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Sexual risk-taking among young Swedish men testing for STI

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ABSTRACT

Objectives: This study investigates sexual risk-taking among young men testing for sexually transmitted infections (STI).

Sampling method: 452 participants (aged 18–30) completed surveys concerning their backgrounds, sexual risk-taking, and experience with STI.

Results: Over one-third had used alcohol during their last sexual encounter, one-fifth were reluctant to use condoms due to concerns about erection difficulties, 14.7% had experienced sexual coercion and one-fifth reported having had contracted the most common STI, chlamydia trachomatis (CT). Older participants (aged 25–30) were more reluctant to use condoms because of erection worries and to report having had CT. Immigrant men reported more unprotected sex while men who have sex with men (MSM) were more exposed to sexual coercion than others, but less likely to use alcohol when having sex.

Conclusions: There are important differences in sexual risk-taking within the group of young men testing for sexually transmitted infections which need to be taken into account in developing effective counselling and promotion strategies in sexual and reproductive health care. Further research on young men's sexual risk-taking is needed to broaden understanding of factors associated with young men's sexual health.

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Young men; unprotected sex; condom use; sexual debut; chlamydia trachomatis; erection difficulties; SRH

Introduction



There is a growing awareness that health is affected by sociocultural gender-related behaviours [1–3]. Women traditionally have taken on more responsibility for their well-being than have men. For example, a survey carried out among all Swedish Youth Clinics showed that approximately 85–90% of all visitors were young women [4]. When it concerns sexually transmitted infections (STI), women are more likely to be diagnosed with STI than men, but this likely reflects women's greater likelihood of seeking help for health issues; moreover, women tend to be offered more opportunities for testing across the EU/EEA [5].

From a sexual and reproductive health (SRH) care perspective, men's sexual health and its determinants need to be studied more often so appropriate policies can be developed. A recent US study has shown that men were more likely to have a STI diagnosis if they engaged in sexual risk-taking, e.g., had a greater number of casual sexual partners and more frequent engagement in casual sex behaviours before 18 years of age [6].

When studies have focussed on men's sexual risk-taking and SRH, they have tended to treat males as a homogeneous group, even though specific groups such as younger men, men with immigrant backgrounds, and men who have sex with men (MSM) are typically identified as groups likely to experience STI [7]. The most common STI, chlamydia trachomatis (CT), is highest among the 20–24 age group of males across the EU/EEA as well as in Sweden [7],

although a Swedish study in a clinical setting found that the mean age of CT-positive males was somewhat older, at 27 years [8]. In regard to ethnic background, one Swedish study found that immigrant men engaged in more sexual risk-taking than men with Swedish background, including having unprotected sex [9]. It should be noted that the higher prevalence of CT in men with immigrant backgrounds can be related to other variables such as lower socio-economic status. Communities with a high population of ethnic minority groups are known to experience greater overall health risks [10,11]. Lastly, previous research suggests that young MSM are less likely than young men who have sex with women (MSW) to use protection with casual partners and are therefore more exposed to the risk for STI [12,13]. One study on young MSM found that early sexual debut increases sexual risk-taking, including engaging in unprotected sex [14].

Studies conducted in various national settings have found that an important determinant of sexual risk-taking is the use of drugs such as alcohol and hash/marijuana during sexual encounters; those under the influence of drugs or alcohol are more likely to engage in unprotected sexual intercourse [15,16]. The important influence of alcohol on sexual risk-taking was also found in a Swedish study, which showed that high alcohol consumption was associated with the risk of contracting CT, even with demographic and socio-economic factors taken into account [17].

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Other factors associated with sexual risk-taking and SRH have received less research attention. For example, erection problems are rarely investigated as influences on sexual risk-taking. An exception was a US study conducted at a public STI clinic which found that more than one-third of young men aged 18–35 reported that condom use was associated with erection loss; men who worried about erections reported engaging in more unprotected sex through inconsistent condom use [18].

Experiences with coercive sex (i.e., being pressured or forced to take part in sexual activities) are also often overlooked by researchers as impacting risk-taking among young men. One exception is a national US study ($N=1400$) focussing on young men (aged 18–34). Males with a history of sexual coercion were reported to be more likely than their peers to have exhibited recent sexual risk-taking, that is, having more partners and receiving an STI diagnosis [19]. Similarly, a national Swedish study aimed at identifying youth at high risk of CT found that the experience of coercive sex was associated with a higher prevalence of CT [20].

Aims

The overall aim of this study is to explore sexual risk-taking among young men and to examine whether there are variations in sexually risk-taking in terms of age, ethnic background, and sexual preference. The research questions are as follows:

- To what extent can the group of young men testing for STI be characterised as sexual risk-takers? Sexual risk-taking includes being at a young age at sexual debut, engaging in unprotected intercourse, using alcohol or hash/marijuana at the last sexual occasion.
- To what extent do young men testing for STI experience situations which are likely to promote sexual risk-taking and the chances of STI? In this regard, the study examines erection difficulties and condom use as well sexual coercion.
- Are there important subgroup differences in sexual risk-taking among young men in testing for STI? Groups examined are based on age (comparing young men aged 18–24 to those aged 25–30), ethnicity (comparing men with Swedish background to young men with immigrant background), and sexual preference (comparing men who have sex with men to men who have sex with women).

As indicated above, relatively little attention has been paid to variations in sexual risk-taking and sexual and SRH care among young men. This study contributes important new knowledge on this topic that can be used to develop more effective public SRH programs.

Methods

Participants

The sample included 452 men (aged 18–30 years) recruited from those seeking assistance from an STI testing clinic in Gothenburg (the second largest city in Sweden), between

September 2016 and April 2017. Information about the study was distributed at the reception desk. After reading this information, young men were asked if they were willing to participate. Those giving verbal consent were given questionnaires along with a cover letter with additional information about the study. According to the importance of integrity and confidentiality, measures were taken with physical places arranged in order to allow the participants to fill out the questionnaire in privacy. All study protocols were reviewed and approved by the regional ethical board in Gothenburg prior to the initiation of the study.

The following groups were identified according to age, background, and sexual preference: younger participants aged 18–24 ($N=207$) and older participants aged 25–30 ($N=240$); young men with immigrant backgrounds ($N=134$) and young men with Swedish background ($N=315$); and MSM ($N=75$) and (MSW) ($N=372$).

Questionnaire

The following questions were asked regarding sexual risk-taking: 'How old were you when you had sex with someone else for the first time?', 'With how many individuals have you had unprotected sex within the past 12 months?', 'Did you use alcohol in connection with your last sexual occasion with someone else?', 'Did you use hash or marijuana at your last sexual occasion with someone else?' Evidence of past sexual risk-taking was also obtained by asking respondents if they had tested for CT previously, if they tested for CT routinely, and if they had ever had a positive diagnosis of CT.

Questions were also developed to measure situations that might promote sexual risk-taking. To discover if erection difficulties might promote sexual risk-taking, respondents were asked if the following was true: 'I don't want to use a condom, because I'm worried I'll lose my erection when I use a condom.' To examine experience with coercive sex, respondents were asked if they had engaged in the following activities against their will: 'masturbated for someone else,' 'had vaginal intercourse,' 'had oral sex,' and 'had anal sex.' If the participant replied yes to any of these questions they were considered to have engaged in coercive sex.

Analyses

Data were analysed using SPSS 23. To test whether proportions were statistically significantly different in sample subgroups, a chi-square test of independence with $\alpha < 0.05$ as the criterion for significance was used, meaning that the value lies outside ± 1.96 for the adjusted standardised residuals. To test whether age at sexual debut and number of sexual partners were different between the subgroups in the sample, an independent t-test was performed with $\alpha < 0.05$ as the criterion for statistical significance. Additionally, the assumptions of homogeneity of variances were tested using Levene's F test.

Results

Survey results suggested that the group of young men being tested for STI in this study were moderate sexual

Table 1. Sexual debut, number of partners and unprotected sex means by subgroups of young men.

	<i>N</i>	<i>M</i>	<i>SD</i>	<i>p-value</i>
Sexual Debut				
18–24 years	197	16.3	2.07	.012
25–33 years	231	16.8	2.60	
Immigrant background	125	16.5	2.59	.963
Swedish background	303	16.5	2.31	
MSW	357	16.5	2.44	.849
MSM	71	16.6	2.21	
Number of unprotected sex				
18–24 years	191	3.56	4.50	.292
25–30 years	221	4.09	5.47	
Immigrant background	121	4.66	5.82	.050
Swedish background	291	3.48	4.66	
MSW	340	3.98	5.24	.236
MSM	71	3.20	4.02	

risk-takers. While the overall mean age for sexual debut in the sample was moderate, at 16.6 years, the median number of occasions of unprotected intercourse in the past 12 months was relatively high, at 3.8. Over one-third (36.1%) had used alcohol on their last sexual occasion, although only 7% had used hash/marijuana. A modest amount (17.3%) were reluctant to use a condom due to erection worries, while the experience of sexual coercion was reported by 14.7% of the men. The consequences of risk-taking were evident in findings that a high percentage of the sample (71.7%) reported having had previously tested for CT, while 41.8% routinely tested for CT and 21% had experienced a CT infection.

Some significant age differences in sexual risk-taking were found. The independent sample t-test showed that younger participants (aged 18–24) had a significantly earlier sexual debut than older participants (aged 25–30), $t(426) = -2.53$, $p = .012$ (Table 1). There was however no significant age difference in incidences of unprotected sex in the past 12 months, in using alcohol or hash/marijuana at their last sexual occasion and in experience with sexual coercion. Older participants were significantly more likely than younger participants to report reluctance to use a condom due to erection worries $\chi^2(1, N=441) = 5.46$, $p = .014$. The effect size was small, $\Phi = 0.12$ (Table 2). It was not surprising that a larger proportion of older participants (aged 25–30) reported having been tested for CT previously significantly more often than younger participants (aged 18–24). A χ^2 analysis of difference between sample frequencies was statistically significant $\chi^2(1, N=432) = 12.22$, $p = .001$. The effect size was small, with $\Phi = 0.17$ (Table 3). Also, older participants (aged 25–30) were found to report having been infected with CT significantly more times than younger participants (aged 18–24) $\chi^2(1, N=420) = 6.71$, $p = .010$. The effect size was small, with $\Phi = 0.13$ (Table 3).

There were fewer significant differences in sexual risk-taking between men with Swedish background and men with immigrant background. The overall mean age for sexual debut was similar for the two groups. An independent sample t-test showed however that young immigrant men reported statistically significantly more sexual partners with whom they had had unprotected sex compared to young men with Swedish background men $t(187) = -1.976$, $p = .050$ (Table 1). There were no significant group differences in reluctance to use condoms because of erection worries or in the experience of sexual coercion. Nor were there

significant differences by ethnicity regarding having previously been tested for CT and/or having been infected by CT (Table 3). Nevertheless, young men with immigrant backgrounds reported routine testing for CT significantly more often than men with Swedish background $\chi^2(1, N=340) = 3.93$, $p = .028$. The effect size was small, with $\Phi = 0.11$ (Table 3).

There were also few significant differences in sexual risk-taking between the groups of MSM and MSW. These groups were similar in terms of age of sexual debut, number of incidences of unprotected sex in the last 12 months, reluctance to use a condom due to erection worries, and use of hash/marijuana during sex. This finding is in contrast to previous research in that MSM have been found to engage in more unprotected sex than others, which was not the case here. There were two significant group differences, however. MSW were found to be significantly more likely than MSM to use alcohol at their last sexual occasion $\chi^2(1, N=424) = 4.84$, $p = .028$. The effect size was small, with $\Phi = -0.11$ (Table 2). A significant difference also was found with MSM reporting more experiences of sexual coercion compared with MSW $\chi^2(1, N=424) = 25.38$, $p = .001$. The effect size was small to moderate, with $\Phi = 0.26$ (Table 2). There were however no significant differences found between MSM experience of or testing for CT, compared with MSW.

Discussion

The study explored the extent of sexual risk-taking and potential circumstances that would likely lead to sexual risk-taking in a sample of young men testing for STI and to examine whether there are variations in by age, immigrant status and sexual preference.

Several findings were especially noteworthy, with potential implications for SRH care prevention programs and clinical practices.

Over one-third of the young men had used alcohol during their last sexual encounter, a higher proportion than was found in a Swedish national study, targeting youth in similar age group (10). A larger proportion of the present sample also reported having used hash/marijuana when last having sex compared to the national study [10]. Drug use likely contributed to the likelihood of young men in this sample being tested for the most common STI, CT. Prevention programs in SRH care may need to increase young men's understanding of how alcohol and hash/marijuana use may undermine their ability to engage in safe sex.

The study showed that almost 20% of the young men seeking STI tests reported that they were reluctant to use condoms because of a fear of erection problems; this would likely put them at increased risk for a CT infection. A US study found that such concerns was associated with engagement in more unprotected sex [18]. Men in the 25–30 age group were much more reluctant than younger men to use condoms due to worries about erection difficulties. Counselling could take up the issue of erection worries when it comes to convincing young men to practice safe sex.

Men with immigrant backgrounds had more unprotected sex than other men, which fits to a certain extent

Table 2. Results of Chi-square test and descriptive statistics for aspects of sexual risk taking by subgroups of young men.

	Age groups		Background		Sexual preferences	
	18–24 years	25–30 years	Swedish background	Immigrant background	MSW	MSM
Alcohol last sex						
Yes	76 (39%)	77 (34%)	111 (37%)	42 (35%)	136 (39%)	17 (24%)
No	120 (61%)	151 (66%)	193 (63%)	79 (65%)	217 (61%)	54 (76%)
Hash and/or Marijuana Last sex						
Yes	13 (7%)	17 (7%)	19 (6%)	11 (9%)	23 (7%)	5 (7%)
No	184 (93%)	212 (93%)	285 (94%)	112 (91%)	332 (93%)	66 (93%)
Erection problems						
Yes	64 (31%)	83 (35%)	109 (35%)	37 (28%)	125 (34%)	21 (28%)
No	142 (69%)	154 (65%)	204 (65%)	94 (72%)	245 (66%)	54 (72%)
Erection worries and condom use						
Yes	26 (13%)	51 (22%)	53 (17%)	22 (17%)	68 (19%)	8 (11%)
No	179 (87%)	185 (78%)	259 (83%)	107 (83%)	299 (81%)	66 (89%)
Sexual coercion						
Yes	28 (14%)	34 (15%)	39 (13%)	23 (19%)	37 (11%)	24 (35%)
No	166 (86%)	192 (85%)	261 (87%)	98 (81%)	314 (89%)	45 (65%)

Table 3. Results of Chi-square test and descriptive statistics for aspects of CT testing by subgroups of young men.

	Age groups		Background		Sexual preferences	
	18–24 years	25–30 years	Swedish background	Immigrant background	MSW	MSM
CT testing						
Yes	126 (63%)	184 (79%)	220 (71%)	90 (72%)	252 (70%)	58 (80%)
No	73 (37%)	49 (21%)	88 (29%)	35 (28%)	107 (30%)	15 (20%)
Testing as a Routine						
Yes	54 (38%)	87 (44%)	94 (38%)	49 (51%)	109 (40%)	32 (49%)
No	88 (62%)	111 (56%)	150 (62%)	47 (49%)	165 (60%)	33 (51%)
CT experience						
Yes	30 (15%)	59 (26%)	63 (21%)	26 (21%)	73 (21%)	14 (20%)
No	165 (85%)	166 (74%)	235 (79%)	97 (79%)	276 (79%)	57 (80%)

with the finding that these men also reported having more regularly tested for CT compared with native men. This finding is consistent with a recent Swedish study, where young men with immigrant backgrounds reported more sexual partners with whom they had had unprotected sex than did native young men [9].

Finally, sexual coercion is doubtless a risk factor for sexual health among young men and previous research has shown that it is associated with the frequency of unprotected sexual activities [21]. Our finding that one out of six men had been involved in sexual activity that was not voluntary is noteworthy and is a matter that should be recognised by clinicians working with SRH among young men. This was especially a problem for MSM and was possibly the most alarming result from the study. One-third of the MSM had been exposed to sexual coercion in some form, compared to only one tenth of MSW. One possible explanation for this difference might be that sexual coercion has different connotations for these two groups. For instance, as has been suggested, coercive behaviour among MSM can be mutual [22] (which of course can also be true for MSW), and that younger MSM may have less control in their sexual decision-making when having sex with an older partner [22,23].

Another explanation for the alarming number of MSM who experience sexual coercion concerns differences regarding sexual consent. Sexual consent is commonly defined as either an agreement or a willingness to have sex, or as someone giving permission or approval to have sex. However, it has been argued that there exists a non-verbal societal script among MSM regarding sexual consent. According to this script, sexual consent in sexual activities is more likely to involve nonverbal cues; for instance, not doing or saying anything to stop or accept

the sexual advances of another person is often perceived as consent [23]. Awareness of what constitutes sexual coercion in sexual encounters involving young men needs much more attention in clinical settings and in the development of prevention strategies in SRH care, especially after recent 2018 legislation in Sweden introduced the principle of consent (<https://www.riksdagen.se>).

Limitations

Generalising the study's results must be done with caution for the following reasons. First, the use of self-reported data may limit the validity of the data used in the analysis, since individuals may report their experiences in an overly positive light and may have by default better health seeking behaviour. Second, the study sample included young men (aged 18–30 years) testing for STI at a clinic and research suggests that this younger group is more involved in sexual risk-taking, so the results may thus not represent all young men in the general population, especially those who are not visiting a clinic for testing. Third, the study included alcohol consumption and use of hash/marijuana, but not for other substance use, such as crystal meth, cocaine, GBL, which is a component of sexual behaviour in many cases. To ensure external validity, a larger study should be undertaken with similar questions.

Conclusion

The purpose of this study was to explore sexual risk-taking and SRH factors in a sample of young Swedish men (aged 18–30) testing for STI and to investigate whether or not there are important subgroup differences in risk-taking and health. Results show that this group engaged in a modest

amount of sexual risk-taking. There are also significant differences with regard to age, immigrant background, and sexual preference. This knowledge can be used to develop appropriate preventive strategies for specific groups of young men testing for CT/STI and to assist clinicians in working with young men involved in testing for STI.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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