small random sample of male undergraduates from one English university. It would be useful to extend this research to other universities and young males from wider socio-economic backgrounds. This would enable researchers to evaluate the impact of social and demographic factors on behaviour and attitudes towards Chlamydia screening. We would also recommend a focussed study to identify the appropriate incentives, service design and branding/communications strategy needed to motivate young males to undertake regular Chlamydia screenings.

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