Removing the stigma of sexually transmitted infections among women

There is a popular perception that women in ‘developed’ countries enjoy an equal existence to men across a range of sociocultural issues, including health. There are assumptions that women now ‘have it all’ in terms of employment and careers, excellent childcare provision, and lifestyle choices. In short, the general view is that the equality battle has been won and the word ‘feminist’ has been consigned to the distant past.

Unpacking these assumptions reveals a rather different perspective. This is clearly evident in the field of women’s sexual health and management of sexually transmitted infections (STIs). Both globally (World Health Organization, 2000) and nationally (Health Protection Agency, 2003), a pattern of inequalities in women-specific STIs prevail.

We have identified five key areas that need to be addressed if women are to enjoy sexual health in the fullest sense (Box 1).

Biological, cultural and socioeconomic vulnerability

Biological vulnerability Physiologically, women are more susceptible to STIs for a range of reasons (McGlynn, 2001). Women are approximately three times more likely to contract an STI per episode of unprotected (vaginal) intercourse than men. The shape and form of the vagina provides an ideal receptacle for pathogens – the thick vascular walls contain an ideal transportation system for infection, while the moist and warm vaginal environment allows a range of micro-organisms to thrive.

Cultural vulnerability Around the world there are still cultural chasms between the sexes that impact on health and perceived health status. Indeed, one of the United Nations Development Programme’s (2000) Millennium Development Goals for the twenty-first century concerns gender inequality.

Attitudes to sexual health issues are no less dichotomous. In western culture, women are still viewed less favourably if they are known to be sexually promiscuous.

A groundbreaking study exploring young women’s views of sex by Thomson and Holland (1994) showed that younger women in particular are subjected to speculation and scrutiny about their sexual reputation. The ‘virgin’ and ‘whore’ dichotomy still prevails to discredit notions of female sexual expression. This encourages passivity and militates against notions of female sexual autonomy.

There is some discomfort in the notion that women may have lower pre-determined sex drives or indeed be as promiscuous as men. In the latter case, this is not because they may like sex but because they trade sex for offspring, food, and protection. Clearly, there is some discomfort in the notion that women may actually like having sex.

Socioeconomic vulnerability In a wider global context, female infilubilation, child-bride systems, and denial of women’s sexual needs and desires are part of a situation that limits women’s sexual rights.

These issues are woven into a global economic framework that leaves women as the most impoverished and marginalised group. This results in poor health, lack of education, low self-esteem, and limited negotiating rights about their own particular needs (WHO, 2000).

In the ‘developed’ world there appears to be a false sense of security regarding women’s sexual health and service provision, based on spurious notions of material comparisons with developing countries.

Wilkinson (1996) indicates that national comparisons of absolute poverty provide very little insight into addressing inequalities within a society.

What appears to be more important for health is an analysis of relative poverty and the groups most vulnerable to its impact. Unsurprisingly, in western cultures women are the most impoverished group at both absolute and relative levels.

Smith (2002) notes that in the UK, women’s average gross earnings are approximately one-third less than men’s.

vakley et al (2003) notes that this leaves many women in a vulnerable position when claiming ownership over their own sexual rights. This results in the view that sex is something that is ‘done to them’ and that they have little control over safer sex practices.

Smith (2002) notes that evolutionary psychologists have added to these ideas with their vox-pop notions that women may have lower pre-determined sex drives or indeed be as promiscuous as men. In the latter case, this is not because they may like sex but because they trade sex for offspring, food, and protection. Clearly, there is some discomfort in the notion that women may actually like having sex.

References


Stigma and vulnerability Diagnostic difficulties Responsive services

KEY WORDS

REFERENCES
male earnings, giving men a substantial financial advantage. This vulnerability is then embedded into everyday life where women lack power, including ownership and rights over sexual activity.

The stigma of accessing treatment While women access health care services more frequently than men, the drivers for attending are usually defined by others. Women often assess their needs in relation to meeting wider functional obligations.

Greer (1999) encapsulates this relationship from a western cultural perspective, stating that ‘more of her life is wasted cleaning things that are already clean, trying to feed people who aren’t hungry, and labouring to, in, from and for chain stores’.

This is often linked to the needs of the family. For example, women will go and seek help if they are tired because they have to continue looking after significant others (children, partner, parents) as informal and unpaid carers.

Ussher (1997) notes that women still carry out the bulk of domestic chores in the private domain. A perceived inability to cope with family tasks is often a primary lever for women to attend to their health. Oakley’s (1994) classic work in this area describes this as part of a paradox of working more and earning less; with women working inside the home for love and gratification and outside of it for money (often poorly rewarded). In some circumstances, women have to make great efforts to access health care services.

Accessing treatment WHO (2000) suggests that women often ‘have neither time nor money for health care’. Also, childcare issues, transport, inappropriate appointment times, difficult appointment systems and the sheer energy, effort and time-management involved can often turn the would-be attender into the problematic ‘DNA’ (Did Not Attend).

These factors are compounded by the visibility and separateness of the STI clinic. This can be disconcerting for women with low self-esteem, as their STI status is

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**BOX 2. KEY POINTS FOR THE EFFECTIVE PROVISION OF SEXUAL HEALTH SERVICES FOR WOMEN**

- Develop genuine patient-centred approaches, built around the needs and understanding of the women concerned. Try asking women what they want. This could involve: reducing practitioner jargon and reassessing STI information materials; facilitating patient advocate schemes; manipulating the clinical environment; and providing outreach STI services.

- Provide accessible yet flexible appointments systems and drop-in services whenever possible, so building provision around patient need rather than organising patients around service provision.

- Keep up to date with new developments in promoting sexual health, diagnosis, and treatment. For example, new developments in non-invasive chlamydia screening (currenly being piloted).

- Adopt a Well Woman approach to provision, covering a spectrum of women’s sexual health needs rather than merely focusing on STI diagnosis and treatment. This would also serve to reduce the visible stigma of the STI clinic or genitourinary medicine (GUM) service.

- Recognise the boundaries: your role is to enable women to deal effectively with STIs and wider sexual health issues. As we have indicated, there are many other socioeconomic and cultural issues that impact on women’s rights to enjoy sexual health. These go far beyond the limited confines of the practitioner-patient relationship. Be sensitive yet realistic; provide information and referral options whenever appropriate but try to avoid being judgemental and adopting the moral high ground. Unsubtle interference, however well intentioned, may do more harm than good.

- Further development and extension of nurse prescribing. This would contribute to building a seamless service for those patients with conclusive diagnoses. The Department of Health (2003) has already introduced limited nurse prescribing for patients with bacterial vaginosis, candidiasis, and uncomplicated genital chlamydia infection. However, a well-considered extension to the prescribing role could reap many patient-centred benefits.

- Take a proactive approach to wider sexual health education and promotion, including the provision of services in a range of everyday settings such as schools and colleges, universities, shopping centres, factories, and offices.

- Abandon the mechanistic medical model approach that dominates training around STIs. The pre-registration curriculum should encourage more comprehensive consideration of wider social, cultural and economic issues that impact upon women’s sexual health choices. Continuing professional development (CPD) should offer much broader opportunities for the practitioner to go far beyond limited practical skills updates for STI diagnosis and treatment.

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**REFERENCES**


often confirmed publicly via service provision that looks only at this one aspect of sexual health.

Also, certain aspects of sexual health provision are far from comprehensive. For example, women presenting with symptoms can often get detection and some treatment from their general practitioner but such services are often fragmented or limited. This contrasts with family planning clinics in which detection is offered but where further treatment is not available on site.

The asymptomatic nature of STIs in women

The definition of being ‘asymptomatic’ is the showing of no symptoms but this may lead to significant physical and financial implications.

In general terms, women with STIs will experience some changes in vaginal discharge. However, due to the nature of vaginal discharge (the effect of the menstrual cycle and other factors that may be physiological or pathological) it can be difficult for women to associate these changes with infection.

Some women do experience lower abdominal pain but this is often non-specific and many women associate this with menstrual cramps or gastric upset.

As Sutton (2001) indicates, when women first contract chlamydial infection, it can be one to four weeks before symptoms appear, if they do at all.

In many cases, women remain asymptomatic for years before an associated syndrome or symptoms start to emerge.

The consequence of undiagnosed STIs

Given the supportive roles carried out by many women, the consequences of becoming ill and hence ‘incapacitated’ have a wider impact than merely those affecting the women themselves.

The inability to carry out the everyday tasks that are expected in both the private and public domain has an impact on the woman’s self-concept and significant others.

Also, the consequences of living with an undiagnosed yet potentially aggressive STI provide a further challenge for effective treatment and management.

As WHO (2000) indicates, untreated infections such as chlamydia can create long-term fertility problems and sepsis that may then lead to greater susceptibility to ectopic pregnancy.

Indeed the recent rising demand for IVF (in vitro fertilisation) treatment has been attributed partly to the increasing prevalence of chlamydial infection, often only discovered when investigations of sub-fertility are made.

Glasier and Gebbie (2002) suggest that the presence of malingering STIs can also be linked with potentially life-threatening conditions such as cervical cancer. Bergstrom (2003) notes that it is not only women living with STIs that are affected physiologically by non-diagnosis.

In pregnancy there is greater risk of pre-delivery detached placenta and having full-term babies with retarded growth. Also, if the women affected are unable to fulfil duties as primary carers, then this burden often falls on other women.

Development of services promoting women’s sexual health

Health care practitioners need to be aware of the subtleties impacting on the everyday lives of women when accessing sexual health services for STI treatment. They also need to consider the implications for practice.

Many women are often seen as ‘other’ and it may be worth remembering that ‘these people’ could be any of us in different circumstances. Suggestions for more effective provision of STI services for women are listed in Box 2.

Conclusion

We have highlighted some of the key issues that impact on women’s sexual health, everyday choices, and lived experience. A range of options to reduce the stigma of STIs is available for practitioners to consider (Box 3).

We believe that two overarching themes emerge, which need to be addressed by practitioners and service providers:

- The need to ‘normalise’ sexual health provision away from operating only as a curative ‘deficit model’ service;
- The imperative to become more patient-centred and less judgemental.

We are all sexual animals and so are capable of contracting STIs, undiagnosed or otherwise, and this includes practitioners.