

Sexuality and health: the hidden costs of screening for *Chlamydia trachomatis*

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In response to a recent expert advisory group report to the chief medical officer, the government has announced the setting up of two pilot schemes to assess the feasibility of a *Chlamydia trachomatis* screening programme in the United Kingdom.¹⁻³ Chlamydia is the most common, curable, sexually transmitted infection in the Western world. Chlamydia infection is largely asymptomatic, but if it is left untreated it can have particularly severe long term consequences for women. These sequelae include pelvic inflammatory disease, ectopic pregnancy, and infertility.⁴

The expert advisory group has recommended that the following groups be targeted for screening: everyone with symptoms of chlamydia infection, all those attending genitourinary medicine clinics, and women seeking termination of pregnancy.¹ There should also be opportunistic screening of young sexually active women under 25 years and of women over 25 with a new sexual partner or two or more sexual partners in the past year. The report identifies family planning clinics and general practice as key sites for screening. It also emphasises the importance of follow up management of infected individuals, which should be carried out in conjunction with genitourinary medicine clinics.

Costs and benefits of screening

The rationale behind targeting women for this screening programme is based on health benefits, cost effectiveness, and accessibility. Firstly, and most importantly, the purpose of the programme is to reduce the morbidity associated with pelvic inflammatory disease. Evidence from countries such as Sweden and the United States shows that screening can reduce the prevalence of chlamydia infection in women⁵ and the incidence of pelvic inflammatory disease.⁶ In addition, computer modelling of the British programme suggests that screening could result in 30 000 fewer cases of pelvic inflammatory disease after five years. Modelling also suggests that screening asymptomatic women—and not men—is the most cost effective option. Finally, no screening programme is likely to be successful if the target population cannot be accessed. Young women are more likely to be current users of a variety of healthcare services and are therefore easier to reach than men of a similar age.¹

While the health benefits of the proposed screening programme are evident, the costs in terms of

Summary points

Screening women—but not men—for chlamydia could have unintended consequences

Experience from cervical screening shows that women have feelings of “contamination,” reduced attractiveness, and sexual dysfunction and that a positive test result is associated with promiscuity

Screening women for chlamydia minimises further men’s responsibility for sexual and reproductive health

Professional and public education about chlamydia should address the health needs of men and women and should not foster gender inequalities

the psychosocial wellbeing of participants are less readily quantifiable. The social and cultural implications of screening for a sexually transmitted infection, especially when that screening is specific to one sex, are far from clear. One specific cost to be considered is that the screening programme may disadvantage women as it will require them to submit to what amounts to surveillance of their sexual behaviour by health professionals. The possible ramifications of the proposed screening programme go beyond the laudable aim of reducing infection and morbidity; the impact on women’s lives, in terms of public scrutiny of their sexuality, may be considerable.

Women, sexuality, and cervical screening

Since the psychological and social costs of other programmes centred on women, such as cervical screening, are now well established we can learn from experience.⁷⁻⁹ Research into the impact of screening on women’s sexuality has shown that this aspect is important in increasing our understanding of barriers to the uptake of cervical screening.^{8 10-12} Two major factors have been identified—the perceived link between cervical abnormalities and sexual activity and the privileged position of men’s sexual behaviour when compared with that of women.¹³ Women with positive cervical smears report feelings of contamination which impact

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BMJ 1999;318:931-3

negatively on self-perceptions of attractiveness and also on sexual functioning.^{8,11} Women associate cervical abnormalities with perceptions of promiscuity and deviant sexual practices.⁸ Thus, the screening process has an active role in labelling women, and this is exacerbated by the fact that the contribution of men to the pathogenesis of cervical neoplasia is barely acknowledged. McKie has elegantly summarised the effect of cervical screening on women's sexuality. "The potentially adverse consequences of sexual intercourse—a private event—can be surveyed and treated through screening services—a publicly based and funded system It is women who transcend this private, public dichotomy and find their lives scrutinised in a manner alien to men The focus is commonly upon women both as transmitters and contractors of relevant viruses ... as both those whose cervixes are surveyed and whose sexual activity comes under surveillance."¹⁰

Reproductive health, responsibility, and chlamydia screening

It is perhaps ironic that advances in health care designed to increase women's health and quality of life, such as cervical screening, have had the unintended consequence of minimising the responsibility of men in sexual and reproductive health issues. This is also true when contraception and termination of pregnancy are considered. The social changes concomitant with the use of the contraceptive pill have generated a belief in men and women that it is women who bear sole responsibility for contraception and avoidance of pregnancy.^{14,15} In addition, the woman's right to opt for termination of pregnancy has facilitated a lack of involvement by the male partner. If continuation of pregnancy is a choice and not a necessity, the likelihood that pregnancy will be viewed as the woman's responsibility alone will be increased.¹⁴ While there are now statutory mechanisms that can compel men to take financial responsibility, these can also disadvantage women who choose not to disclose information about absent fathers.¹⁶ Reducing inequality and encouraging men to take responsibility in sexual and reproductive matters is a complex and challenging public health issue. The strategy of involving men only peripherally in a chlamydia screening

programme—as contacts of infected women—will not improve this situation. Instead, it may reinforce existing inequalities by tacitly acknowledging that it is just too difficult to ask men to take responsibility for their sexual health.

Men, masculinity, and screening

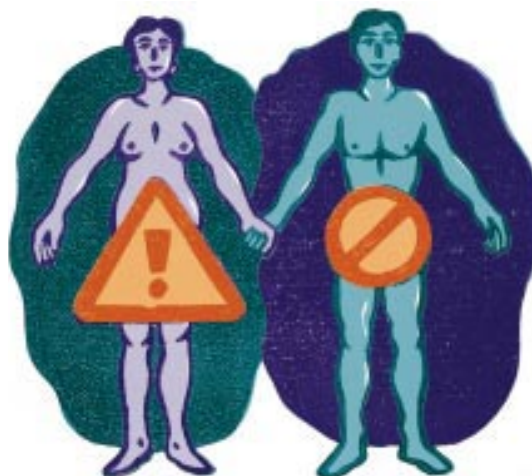
The gender specific nature of the proposed screening programme does more than potentially disadvantage women, it calls into question our ability and commitment adequately to address the sexual health needs of heterosexual men. Health professionals and researchers have been slow to realise that for men, as well as for women, gender roles and expectations may be detrimental to health.¹⁷ In the case of sexual and reproductive health, very little is known about men's beliefs and attitudes. In practical terms, men have effectively been silenced on these issues, because "if both responsibility and accountability are defined as exclusively female, men have neither the social means nor the personal motivation to take a more active interest."¹⁴ Including men in a chlamydia screening programme would provide benefits that would go beyond the obvious health gains from detection and treatment of infection. It would give health professionals and researchers the opportunity systematically to investigate and address men's understanding of their sexuality and sexual behaviour and provide valuable insights into the larger question of men's engagement with their own health and health behaviours.

Role of research and education

Despite the relative longevity of screening programmes in other countries, it is surprising that there is no published research addressing these issues explicitly. In our own exploratory study of the possible effects of screening, we have found that women diagnosed with chlamydia experience a variety of difficulties. For example, they associate sexually transmitted infections with stigma, experience feelings of isolation and guilt, and fear their partner's reactions to the diagnosis.¹⁸ These findings are important because they suggest that acceptability of screening may be a major barrier to uptake. In Sweden, screening is accompanied by a proactive sex education campaign. This has had a positive impact in increasing awareness and reducing the potentially disruptive effects of notifying partners and behavioural change on individuals and relationships.¹ The advisory group recommends that professional and public education initiatives to increase awareness and reduce stigma are "an essential pre-condition" to the successful implementation of a screening programme. Designing such education would require a coordinated programme of research and rigorous evaluation of interventions.¹ However, to date, the government has not committed itself to any educational initiatives. The ultimate effect of this decision on the proposed pilot projects is unclear.

Conclusion

Increasing the acceptability of a chlamydia screening programme will be integral to its success. Women's attitudes to screening will be profoundly influenced by



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the prevailing sexual ideology—an ideology in which the double standard of sexual behaviour (the acceptability of men's sexual activity versus the disease consequences of women's) still prevails.¹²⁻¹³ The relatively small part that men will be required to play in the screening process not only disadvantages women but fosters the continuing lack of recognition that men also suffer the consequences of gender inequalities in the maintenance of their health. Full consideration of these issues is important if we are to develop health education programmes that will increase the acceptability of any future screening programme and ensure that it does not impact negatively on perceptions of female sexuality.

Competing interests: None declared.

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(Accepted 18 January 1999)

The World Bank and world health Healthcare strategy

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The World Bank estimates that 1.3 billion people live in absolute poverty, which means that about a quarter of the world's population earns less than \$1 a day. With the world's population projected to almost double over the next century (from 5.3 billion in 1990 to around 10 billion by 2100, and mostly in poorer populations) malnutrition, childhood infections, poor maternal health, and high fertility will remain substantial challenges in real terms. Overall, however, the pattern of the global disease burden is shifting away from communicable diseases to non-communicable diseases as high fertility and mortality are being replaced by low fertility and mortality (fig 1). By 2020, the bank estimates that the share of the global disease burden from non-communicable diseases will be 57% (up from 36% in 1990), and the contribution from infectious diseases, pregnancy, and perinatal causes will have fallen to 22% (from 49% in 1990) (fig 2).¹

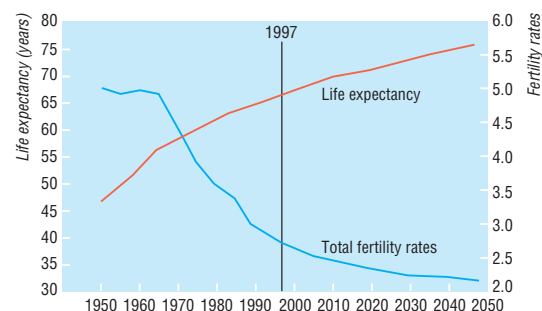


Fig 1 Known and projected worldwide life expectancy and fertility rates

Summary points

A quarter of the world's population earns less than \$1 a day

The World Bank believes that governments need to find an "optimal balance" between public and private sectors in the financing and delivery of health care

The bank's priorities focus on mobilising the female work force, enhancing the performance of healthcare systems, and ensuring sustainability of health care

However, it accepts that it needs to sharpen focus through greater selectivity, more rigorous evaluation of projects, and greater collaboration with governments and other agencies

Critics argue that the bank's policies do not have the flexibility to achieve their goals

Despite the magnitude of the healthcare challenge, the bank believes that affordable solutions are available, but it blames governments and the private sector for rendering policies ineffective. The bank's prescription for global health care is the marriage of public and private sectors, so that neither has too little or too much involvement. The bank warns that "in low

This the second in a series of six articles examining the World Bank's role in international health

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BMJ 1999;318:933-6