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Informal talk: shaping understandings of sexually transmitted infections (STIs) in rural Australia

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ABSTRACT

Introduction: Although there have been great strides in the prevention, care and treatment of sexually transmitted infections (STIs, including HIV) in Australia, the increasing trend towards higher rates of some STIs is of concern, especially reports of higher rates of chlamydia in inner regional areas. Reasons for these changes are unclear but suggest there is an inconsistent use of prevention measures and ambivalence towards acting responsibly around sexual behaviours. Understanding an individual's response to the circumstances or contexts in which knowledge about STIs are operationalised in rural communities becomes central to recognising how individuals experience health and illness, especially for developing interventions to prevent the transmission of STIs. The aim of this research is to understand how individuals in rural communities make sense of their experiences in relation to STIs and how rurality influences discussion about STIs and health-seeking behaviours.

Method: In-depth interviews with 24 participants, 18 females and 6 males, aged between 19 and 65 years provide the data for the study. Methodological principles of 'grounded theory' underpin the analysis. An eclectic approach to grounded theory was used in the current study that was derived from a number of authors.

Results: The findings revealed that a number of contexts shape the actions and reactions of rural individuals towards STIs. These include 'public and private world of individuals', 'forms of talking in rural communities' and 'managing information and use of health services'. Factors that shape social life in rural communities such as the social bonds that are present, the relationships developed, and the way in which people behave influence the public and private aspects of rural life. Different forms of talk were identified that indicate that sexual issues are discussed in a number of informal ways and encompass distinct experiences of conveying

information with regard to sex and STIs. Managing information and use of health services occurs when individuals assess and identify the need to access services for STIs.

Conclusions: The strength of this research lies in the identification of a number of contexts such as the private–public divide and types of talk where informal mechanisms encourage individuals to conform and comply with community rules and values. Using informal talk as a health promotion and or prevention strategy in rural locations can provide an alternative approach to potentially changing social norms. It would be possible to extend the idea of positive informal talk to include symbols and imagery that encourage individuals to seek treatment and provide a more positive view of 'reputation'. Engaging rural individuals in positive talk about sexual risk, access to treatment for STIs, and provision of accurate knowledge can help to build new 'social norms' that encourage new interpretations.

Key words: Australia, rural communities, rural health services, rural population, sexually transmitted diseases.

Introduction

Although there have been great strides in the prevention, care and treatment of sexually transmitted infections (STIs, including HIV) in Australia, the increasing trend towards higher rates of some STIs is of concern[1], especially reports of higher rates of chlamydia within inner regional areas[2,3]. Reasons for these changes are unclear but suggest there is an inconsistent use of prevention measures and ambivalence towards acting responsibly around sexual behaviours. Understanding an individual's response to the circumstances or contexts in which knowledge about STIs are operationalised in rural communities becomes central to recognising how individuals experience health and illness, especially for developing interventions to prevent the transmission of STIs.

Within rural communities, a number of circumstances or contexts, such as the overlap between public and private aspects, shape their experiences and thus influence behaviours. Underpinning these experiences and behaviours are formal and informal modes of control and regulation of sexuality. According to Weeks[4], the formal level involves the influence of the church and state, for example marriage, divorce, sexual unorthodoxy that affect the patterns of sexual behaviour. The informal level includes factors such as symbols that associate sex with danger and risk[5], the notion of self-responsibility and regulation of moral behaviour[6]. These informal modes of control and regulation intersect with the way in which society perceives and understands STIs and may affect the reaction of others, for example fear, sympathy or disapproval[7]. Through interactions the meanings that individuals attach to things influence the way in which they act or the way in which they manage situations[8]. What is implied is that individuals construct divergent meanings about sex, sexuality and STIs through the process of interaction. Thus, the creation of shared meanings through these interactions becomes an individual's social reality where meaning constantly changes[9].

Shared meanings about STIs in rural communities are thus subject to change through interactions with the self and others. However, difficulties with stigma, confidentiality and anonymity in rural communities also pose problems[10,11], as can talking about STIs, because of the tendency towards conservative beliefs and values[12], stoicism and silence around STI testing[13]. Compounding the issues of stigma, confidentiality and anonymity are a number of conditions that shape the way in which rural communities understand STIs, and these can potentially influence decisions about health care access in rural communities. These include deficiencies in health resources and infrastructure in rural areas[14-18], and cultural and social norms such as individual values and beliefs[19,20].

This article aims to contribute to explanations of how rurality affects an individual's constructed notions of STIs. Driving the research discussed in this article is the need to understand how individuals in rural communities make sense of their experiences in relation to STIs and how rurality influences discussion about STIs and health-seeking behaviours.

Setting

The study sites encompass an inland rural region of the state of New South Wales (NSW) in Australia. The selected study region covers a large geographic area (130 000 km^2). According to the Australian Bureau of Statistics, the estimated resident population of NSW was 7.25 million[21]. The study region represents 12.3% of the population of NSW with a median age of 39 years (state average 37.7 years[22]). There is a comparatively large proportion (21.3%) of Aboriginal and Torres Strait Islander population of NSW resident within the study region. The overall representation of Indigenous population in the state-wide statistics is 208 364 persons or 2.2% of the population[23].

Almost two-thirds (64.2%) of the population earn less than AU$600/week. Health services in the region are provided by medical practitioners, public hospitals, multipurpose health services, community health centres, Aboriginal community controlled organisations and two sexual health clinics. There is a mix of specialist services provided either from the major referral hospitals or through formal networking arrangements with other health areas. Importantly, as far as the delivery of health services in the region is concerned, the issue of transport is an important one for rural residents. The driving time from smaller towns to larger regional centres for services takes approximately 3–4 hours one way. This is similar to other regional areas in NSW.

Methods

Sample and data collection

Sampling for this study was initially undertaken using a theoretical sampling frame that guided the selection of participants. The topics in the sampling frame were based on relevant issues, categories and themes that were identified in the literature as well as state-wide health surveillance data[24]. This initially included age, gender, Aboriginality, STI experience, socioeconomic status and sexual orientation. For greater contrast and clarity, these categories broadened as the research progressed and included individuals who may not have had any experiences with an STI. The development of conceptual categories directed the sampling and continued until no new data, concepts or further variation was identified within the categories. Participants provided contrasts based on the following categories: age, gender and type of contact with an STI, place of residence, education level, employment level, Aboriginality, socioeconomic status and relationship status. Some difficulties were experienced accessing Aboriginal, male participants and non-heterosexual participants. For example, only four of the 24 participants identified themselves as Aboriginal and of these one was a male. Similarly, the entire study sample comprised of participants who reported their sexual orientation as heterosexual (Table 1).

The participants were 24 rural residents recruited using a variety of approaches which included the use of posters, pamphlets, and advertisements via the internet, radio, print media, word of mouth and snowballing. Participants gave written informed consent and were free to use a pseudonym. One researcher (the first author) undertook the interviews, which varied in length between 30 min and 2 hours. Telephone interviews with three participants took place when face-to-face interviews were not practical. A digital voice recorder recorded all interviews except one telephone interview when it was not practicable to record. The interviews took place in both public and private locations that ensured privacy and safety for the researcher and participants. Topics in the interview guide were based on the literature as well as those that emerged from analysis of the interviews. These included descriptions of sexual risk, what factors and strategies were important when the accessing services, what was known about STIs, what factors were important to understanding the link between sex and STIs, their sexuality, culture, and the way health care was approached. The places of residence have intentionally been withheld within this article to maintain participant's confidentiality and privacy.

Table 1: Demographic characteristics of participants

Demographic	Frequency *n* (%)
Age group (years)	
<20	2 (8.3)
21-25	5 (20.8)
26-30	2 (8.3)
31-35	2 (8.3)
36-40	0
41-45	3 (12.5)
46-50	3 (12.5)
51-55	4 (16.7)
56-60	1 (4.2)
61-65	2 (8.3)
Gender	
Woman	18 (75.0)
Man	6 (25.0)
STI experience	
Self affected	13(56.5)
No contact with STI	6 (26.1)
Knew someone with STI	5 (17.4)
Socioeconomic status	
High	2 (8.3)
Low	3 (12.5)
Medium	16(66.7)
Unassigned	3 (12.5)
Sexual orientation	
Heterosexual	24 (100)
Ethnicity	
Aboriginal	4 (16.7)
Non-Aboriginal	20 (83.3)

STI, Sexually transmitted infections.

Data analysis

An eclectic approach to grounded theory was used in this study[25-33]. One of the major differences between grounded theory and other approaches to qualitative inquiry, according to Strauss and Corbin[25], is its emphasis on theory development. A grounded theory approach focuses on the development of a theory that comprises an integrated set of concepts that show relationships[34]. Simultaneous data collection and analysis occurs in a spiral mode with each informing the other[25,35]. Analysis begins early in the process to allow further data collection to become increasingly focused and refined[25,36]. As the analysis proceeds, creativity in the development of abstract ideas and new connections between conceptual ideas results in analytic interpretations of the participants' worlds and processes[28,36]. The researcher's background assumptions and perspectives shape his or her conceptual sensitivity towards certain processes in the data[33]. Browne[37] argues that scrutinising the extent to which the researcher's experiences and interpretations influence the inquiry is an important aspect in the assessment of rigour in the research process. Consequently, attention to issues of reflexivity throughout the research process can help to evaluate the impact of the researcher on the research process and fosters creativity[33].

In this study, movement back and forth between data collection and analysis facilitated integration of analysis with

data collection. The data were analysed by the first author, then revised by the co-author and other study supervisors. Several iterations of the analysis were undertaken until there was consensus among the study team.

Words, sentences or paragraphs were coded using constant comparison[26], then subsequently organised into concepts and categories. Through the next stage of analysis, focused coding and synthesis of codes[33], a comparison of codes and data ensured the consolidation of data and refinement of the main themes. For instance, a comparison of situations led to the following propositions: STIs are invisible, hidden, and become public when a person has to disclose information to their doctor or tells others, but public disclosure is limited to those who are perceived to be able to provide support.

Following on from focused coding, axial coding[25] was undertaken, which involved linking categories with subcategories. The subcategories explained the category by elaborating the relationships according to their properties and dimensions. For example, relationships had the property 'type of relationship', such as doctor/ mother/ son/ daughter relationship. They also had the dimension 'distance', such as close or distant relationship.

As the research progressed, the proposition became even more refined as negative cases emerged in the data. Negative cases represented extreme points on the dimensional range of concepts and provided alternative explanations for the developing analysis[25,33]. In the present study, a negative case represented someone who had not had any sexual or STI experiences, thus had nothing to conceal or disclose.

Selective coding[25] and theoretical coding[29] followed axial coding and involved the development of a core category and the systematic connection to other categories[25,29]. According to Glaser, theoretical coding refers to the relationships between categories and their analytical presentation[27,29]. Glaser presents over 18 coding families that allow variability, precision and clarity in the analysis and presentation of data. The coding families provide a logical and broad way in which to integrate the analysis in a conceptual direction. For example, the forms of talk were a dimension of the larger category of public versus private life of rural individuals. Each form of talk was a combination of categories with a set of properties that reflected interaction processes and different degrees of control in information about STIs. Data collection ceased when the categories and dimensions were saturated.

To ensure rigor and trustworthiness of the study, concepts such as credibility, originality, resonance usefulness[33] and reflexivity[9] were used. All attempts were made to present a true reflection and richness of the participants' experiences in the findings by including excerpts in the participants' own words. Full copies of the transcripts were shared with colleagues to ascertain alignment of the coding schema with the accounts of the participants and to establish validation of the study findings. Throughout the study, reflexivity provided a mechanism to address the underlying assumptions of the first author who worked in the area of Sexual Health and lived in the area. These reflections are reported elsewhere[38].

Ethics approval

This study received ethical clearances independently from the relevant university as well as the designated local state health services' Human Research Ethics Committees (#HEO4/181).

Results

Twenty-four rural residents, 18 females and 6 males, aged between 19 and 65 years of age (median age of 42) were recruited to the study. Participants were employed on a full-time or part-time basis and had incomes of below $500–$599 per week. Place of residence varied from a regional centre to small villages. The specific places of residence have intentionally been withheld within this article to maintain participants' confidentiality and privacy. All participants identified themselves as Australian and as heterosexuals.

The findings revealed that a number of contexts shape the actions and reactions of rural individuals in relation to the management of private information and access to services for STIs. These include 'Public and Private World of Individuals', 'Forms of Talking in Rural Communities' and 'Managing Information and use of Health Services'.

Public and private world

Participants identified that a number of factors such as high visibility, strong sense of attachment and networks within rural communities encourage the development of stereotypes, especially when a breach of social norms occurs. One of the strategies utilised to combat the public–private divide is the concealment of STIs.

> *I mean everyone knows everybody else in this town. That's the way I feel about it. Everyone seems to know everybody else's business or wants to make it their business. So it's very simple to find out things about anybody, doesn't matter who they are, you only have to mention a name down at the pub and someone's going to know their name and what they've been up to.* (Informant 19, male 46 years)

Participants stated that maintaining a separation between their professional and personal lives was not always possible in rural communities due to the level of visibility and surveillance undertaken by some members of the community. They guarded the way in which they conducted their daily activities for fear of judgement. Participants labelled young women who breached social 'norms' and who did not conform to acceptable conventions as 'sluts', 'dirty' and 'promiscuous'.

> *You know when you are living or working in a small town, you have to be a lot more circumspect about what you do. It does not mean you cannot do it; you just need to be more circumspect about it. Individual tend to think because they are paying your salary they also own you.* (Informant 6, female 53 years).

Forms of talking in rural communities

From the analysis, it became clear that participants felt that informal mechanisms of information dissemination occurred via different forms of talking. These forms were identified as 'grapevine talk', 'using metaphors' 'intentional or 'confessional talk', and 'talking differently in interactions'.

Grapevine talk: Participants believed that the grapevine, or rumour and gossip, was a regular part of rural life, and was a way of conveying positive and negative information via an informal communication process. Positive messages conveyed by the grapevine were for education purposes or as a protective mechanism.

> *My cousin, she had been married for a few years and she found out she had genital warts. She caught them off her husband but it did not affect her fertility… He had had them for years as well, probably before he had married. … It came through the grapevine, through her mother to my mother and my mother blabbed, she told me… I think she told me to protect me, so that it would not happen to me…* (Informant 16, female aged 44 years).

The fear by the participants that gossip can be very negative may influence actions and create some difficulties, especially as there is a lack of control in the flow of information. For example, the following participant explains that she did not want to risk exposure to her reputation following her experience of a sexually transmitted infection:

> *I was always fairly careful. I mean small towns are prone to gossip anyway and that was not something [STI] I was going to advertise about myself.* (Informant 6, female 53 years)

Participants who have knowledge and an understanding of the structure of rural towns knew that they needed to protect their information from being the subject of negative gossip by conforming to the social norms of the town. For example, the stereotyping that can occur because of a person's appearance is illustrated as:

> *… these two girls were there … they dress up more than most individual dress up to go to the pub … it's quite fascinating to sit there and look at them and they really do dress up, make up and everything, and everyone thinks they're Barbie dolls.* (Informant 15, male 20 years)

The malicious and sustained talk in rural communities contributes to the marginalisation and isolation of those who may exhibit 'undesirable' behaviours or have an unusual appearance.

Using metaphors: Participants used metaphors to represent STIs as a symbol for punishment and retribution. Terms such as the plague, flu, prison sentence or death were used to reflect the anxieties that individuals attach to values about sexuality and associated contagion, as the following example highlights.

> *And I went back home and … [child] was born and then it was after that that I got the problems and when I told my doctor that my husband had been playing up prior that's when he said I think you've got something off your husband because I did notice he had like a blistery sore on his penis. But you know I was naïve; my mother hadn't even told me the facts of life, I didn't really know anything. I was just out to have a good time and I sort of suffer for it … it's looked upon as if it's the plague.* (Informant 5, female 53)

The theme of punishment suggests that individuals should suffer for the crime they have committed; that is, for having an STI. Over time, the language used to portray fear in relation to herpes has changed. The perception by participants that flu is an illness gives a visual image of how a person may be feeling. Informant 7 perceived that having herpes is a punishment for life:

> *…it's like having flu for your whole life and realising you're gonner have it for the rest of your life.* (Informant 7, female 19 years)

The morbidity associated with HIV infection has increased an awareness of death potentially being part of infection with STIs. This suggests that within the community there is a hierarchy of understanding regarding STIs. There was a perception by participants that HIV was the worst STI and the most serious because it could cause death, and STIs such as chlamydia, warts and syphilis were nasty in some way. However, HIV infection conjured up fears of death in the public mind:

> *It wasn't till my early 20s, which is in the '80s, when I learned about chlamydia and genital warts and all those other nasty little things. But chlamydia was the mark of a new… it seemed like they just discovered it or something. Syphilis is pretty wicked and genital warts are very insidious. No, those two would be pretty bad, and chlamydia, well that can 'cause all sorts of problems; that's nasty. That's a silent one, that can make girls infertile and does it cause a cancer as well? So they're all nasty in their own way.* (Informant 16, female 44 years)

The public perceptions if STIs are subject to a number of influences that individuals used to construct different notions about STIs. The metaphors used by participants to describe STIs suggest that there is a sense of insecurity and fear of infection that shapes their views of STIs.

Intentional or confessional talk: Another form of informal talk is intentional disclosure or confessional talk. For some participants, confession occurred over a drink when they were with their friends or when they discussed a safe topic. Being comfortable with and knowing the other person means that admissions are easier and the obligation of revealing secrets within relationships becomes a 'norm'.

However, there were occasions when a social network may have had negative consequences following disclosure of an STI:

> *…unless you've got a real close network of friends it would be hard to talk about it if you had a sexually transmitted disease. But it's amazing. Some friends aren't as accepting as other friends. Like seeing some friends are not like touching*

you like if they don't know anything about it. (Informant 10, female aged 23 years)

Some participants also made a direct disclosure to trusted family members. A certain level of trust was an important component of the relationship. There may also be a requirement to tell others because of contact tracing.

It probably put a bit of strain on the relationship. Because I didn't tell my girlfriend about that girl I had sex with the week before we went out, because in my mind that had gone and past and I didn't want anything to do with that. … But then I started going out with my girlfriend so I just sort of didn't worry about her …but then I realised I had it and I had to tell her and tell her about that other girl that I had sex with before. And she took it alright, a bit quiet. (Informant 15, male 20 years)

Talking differently in interactions: Talking differently in interactions explores how talk between men and women differs. For example, participants articulated that men talk about certain things concerning sex with other men that they could not talk about with women. Men are more relaxed around other men and feel comfortable because they have a shared understanding of sexual issues:

… it's always a topic of conversation over a beer. Different women you've been with, and what, what you do differently, getting down to positions of sex, that type of thing. Just exploring different stuff. I suppose it shouldn't be something over a beer but that's what it gets to. (Informant 19, male 46 years)

In contrast to the talk between men, talk between women focused on general sexual issues as well as discussions associated with unsafe sex. Participants reported that STIs were not a topic discussed at social gatherings, although some women sought advice from female friends about what to do when they have had unsafe sex.

…sex in general we talk about but we just don't go past the sex bit; we've never spoken about nothing like that [STIs]. Well we've had some pretty weird dinner party topics but nothing to do with sexually transmitted infections at all in fact. (Informant 8, female 25 years)

Managing information and use of health services

Faced with the need to access health services for care and or treatment, individuals will need to disclose personal information to health professionals, as well as assess and recognise the risk of acquiring an STI. For participants to disclose private information, they need to make assumptions and judgements about privacy, such as when would be the best time, what is required and what to disclose about their STI to medical practitioners.

One informant stated that when she discovered she was pregnant it was the impetus to 'get tested' for STIs. 'Getting tested' meant that she was able to control the timing of access to services. However, some participants were passive and preferred the medical practitioners to take action. The following informant justifies her reasoning as follows:

I just wish the doctor had offered some other things as well. Like some testing or whatever and I think I would have been agreeable to it… So I never made the appointment to come in and have a screen or a STI check and I was hardly ever at the doctors so was not an opportunity for testing there I suppose. (Informant 11, female 32 years)

When accessing health care, participants valued the professional and personal attributes of medical practitioners, particularly a trusting relationship.

Well I think I would be less inclined to go to a doctor that I did not have a good relationship with. I wouldn't want to open up as much, which could cover a hell of a lot of the story if I didn't tell them it all and they mightn't find out what's wrong with me or anything like that because I'm covering 90 per cent of the story up. (Informant 17, female 24 years)

When there was a personal relationship with the medical practitioner, some participants felt that it was easier to

disclose sexual issues and they were able to control the timing of that disclosure. However, for others anonymity was preferred so they went elsewhere.

Although the presence of sexual health clinics provides alternatives for individuals who prefer anonymity, the fear of recognition by others in public places, such as sexual health clinics in small rural towns, meant that participants were cautious as to how they accessed services.

> *…sometimes you have got to wait for a considerable time to get in for the appointment and then you will get other individual, sort of young girls in the waiting room. …everyone sort of looks in the different corners of the room trying to avoid each other and I think that makes you uncomfortable and you sort of feel uncomfortable.* (Informant 20, male 45 years)

Discussion

This study aimed to contribute to explanations of how rurality affects an individual's constructed notions of STIs.

The key insights from this study highlight the consequences of informal communication channels within rural areas for people who have an STI, and draw attention to how they take into consideration moral sanctions in their interactions with others when talking about sex and STIs. The construction of a hierarchy has implications for the choices made in relation to health care, safe sex behaviours and notions of risk.

Although constructed notions of STIs communicated via informal communication mechanisms such as gossip are commonplace in rural Australia[10,39], no previous work on the forms of talk undertaken in rural contexts has been identified within the literature on STIs. Further work in this area could extend the notion of forms of talk, and explore other possible variations of such forms. Exploration as to how meanings about STIs have changed, that is, why some have emerged as normative, and how power operates from a cultural and intercultural perspective, could help shape new meanings.

Notably, the hierarchy of STI understandings appears to be absent from the literature. The hierarchy demonstrates levels of seriousness of illness that range from not serious to death. These perceptions can potentially influence an individual's decision to seek health care for the prevention, care and treatment of STIs, as well as disclose about sexual behaviours[40]. This indicates an important area at which crucial preventative interventions could provide significant impact on the control of STIs and create an enabling environment. Extending prevention activities to address the hierarchy identified in this study could promote a better understanding of notions of risk and safe sex, particularly in relation to notions of normalising unsafe sex[41].

When seeking services for sexual health, preventing public exposure and maintaining a credible reputation are important due to the high visibility of residents in rural communities. The findings reinforce the importance that trust and continuity of care have for healthcare practitioners and their patients, especially the decision to raise sensitive issues and break the silence associated with STIs[42]. Ensuring continuity of health care in rural communities could increase the potential for disclosure of STIs to health practitioners.

The informal communication mechanisms present within rural communities identified in this study present a number of challenges for health promotion and the control of STIs. These include issues such as how to address misconceptions about STIs and change social norms, how to encourage positive messages and symbols, and how to empower individuals to make positive decisions in relation to healthy lifestyles or use of health services. Addressing these challenges will require a focus on strengthening STI education in general rather than focusing on specific diseases such as HIV, as well as improving communication to reflect the use of positive symbols in the mass media.

Some limitations of the present study need to be acknowledged. Though conduct of the study occurred in a rural setting encompassing a large geographic area, it is, nonetheless, limited to the operational jurisdiction of one state area health service. A comparison with other locations

such as metropolitan areas would increase the comprehensiveness of the present study and explore whether the same or different informal talk is present.

Conclusion

The strength of this research lies in the identification of a number of contexts such as the private–public divide and types of talk where informal mechanisms encourage individuals to conform and comply with community rules and values. This is an important finding that has implications for the way in which prevention of sexual disease can potentially occur in rural locations. Using informal talk as a health promotion and or prevention strategy in rural locations can provide an alternative form to change social norms. It would be possible to extend the idea of positive informal talk to include symbols and imagery that encourage individuals to seek treatment and provide a more positive view of 'reputation'. Engaging rural individuals in positive talk about sexual risk, access to treatment for STIs and provision of accurate knowledge can help to build new 'social norms' and thus encourage the construction of new interpretations.

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