Opportunistic screening for Chlamydia: a pilot study into male perspectives on provision of Chlamydia screening in a UK university

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ABSTRACT

Background Since 2003, the University of Leeds has been a pilot site for the National Chlamydia Screening Programme (NCSP), which offers opportunistic screening to asymptomatic people under the age of 25. Uptake among men is low. The purpose of this study is to explore perceptions and acceptability of the provision of Chlamydia screening in the University of Leeds among 18–25-year-old male students.

Methods Using a purposive sample of 15 male students aged between 19 and 24, two focus group sessions were conducted within university grounds.

Results Thematic analysis of the data revealed that male attitudes about Chlamydia screening were affected by: (1) lack of knowledge about Chlamydia and screening; (2) social embarrassment about Chlamydia; (3) reluctance to seek medical help; (4) perception that Chlamydia was a ‘woman’s disease’ and (5) indifference about health promotion campaigns.

Conclusion To encourage the uptake of opportunistic screening of Chlamydia, men under 25 years should be made aware of their responsibility for their own sexual health. Emphasis can also be placed on the non-invasiveness, ease and privacy of the test.

Keywords Chlamydia trachomatis, opportunistic screening, university students, young men

Introduction

Chlamydia trachomatis is the most commonly diagnosed sexually transmitted infection (STI) in the UK.3,4 Although the majority of cases are asymptomatic,3,4 if left untreated, the infection can have serious consequences in both women and men.5–7 The highest incidences occur in the 18–25 age group.2,6–10 In 2003, the National Chlamydia Screening Programme (NCSP) was established offering opportunistic screening to asymptomatic people under the age of 25 in sites not traditionally associated with sexual health.3,11 Emphasis is on screening sexually active women under 25 years old for Chlamydia.6,9,12,13 It has been argued that screening asymptomatic women is more cost-effective than screening men,12,14 that women suffer greater long-term morbidity and that they are easier to target opportunistically because they are greater users of the health services.9,13,15 In the first year of the NCSP, 15,241 women were screened compared with 1172 men.3 The small number of males is worrying because men are equally at risk from Chlamydia. Chlamydia is associated with male sub-fertility,14 prostate cancer16 and increased transmission of human immunodeficiency virus (HIV).7 Crucially, the emphasis on women overlooks the role of men in the spread of the infection.6,17 The purpose of this study is to explore perceptions and acceptability of the provision of Chlamydia screening in the University of Leeds among 18–25-year-old males. The University of Leeds is one of the largest universities within...
the UK18 and was a pilot site for the NCSP. The screening programme, entitled ‘C-Swab’, has been running on campus for the past 4 years.19 It consists of free drop-in sessions held weekly in the students union on campus. Leeds Student Medical Practice with the University of Leeds deliver the programme.20,21 It is promoted using posters, leaflets and websites.20–22 An audit of this programme and the accompanying promotional material has not yet been performed.20

**Methods**

A qualitative approach was utilized as this was an exploratory study of male views about Chlamydia screening. Focus group methodology was selected as it generates data quickly and efficiently within a short period of time.23 Focus groups have been shown to be less inhibiting than one-to-one interviews24,25 and are suitable for capturing the dominant discourses of a social group.26,27 They are also a useful means to engage people’s views on sexual health. Since sexuality of students is shaped and influenced by interactions with peers, focus groups provide the conditions under which people share sexual experiences.28,29 Social desirability bias has been found to be no different to that of surveys and qualitative research on other topics.29–31

Participants were recruited through advertisements placed on notice boards throughout the campus. The inclusion criteria were males aged between 18 and 25 and who were students of the University of Leeds. No specific attempt was made to enrol students with prior knowledge of the Chlamydia screening programme. We sampled purposively to obtain two groups of eight men. Only 15 attended the focus group sessions. The missing participant gave no reason for the absence. Those who agreed to take part were aged 19–24 and were from a range of academic courses. Ethical approval was sought and approved by the Medical School Ethics Committee at the University.

Both focus groups lasted 2 h and were conducted in a teaching room on campus during term-time. This was an accessible and familiar site for participants, creating a comfortable and relaxed environment for open discussion. A male moderator stimulated discussion using a question guide, probing knowledge about Chlamydia and the ‘C-Swab’ campaign. However, participants interacted easily and most of the discussion on beliefs was participant-led and unprompted, providing rich data for the analysis. The groups were observed discretely by two others. All participants signed a consent form, assuring confidentiality and anonymity. Random pseudonyms were assigned to participants to protect identities.

Tapes were fully transcribed and analysed using thematic analysis.27 Textual data were scrutinized for differences and similarities within themes. Issues that generated the most discussion were prioritized. Data analysis involved two independent researchers and was checked by a third. Given the homogeneity of our focus groups, we make no claims for the generalizability of our findings to the UK male student population.

**Results**

Five themes emerged from the data: (1) lack of knowledge about Chlamydia and screening; (2) social embarrassment about Chlamydia; (3) reluctance to seek medical help; (4) perception that Chlamydia was a ‘woman’s disease’ and (5) indifference about health promotion campaigns.

**Lack of knowledge about Chlamydia and screening**

The participants were only vaguely aware about the screening programme and were not sure what screening entailed and why it was beneficial:

*I know that it’s sort of encouraged, I mean they suggest it. Like when I went for my MMR last year they were giving out like, packs [on ‘C-Swab’] and in the union last week, and other places. When I went for my MMR there were loads of [Chlamydia] tests given out, they basically gave this pack to everyone.*

*(John, Group 1)*

Only one participant (Phil, Group 1) had been screened and he took the opportunity to inform the others about the process and symptoms. This prompted the others to state that partaking in focus groups was a good way to learn about Chlamydia. Of the others, seven knew it was a urine test, while some thought it involved an invasive swab (‘a probe-type thing’). Another thought testing would cost him money.

Most participants had heard of Chlamydia but had limited knowledge about the disease. There were misconceptions about the symptoms caused by Chlamydia, with some citing a rash or warts, while others thought that it might lead to complications such as infertility and impotency. Only two participants knew that Chlamydia can be asymptomatic. Participants held a greater awareness about other STIs, namely syphilis, herpes and HIV and viewed Chlamydia as being less serious than other STIs:

*It is treatable though, I mean, maybe that makes you more laissez faire about it. You think ‘it’s not, like, the end of the world. You can go to your GP and get it sorted, not like something that would last for life.*

*(James, Group 1)*
Social embarrassment about Chlamydia

Interestingly, the participants did not view Chlamydia as a stigmatized disease like HIV, gonorrhoea and syphilis. It is possible that Chlamydia is seen to be similar to genital warts, which tends not to be stigmatized due to the discourse surrounding it, avoiding the historical ‘high-risk’ groups and association with sexual deviance.32,33 However, being publicly seen to seek medical help provoked embarrassment. Participants were self-conscious about even reading a poster promoting the ‘C-swab’ programme:

Andy, Group 1: You don’t want to stop and stare at it.
James, Group 1: No.
Fred, Group 1: No, with everyone looking at you!
Andy, Group 1: Thinking, ‘hmm, he’s infected!’

Many participants feared meeting an acquaintance at the GP surgery or GUM clinic. It would suggest that something was wrong with them. Phil (Group 1) attempted to alleviate others’ fears of GUM clinics with his outburst:

I’ve been to the clinic. It was a bit embarrassing, going for the first time. It’s not all that bad after you know what it is like.

It has been suggested that although there will always be people who are embarrassed about issues relating to sexual health, providing information and tests in informal settings (e.g. nightclubs)34 can boost men’s willingness to be tested.35,36 However, the participants maintained that openness about Chlamydia screening was almost farcical:

Yeah, can’t have people lining up for Chlamydia testing in the union. Imagine if you walk into a friend: ‘Hi mate, what are you doing?’ ‘Just lining up for Chlamydia screening!’ Everybody laughs

(Gaz, Group 1)

Reluctance to seek medical help

The majority of participants stated that they would be unlikely to partake in opportunistic Chlamydia screening. They spoke of urban myths of invasive treatments and other people’s bad experiences as justification:

After I heard that it involved a probe up your penis, there was no way I was going to get tested!

(John, Group 1)

Another participant thought that sexual health-seeking behaviour was detrimental to general health because he had heard that multiple visits to the GUM clinic put you at risk of being refused life insurance.

Sexual health-seeking behaviours were not considered the norm for men:

Well, I think that if you are sensible, you can be reasonably confident that you won’t have a problem. But at the same time, I think, I know some people who would be reluctant to go even if they haven’t been sensible. I guess it is irrational, I don’t know why.

(Chris, Group 2)

This was partially explained by participants being discomforted about talking about sexual health to GPs:

It’s difficult to talk to strangers about personal things as it’s not really the type of thing that you would want to chat to someone you don’t know about.

(Chris, Group 2)

It was also suggested that Chlamydia did not rank highly among the variety of risk that men take on a daily basis:

You just don’t want to believe that that sort of thing would happen to you so you sort of ignore it. I think that it would drive you insane if you started to think about every type of illness, not just STIs.

(Tom, Group 2)

Both groups admitted that they rarely visited a GP. It was evident that the men’s reluctance to partake in Chlamydia screening was linked to a general feeling that ‘real’ men do not need to visit doctors:

Guys don’t admit that they are ill as easily as women. For example, my dad has never admitted to being ill in the last 20 years and my mother will tell you that she is ill the day before she falls ill.

(Ian, Group 2)

However, participants advocated promotion of routine health checkups among men:

It would be good if it was like going to the dentist, you just did it regularly.

(Tom, Group 2)

This would normalize sexual health-seeking behaviours:

It wouldn’t be, like, ‘I’m at risk’. It would just be something everyone did.

(Andy, Group1)

There was a strong contention that men were a forgotten group whose needs were not considered as important as those of women. They maintained that the health services were more ‘user friendly’ for women and that health professionals were more knowledgeable about women’s problems:

Other specialties in medicine have a supportive community, e.g. gynaecology for women, but there really isn’t anything for men.
Perception that Chlamydia was a ‘woman’s disease’

Most participants perceived heterosexual men as being relatively invulnerable to infection, instead viewing it as a problem for women ‘and maybe, like, I don’t know; gay men? I know that they are more at risk of HIV’. This misconception has been reported elsewhere.29,37,38 At-risk and infected males who believe Chlamydia to be a ‘women’s disease’ may not perceive themselves to be at risk and therefore may not modify their sexual behaviours or get tested.15

Participants maintained that they could avoid Chlamydia by being wary of ‘risky types’ of women. They ‘could tell by looking at a girl’ whether or not she would have Chlamydia:

John, Group 1: I know this sounds bad, but I think it is how guys think. It sort of depends on what the girl’s like. If you thought she did it before or, like, regularly, or if you didn’t know her that’s different from a friend.

Ben, Group 1: Yeah, it would be different if it was someone you knew.

Fred, Group 1: I mean, that is probably the way I would think. I know it’s not right but you do think differently depending on the girl. Like someone you know, versus someone you met at a club or something.

This is similar to Connell et al.39, who found that men relied on visual cues and a woman’s reputation gleaned from male friends to assess the risk of STIs.

Focus Group 1 associated students and university life with engagement with ‘risky’ sexual behaviours. ‘At Uni. people get drunk and have unprotected sex, they are obviously gonna be at a greater risk’. Interestingly, the focus group distanced themselves from likelihood of infection by connecting it solely with behaviour exhibited in Freshers’ Week. ‘Students sleep around in freshers week: fact!’ The connection with Freshers’ Week acted as a mental barrier to the possibility of being at risk of infection now. Even discussion on health promotion revolved around targeting the ‘young freshers’.

Indifference about health promotion campaigns

The dominant feeling was that the posters advertising Chlamydia screening on campus were ‘boring’ and that posters in general are not read by men unless they contain drink or food offers. Apart from the embarrassment of having to read the posters and flyers in public, one participant maintained that there was only one way to get men to think about Chlamydia testing and that was to put them ‘above urinals’.

The groups maintained that increasing awareness about Chlamydia and the availability of Chlamydia screening on campus would require a more innovative approach than the usual flyer and poster. It seems that the bombardment of health messages on posters has caused students to be blase. Suggestions to raise awareness on campus included the use of ‘campus web or screen savers in the library’, information on the back of flyers for nightclubs or on bus tickets and articles in the student paper. They also thought that screening should come to them, such as having a van circulating halls of residences collecting samples or sending urine pots to halls of residence so that ‘you could take the test in your own time’. They preferred this to visiting the GP service on campus or a GUM clinic.

Of particular importance to the men was the emphasis on the non-invasive nature of testing:

Gaz, Group 2: You need to emphasise that it would be painless, quick, no effort and they will be given privacy.

Oliver, Group 2: Showing that you don’t have to get naked. Knowing that it is a urine sample would also make a big difference.

Use of humour was considered very important to grab males’ attention:

Mike, Group 1: In Freshers’ Week, there were these people dressed up as massive condoms outside the union (Laughter of group) ... I think they were sort of, promoting, kind of condoms and safe sex and that...

John, Group 1: If it’s funny...

Pete, Group 1: You pay attention.

Fred, Group 1: It catches your eye and you think about it.

Andy, Group 1: Because they are making a joke of it, it’s not you know, embarrassing or anything.

Mike, Group 1: And people dressed up as massive condoms strutting around outside the union... hilarious! (Laughter of group)

Discussion

Main findings

Males distanced themselves from Chlamydia by labelling it as a ‘woman’s disease’. It is possible that the emphasis on women in the Chlamydia screening campaign has led men to misinterpret that they are not affected. Duncan and Hart6 have argued that men’s beliefs and attitudes about sexual health are under-researched because of the responsibility and accountability being defined as being exclusively female in health promotion.

Similar to Lear’s study37 on sexual behaviours in American universities, the men tended to negotiate the risk
of STIs by avoiding ‘risky’ women rather than through condom use. Lear's study was over 10 years ago yet male roles and actions within relationships are still not seen to be detrimental to sexual health. The participants unashamedly demonstrated lack of knowledge about Chlamydia and had justifications for not wanting to be tested. They also thought that services were geared towards women. Apart from one, they did not view their actions as having consequences for their female partners. There is a tendency in the epidemiological and medical literature to construe women as a 'high risk' group like homosexuals for STIs. This insinuates that the 'general population' are heterosexual men who are affected by rather than responsible for their own sexual risk taking.

**What is known about this topic**

Little is known about male perceptions of Chlamydia screening despite research consistently showing that young men are the least informed about STIs. There are studies on the effectiveness and cost-effectiveness of Chlamydia screening and evaluations of innovative methods for targeting young men in sexual health campaigns. The use of Internet, popular print media, face-to-face communication, hotlines, stalls at college events and games improved the uptake of Chlamydia screening.

**Limitations of this study**

This is a small-scale study restricted to two focus groups on one screening site. There were time and financial constraints due to the study being part of a degree course. It is also possible that the researchers have accessed individuals who are the most willing to partake in a focus group and to vocalize views on Chlamydia. The focus groups were peer-led and such groups can lead to a loss of objectivity. To combat this, an older experienced researcher examined the transcripts and helped the research group sustain a distance in larger qualitative studies on university students and used to help tailor future campaigns to the young male audience.

**What this study adds**

Behaviour can be argued to be affected by attitudes, self-efficacy and perceived control and consequence. Participants’ beliefs about Chlamydia screening were informed by risk perception, lack of knowledge, social embarrassment about seeking help and indifference about health promotion campaigns. There was a consciousness amongst participants that sexual health-seeking behaviours should be normalized, which can be done through the promotion of men’s health. This reflects the ‘risk thesis’ that states that since the 1990s, individuals are concerned about restricting behaviours in order to maintain healthy bodies. Our findings can be extrapolated in larger qualitative studies on university students and used to help tailor future campaigns to the young male audience.

**Conclusion**

To encourage uptake of opportunistic screening of Chlamydia, men under 25 years should be made aware of their responsibility for sexual health. Emphasis can also be placed on the non-invasiveness, ease and privacy of the test.

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