

Stigma on Sexually Transmitted Diseases and the Patients

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ABSTRACT

Background: Sexually Transmitted Infections (STIs) seem that stigmatization can negatively impact any individual and their close associates, who have been identified as participating in socially undesirable activities. This study were undertaken with the objective to find out stigma of the Sexually Transmitted Infections (STIs).

Materials and methods: This hospital based cross sectional study was conducted to assess the Sexually Transmitted Infections (STIs) related stigma among the 240 outdoor patients at the Out Patient Department (OPD) of Dermatology and Venereal diseases of Dhaka Medical College Hospital, Bangabandhu Sheikh Mujib Medical University (BSMMU) Hospital and Sir Salimullah Medical College Hospital, Dhaka, Bangladesh.

Results: The mean age of the respondents was 36 ± 6.17 years where most of them (60%) were in age group 31-40 years. Almost one-fifth (17.5%) of them were illiterate and almost half (47.5%) were housewives. Most of the respondents (82.5%) were living with their partner and majority (57.5%) had average monthly family income $\leq 15,000$ BDT. Majorities (37.5% and 32.5%) of the respondents were diagnosed with Pelvic Inflammatory Disease (PID) and diagnosed Non-gonococcal urethritis respectively in the Out Patients Department (OPD). Most commonly using the contraceptive method was condom (35%) among the respondents. Among the respondents, 57.1%, 51.9% and 16.7% respondents who had moral stigma, social and internal stigma respectively were receiving treatment from health care providers. Significant statistical associations were found with a level of stigma and receiving treatment from health care providers. Significant statistical associations of marital status with level of stigma and occupation with the level of stigma. Significant association also found in methods used for contraception between the level of stigma.

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Conclusion: Provision of integrated services through more reproductive and sexual health related education and campaigns needed to address and overcome the stigma associated with STIs.

Key words: Stigma; Sexually transmitted diseases; Contraceptive methods.

INTRODUCTION

Sexually Transmitted Infections (STIs) remain a worldwide public health concern¹. STIs are a group of illnesses which are caused by infections transmitted by sexual contact through exchange of semen, vaginal fluid secretion, blood or blood products and other fluids or by direct contact with the affected people with STIs. More specifically STIs are defined as alteration pattern of infections or syndromes that are epidemiologically heterogeneous, but all of which are almost always or at least often transmitted sexually². The trend and pattern of STIs used to vary from region-to-region, especially in large nations like Bangladesh, India etc³.

Sexually Transmitted Infections (STIs) are the most frequent infectious diseases in the world^{4,5}. At the same time and counter productive STIs are a highly stigmatized condition⁶⁻¹⁰. Stigma surrounding STIs and its contribution to negative health outcomes is a problem recognized by policy makers such as UNAIDS and the World Health Organization^{11,12}. The perceived fear of being stigmatized by health care professionals negatively interferes with people's health seeking behavior and access to preventive health care services (e.g STI testing). In Goffman's seminal work on stigma, 3 categories were identified- physical stigma, moral stigma and stigma of tribe. Physical stigma denotes to any visible mark or deformity in the body, moral stigma relates to social norms and delineations of good and bad behavior, and stigma of tribe arises from attributes ascribed to a particular race, nation or religion^{6,13-16}. Indeed, stigmatizing attitudes toward STIs among health care professionals can have severe consequences for clinical decision-making, such as lower prescribing intention regarding HIV pre-exposure prophylaxis^{17,18}. This is aggravated by health care professionals' insufficient knowledge about sexual problems including their lacking competencies in taking sexual medical history which in turn might promoted eleterious attitudes toward patients with STIs¹⁹⁻²¹.

MATERIALS AND METHODS

A hospital based cross sectional study was conducted to assess the Sexually Transmitted Infections (STIs) related stigma on STIs patients. The study was conducted at the Out Patient Department (OPD) of Dermatology and Venereal diseases of Dhaka Medical College Hospital, Bangabandhu Sheikh Mujib Medical University (BSMMU) Hospital and Sir Salimullah Medical College Hospital, Dhaka, Bangladesh. Total 240 study samples aged ≥ 18 years were selected purposively who took STIs treatment services from the study places.

A pre-tested semi-structured questionnaire with informed written consent was used for data collection through face-to-face exit interview during the period of July to December 2017. 'Stigma and Shame scale' with five point Likert scale categories ranging from 'strongly disagree' to 'strongly agree' was used in the study. Statistical analysis was carried out by using IBM SPSS version 23. The analysis was carried out by using descriptive and inferential statistics, presented with frequency tables and charts.

The study was approved by the Institutional Review Board of National Institute of Preventive and Social Medicine (NIPSOM) Dhaka, Bangladesh.

Results

This study was carried out among 240 outdoor patients at skin & venereal disease department. Table I-Depicts the

distribution of the respondents by their socio-economic characteristics. Age distribution of the study participants ranged from 18 to 50 years old, with a mean age of 36 ± 6.17 years. Stratification by age into different categories showed that most of the respondents (60%) belonged to the age group of 31-40 year and most of them (82.5%) described themselves as married at the time of interview. The literacy level, where almost one-fifth (17.5%) of them were illiterate and almost half (47.5%) were housewives. Most of the study respondents (82.5%) were living with their partner. Majority (57.5%) of the respondents were from lower income families with income $\leq 15,000$ BDT.

Figure 1 Illustrates, majorities (37.5% and 32.5%) of the respondents were diagnosed Pelvic Inflammatory Disease (PID) and diagnosed Non-gonococcal urethritis respectively in the OPD.

Table II- Portrays that most common using contraceptive method was condom (35%) among the respondents and only 2.5% taken permanent method. Among the condom users, 57.14% respondents were using condoms in the last 3 month regularly. Majority (87.5%) of the regular condom users used condoms for contraception and only 2.5% used to prevent STIs.

Table III-Shows stigma related to the Sexually Transmitted Infections (STIs) among the respondents. STIs is a sign of a weak character, feeling dirty when the doctor examined for an STIs and getting an STIs means have no moral were most cited as agree by the respondents.

Table IV-Shows that 57.1%, 51.9% and 16.7% respondents who had moral stigma, social and internal stigma respectively were receiving treatment from health care providers. The association between level of stigma and receiving treatment from health care providers was statistically significant ($p=0.000$). Table V Reveals significant association of marital state with level of stigma ($p=0.000$) and occupation with level of stigma ($p=0.001$). There were also found significant associations of methods used for contraception with level of stigma ($p=0.000$).

Table I : Socio-economic state (n=240).

Variables	n	%
Age group (Years)		
18-30	48	20
31-40	144	60
41-50	48	20
Mean \pm SD= 36 \pm 6.17		
Respondent's marital state		
Unmarried	6	2.5
Married	198	82.5
Separated	6	2.5
Divorced	12	5.0

Widow	18	7.5
Respondent's education		
Illiterate	42	17.5
Primary	90	37.5
Secondary	66	27.5
Higher Secondary & above	42	17.5
Respondent's occupation		
Businessman	12	5.0
Day laborer	42	17.5
Housewife	114	47.5
Employer	72	30.0
Living state		
With partner	198	82.5
Without partner	42	17.5
Average monthly family income BDT		
≤5000	6	2.5
5001-15000	132	55
>15000	102	42.5

Table II : Utilization of contraceptive methods.

Variables	n	%
Method used for contraception (n=240)		
Condom	84	35
IUDs	24	10
Contraceptive pill	54	22.5
Contraceptive injection	24	10
Permanent method	6	2.5
Using condom for last 3 months (n=84)		
Yes	48	57.14
No	6	7.14
Not sure	30	35.71
Reason for using condom (n=48)		
For contraception	42	87.5
To prevent STIs	6	12.5

Table III : Stigma related to the Sexually Transmitted Infections (STIs).

Stigma	Strongly disagree	Some what disagree	Don't disagree or agree	Some what agree	Strongly agree
I would feel dirty if a doctor examined me for a STIs	0 (0)	18 (7.5)	36 (15)	162 (67.5)	24 (10)
Getting a STIs would make me feel lonely	0 (0)	24 (10)	36 (15)	144 (60)	36 (15)
Getting examined for a STIs makes people think I have no Morals	0 (0)	54 (22.5)	36 (15)	120 (50)	30 (12.5)
Most people I know think that a STIs is a sign of a weak character	0 (0)	24 (10)	30 (12.5)	174 (72.5)	12 (5)

Getting a STIs means I have no morals	0 (0)	60 (25)	30 (12.5)	132 (55)	18 (7.5)
Shame					
Getting a STIs means a person is dirty	6 (2.5)	72 (30)	42 (17.5)	108 (45)	12 (5)
People with STIs have been hanging with the wrong crowd	6 (2.5)	42 (17.5)	54 (22.5)	126 (52.5)	12 (5)
Getting a STIs means I don't keep myself clean	0 (0)	72 (30)	60 (25)	90 (37.5)	18 (7.5)
People with STIs should be ashamed of themselves	0 (0)	78 (32.5)	42 (17.5)	108 (45)	12 (5)
Getting a STIs means I don't take care of myself	0 (0)	78 (32.5)	60 (25)	90 (37.5)	12 (5)
Getting examined for a STIs means I'm not clean	0 (0)	60 (25)	72 (30)	96 (40)	12 (5)

Table IV : Association between the level of stigma and receiving treatment from health care providers.

Level of stigma	Receiving treatment from health care providers			Total	χ^2	p value
	Not sure	No	Yes			
Moral stigma	0 (0)	18 (92.9)	24 (57.1)	42 (100)		
Social stigma	6 (3.7)	72 (44.4)	84 (51.9)	162 (100)	20.16	0.000
Internal stigma	0 (0)	30 (83.3)	6 (16.7)	36 (100)		

Table V : Association between the level of stigma and marital status, occupation, method used for contraception

Variables	Level of stigma			Total	χ^2	p value
	Moral	Social	Internal			
Marital status						
Unmarried	0 (0)	0 (0)	6 (100)	6 (100)		
Married	36 (18.2)	132 (66.7)	30 (15.2)	198 (100)		
Separated	0 (0)	6 (100)	0 (0)	6 (100)	31.23	0.000
Divorced	0 (0)	12 (100)	0 (0)	12 (100)		
Widow	6 (33.3)	12 (66.7)	0 (0)	18 (100)		
Occupation						
Businessman	0 (0)	12 (100)	0 (0)	12 (100)		
Day laborer	0 (0)	36 (85.7)	6 (14.3)	42 (100)	22.59	0.001
Housewife	24 (21.1)	72 (63.2)	18 (15.8)	114 (100)		
Employer	18 (25)	42 (58.3)	12 (16.7)	72 (100)		
Method used for contraception						
Condom	18 (41.4)	48 (57.1)	18 (21.4)	84 (100)		
IUDs	12 (50)	6 (25)	6 (25)	24 (100)		
Contraceptive pills	56 (11.1)	48 (88.9)	0 (0)	54 (100)	49.53	0.000
Contraceptive methods	0 (0)	18 (75)	6 (25)	24 (100)		
Permanent method	0 (0)	6 (100)	0 (0)	6 (100)		

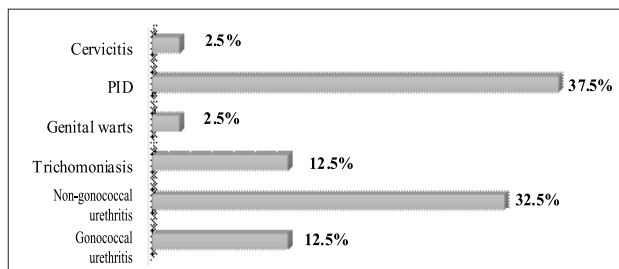


Figure 1 : Distribution of the respondents by STIs diagnosis.

DISCUSSION

Although qualitative studies of stigma are better suited to understanding personal experiences with stigma, expressions of stigma and the manner in which this affects an individual's behavior, the ability to quantitatively assess stigma within a population is also useful for ascertaining relationships that can inform program planning. In this population of women from a high-risk neighborhood, higher levels of internal stigma were associated with not having been tested or treated for STIs in the past year²².

This study demonstrates that the mean age of the participants was 36.43 ± 6.173 years. Most of the participants (60%) belonged to the age groups 31-40 year. This result shows that they are the vulnerable age group in the society. Another study was on STIs patients researchers were found that the age group 16 to 30 years and their mean age 25 years²³. In this study the educational status of the respondents 82.5% were literate and 17.5% were illiterate, and majority (57.5%) of the respondents were from lower income families with income $\leq 15,000$ BDT which is similar with the study done²⁴. In this study 37.5% of the respondents were diagnosed Pelvic Inflammatory Disease, 32.5% were diagnosed Non Gonococcal Urethritis, 12.5% were diagnosed Gonococcal Urethritis, 12.5% were diagnosed Trichomoniasis, 2.5% were Genital Warts, 2.5% were Cervicitis. Study in South Kerala, researchers were found that Herpes genitalis (34.1%), Syphilis (17.6%), non gonococcal urethritis (12.9%), Gonorrhea (10.5%) and Chancroid (2.3%) and Trichomoniasis (2.3%)²⁵. Another study in Maryland researchers found that participants were diagnosed by chlamydia, pelvic inflammatory disease (Female only) Syphilis, Herpes or warts. Among the participants 37% of male and 70% of female participants reported having received STD test in the past year²⁴.

The study revealed that the most common using contraceptive method was condom (35%) among the respondents and only 2.5% took the permanent method. Among the condom users, 57.14% respondents were using condom last 3 month regularly. Majority (87.5%) regular condom users were used condom for contraception and only 2.5% were used to prevent STIs.

Key findings of this study shows that association of marital

state with level of stigma ($p=0.000$) and occupation with level of stigma ($p=0.001$). There were also found significant association of methods used for contraception with level of stigma ($p=0.000$). The findings of this study are similar to the study in South Kerala^{23,24}.

The present research has been undertaken with the objective to find out stigma of the Sexually Transmitted Infections (STIs). Another study in Maryland researchers found that socio-demographic conditions poverty, poor education, poor knowledge are related with stigma⁹.

CONCLUSION

In this study found that a number of both male and female were suffering from STIs and found significant associations related with level stigma. The nature of stigma associated with sexually transmitted infections and its socio-emotional impact, is argued to depend on attributions of responsibility for infection, possible consequences for others, outward manifestations of illness and possible effects on competence. Efforts should be directed towards the provision of integrated services through sexual health related campaigns to address the stigma associated with STI in a more inclusive way.

DISCLOSURE

All the authors declared no competing interest.

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