REPRODUCTIVE HEALTH matters

FEATURE

Socio-cultural influences upon knowledge of sexually transmitted infections: a qualitative study with heterosexual middle-aged adults in Scotland

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Abstract: *There has been a recent global increase in sexually transmitted infections (STIs) including HIV among adults aged over 45. Limited evidence exists regarding middle-aged adults' knowledge of STIs other than HIV. This qualitative study sought to understand middle-aged adults' knowledge of STIs within a socio-cultural context. Individual interviews, based on a life-course approach, were conducted with 31 recently sexually active heterosexual men and women. Participants were aged between 45 and 65 and of mixed relationship status (14 were single, 17 in a relationship). Thematic analysis identified four key findings, including: "engagement with STI-related knowledge"; "general knowledge of STIs"; "learning about STIs from children"; and "limited application of knowledge". The findings allow insight into a neglected area, and indicate that socio-cultural factors influence middle-aged adults' STI-related knowledge acquisition throughout the life course. These are important implications for the prevention of STIs, particularly in addressing the on-going stigmatisation of STIs in older age groups.*

Keywords: middle aged, sexually transmitted infections, knowledge, heterosexual, qualitative research, UK

Background

Rates of sexually transmitted infections (STIs), including HIV, have increased among adults aged over 45 (defined within this paper as "older") globally and within the UK in the last 15 years.[1–4] UK based diagnoses of chlamydia, gonorrhoea, herpes, syphilis, warts and HIV have risen among both heterosexual men and women and men who have sex with men aged 45-65 (defined within this paper as "middle-aged") within the last decade.[2,3] Although young people under 25 and men who have sex with men are at greater risk for STIs within the UK,[2,3] STIs among older adults continue to rise, supported by high mid-life rates of divorce and repartnering.[5,6] In addition, within the UK, around 80% of adult life is spent in very good or good health which is associated with being more sexually active than when in poor health.[7–9,*] Large scale UK-based survey data indicates that 77.7% of men and 53.7% of women from age 50 to over 90 were sexually active in the last year.[9] The sexual domain of healthy ageing remains a largely underexplored area, lacking relevant evidence to shape intervention design and service provision.

STI knowledge plays an important role in preventing infection transmission, often understood as a necessary but insufficient factor within the complex determination of sexual conduct. Most available evidence involving older adults focuses on HIV, associating a lack of knowledge among this age group with increased risks of acquiring HIV and the avoidance of HIV testing.[10,11] Age and socio-structural factors including education and socioeconomic status also influence older adults' knowledge of HIV.[12] There is less understanding of older adults' knowledge of STIs beyond HIV. This is important because other STIs are common, with an estimated 498 million new adult cases worldwide of chlamydia, gonorrhoea, syphilis and trichomonas, including rising rates among

*Although it is notable that healthy life expectancies in Scotland and Northern Ireland, contrary to England and Wales are falling.[7]

older adults within the UK and elsewhere.[1,2,4] In addition, people may assess themselves as low risk for HIV and disregard other STIs. Furthermore, similarly to HIV, other STIs often have unclear or no symptoms.[13]

In order to facilitate reducing risks for STIs among older adults, it is important to understand the socio-cultural processes which are the factors within the shared public environment influencing the acquisition of knowledge. There is a gap in awareness of not only what older adults know about STIs but the social contexts in which this knowledge is acquired. These are essential elements in understanding how sexual health knowledge and wider sexual health literacy is implemented within sexual conduct. Like all knowledge, sexual health knowledge is socially constructed.[14] Berger and Luckmann argue that in the absence of being able to know everything about the world, knowledge about any particular domain is patterned, depending on the individual's social position and its relevance to their lived experience. For areas remote from personal relevance, there is a "social stock of knowledge" which individuals draw on pragmatically in order to manage their lives.[15] This social stock, as applied to sexual health, arises from wider areas of life than formal education.[16] For areas with personal relevance, knowledge is constructed through the complex interplay of individual lived experience, narrative and socio-cultural position. This study therefore addresses late middle-aged adults' knowledge of STIs within these socio-cultural contexts.

Methods

Heterosexual men and women were recruited in a large Scottish city. It was considered that older men who have sex with men, also at risk of STIs, deserve a separate, culturally focused study.[17] A heterogeneous, recently sexually active sample was sought with regard to risk exposure to STIs. In order to capture both the wider social stock of knowledge and its relationship to narrative accounts of lived experience, a two pronged sampling strategy sought participants who had recently used sexual health services and also addressed the larger population of sexually active older adults who had not sought sexual health testing or treatment. As such, adults tested for STIs within the preceding six months in National Health Service [NHS] sexual health clinics were invited to provide demographic data and undertake a single individual interview. Participants experiencing partner change within the last five years were also recruited from public, council-run sport and leisure centres. These are referred to as clinic and community samples respectively during presentation of the data below.

Participants attending NHS sexual health clinics, who had been invited by clinicians to document their interest in taking part in the project, were followed up by JD with further information about the study. A total of 15 (11 women and 4 men) were interviewed from sexual health clinic settings. Within the sport and leisure centres, 989 adults were approached by JD or visited her stall containing publicity information about the study. Interest in taking part was recorded by 281 adults (135 men, 144 women, 2 unrecorded gender). In total, 123 potential participants were excluded; the most common reason was not having changed partner within the last 5 years (n = 117). An additional 65 adults declined to participate before inclusion criteria were applied, 5 eligible participants withdrew and 73 were subsequently not contactable. A final 15 (6 women and 9 men) were recruited from sport and leisure centres. In total, 31 (18 women, 13 men) heterosexual adults undertook interviews: 15 from clinic and 15 from community settings, plus a single pilot interview, included as a community interview (Table 1). Participants were aged between 45 and 65 at the time of interview. Telephone interviews were introduced due to slow recruitment and following requests from potential participants who could not attend face-to-face interviews and declined home interviews. Interviews took place at participants' homes (n = 11), sexual health clinics (n = 3), the university (n = 14) or by telephone (n = 3) between October 2012 and October 2013. All interviews were recorded, anonymised and fully transcribed.

Interviews utilised Flick's episodic interview technique, based on small scale narratives focussing on a particular topic, in this case sexual health. This technique enabled all participants to reflect on recent and past sexual experiences, capturing the complexity of ways in which they acquired knowledge of sexual health.[18] This approach aimed to gather evidence of enduring socio-cultural influences on their knowledge of STIs across the span of participants' lives. Early in the interviews, participants were asked what came to mind when they heard the phrase "sexually transmitted infections". They were subsequently asked