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Where do young Irish women want Chlamydia-screening services to be set up? A qualitative study employing Goffman's impression management framework

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ABSTRACT

We conducted interviews with 35 young women recruited from eight community healthcare rural and urban settings across two regions of Ireland. The aim of the study was to explore where these women thought Chlamydia-screening services should be located. Respondents wanted screening services to be located in settings where they would not be witnessed either asking for, or being asked to take, Chlamydia tests. Respondents were worried that their identities would become stigmatized if others were to find out that they had accepted screening. Findings are interpreted through Goffman's stigma and impression management framework. We conclude with public health recommendations.

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1. Introduction

Chlamydia trachomatis is a bacterial sexually transmitted infection (STI). It is a 'silent infection'—70% of women and 50% of men with Chlamydia are asymptomatic (Peipert, 2003). If left untreated, Chlamydia can cause severe reproductive complications in women, such as infertility and ectopic pregnancy (Tilson et al., 2004). Chlamydia is easy to detect using a urine test and easy to treat with a single dose of antibiotics (Peipert, 2003).

Countries such as the UK have responded to the threat of Chlamydia by introducing screening programmes that proactively detect and treat Chlamydia in young people (LaMontagne et al., 2004). There are two types of screening programmes. *Population screening* involves inviting and offering all eligible members of a population a screening test. *Opportunistic screening* involves offering Chlamydia tests (urine test) to eligible people while they are attending a service setting for reasons that are usually unrelated to STI testing. The focus of this paper is on opportunistic screening for adolescents and young adults.

Opportunistic screening services need to be located in settings that young people use (Chacko et al., 2008; Malta et al., 2007; Mills et al., 2006); and where they would feel comfortable either being asked to take or themselves requesting to receive a test. Identifying user-friendly settings is therefore a first step in setting up any kind of screening programme (Tilson et al., 2004). Overall, however, there has been little formative research that would provide empirical findings to underpin the selection of appropriate screening settings. Internationally, most previous research on young people's STI setting preferences has been based on interviews with urban youth recruited from STI clinics or family planning clinics, thereby reaching the minority of target group individuals who are already attending reproductive and STI services (Goldenberg et al., 2008; Pavlin et al., 2006). Health service planners need better information about the setting preferences of asymptomatic individuals who have not sought out sexual health care (Tilson et al., 2004).

Drawing on Goffman's work on stigma (1963) and impression management (1959), this paper explores the types of settings and conditions governing young Irish women's willingness to take up offers of opportunistic Chlamydia screening. The study is based on semi-structured interviews with 35 women aged 18–29 years of age. This STI-screening preference study is one of the few to be based on interviews with women recruited from community

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healthcare settings, and from rural and urban areas located across two regions of a country (Goldenberg et al., 2008). The objectives of this study were to identify and explore: where young women wanted STI-screening services to be located, why they wanted services to be located in these areas/settings and the nature of any differences in location preferences related to the different characteristics of the women who took part in the study.

1.1. Geographical research on sexually transmitted infections

Medical geographers have long been interested in STIs; geographers in the 1980s, for example, made important contributions in mapping the initial spread and diffusion of the HIV/AIDS virus (Wilton, 1996). The social turn within medical geography (Smith and King, 2009; Smyth, 2008; Kearns and Moon, 2002; Hall, 2000) continued this interest, though bringing with it a renewed focus on individual's personal understandings of health and illness and how these understandings impacted on individuals' attitudes towards STIs and STI treatment facilities (Wilton, 1996).

The past decade has seen medical geographers engage with a variety of STI-related topics such as children's responses to HIV/AIDS in South Africa (Young and Ansell, 2003), the impact of HIV on African communities (Thomas, 2007), STIs and (il)legal pharmaceuticals (Del Casino, 2007; Ford et al., 1997), HIV and community identity (Brown, 2006; Law, 2003), HIV and migration (Elmore, 2006) and the environmental and spatial factors that increase the risk of STI transmission (Marshall et al., 2009).

One of the strongest and most consistent findings to emerge from this research on STIs is the connection between STIs and negative or stigmatized identity (Chiao et al., 2009; Takahashi and Magalong, 2008; Hubbard et al., 2008; Goldenberg et al., 2008; Bellis et al., 2007; Anderson and Kitchin, 2000; Takahashi, 1997). Geographers have found that STIs are commonly associated with connotations of promiscuity, sexual licentiousness and contamination, and that individuals who have STIs often suffer identity devaluation and social disqualification (Takahashi, 1997). STI-related stigma can lead to individuals with STIs losing their jobs, being evicted from their homes, being rejected by their sexual partners, being isolated by their communities and even, in some parts of the world, being killed (Chiao et al., 2009; Chijioke et al., 2009).

Geographers have also discovered that STI-related stigma can have particularly pernicious effects on how individuals view, and subsequently how likely they are to use, health services. STI treatment centres are often associated with images of prostitution, dirtiness and loose sexual morals (Mashamba and Robson, 2002). Many individuals who might be at risk of having an STI therefore fear attending STI treatment centres for testing, worried that doing so could link them to these negative images. One study by geographers working in Ghana found that the government's AIDS programme there was in danger of failing, primarily due to the social stigma associated with AIDS and AIDS treatment centres there (Chijioke et al., 2009). Young people who think that they might have an STI therefore sometimes prefer to attend community healthcare settings such as General Practices (GPs) for testing, where they can avoid the stigma associated with specialist STI treatment centres (Petersen et al., 2009; Goldenberg et al., 2008). However it is important to note that geographers have also shown that particular healthcare settings (even those associated with STIs) may have different meanings for the different individuals who use them (Rapport et al., 2009; Smyth, 2008; Downing, 2008; Kearns and Moon, 2002; Del Casino, 2001).

Geographical research also indicates that some individuals may be more concerned about STI-related stigma than others. STI-related stigma may have particularly negative effects on women (Craddock, 2000); many of the words used for people with STIs such as 'slut' and 'whore' are female specific and have no direct male counterpart (Smith and King, 2009; Ford et al., 1997). The 'sexual double standard' that exists in many countries can enable men to brush off STI-related stigma more easily than women. Consequently women often have greater fears about being associated with STIs, and about attending STI treatment centres, than men do. Additionally, particular sub-groups of men and women might be more or less concerned about STI-related stigma (Wilton, 1996). Social and cultural context can also influence attitudes towards STIs (Smyth, 1998). One recent study in the UK, for example, found that South Asians there were often especially reluctant to attend HIV services so as to avoid losing 'face' and incurring 'dishonor' on themselves and their families (Weston, 2003).

Despite the important work that has been identified here, there are still areas where geographers have noted that there is a need for more research. Geographers (Smyth, 2008; Weston, 2003; Takahashi et al., 2001) have called for more qualitative research to be completed on individuals' experiences of choosing and using health services for STI testing, so as to enable greater exploration of the reasons why individuals opt for particular health service settings. There is a need for this research to be completed on STIs other than HIV, which is the STI that most geographical research has concentrated on. It is also important that this research investigates how 'identity performances' (see the next section) influence how individuals conceptualize, and subsequently how likely they are to use, particular health services for STI testing (Downing, 2008; Del Casino, 2007).

1.2. Theoretical framework: stigma and self-presentation

In 1963 the sociologist Erving Goffman published his seminal work on stigma, which provides a framework for understanding the criteria young people use in making decisions on whether or not to take up an offer of STI screening in a particular setting. Goffman's work has previously been used by studies examining sexuality in healthcare settings (Meerabeau, 1999). According to Goffman (1963), a stigma is an attribute that discredits an individual or a group, rendering them tainted. Stigma results from an individual either possessing characteristics that society considers to be deviant, or from an individual engaging in activities that society views with distaste. Three important subject positions are identified in Goffman's stigma framework. Individuals who do not have any discrediting attributes are referred to as 'normals' (Goffman, 1963, p. 5). Individuals who display obvious signs of deviancy are referred to as *discredited*. Individuals who have unseen characteristics or engage in furtive deviant practices that would stigmatize them if only other people were to know about these activities are referred to as *discreditable*. If these individuals control and manage their discreditable attribute or practices, however, they can pass as 'normal'.

Discreditable individuals are concerned with controlling the release of information that would undermine the impression that they are attempting to foster. They do this by presenting sides of themselves that elicit and confirm positive inferences that others can draw about them, and suppressing sides of themselves that would undermine these inferences. Goffman (1959) refers to this tactical process as impression management. He uses the term performance to refer to all impression management activities that an individual engages in before a particular set of observers (called an audience) to influence their perception of him or her and also the social identity that the individual attempts to construct by engaging in these activities.

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