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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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A B S T R A C T

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.

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.

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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

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.

Performances take place on what Goffman refers to as front-stage areas (Goffman, 1959). A front stage is the physical and social space in which performances are enacted. It is characterized by the presence of audiences. Goffman identifies other stages in his work, the most important of which is the back stage. On back stages, individuals engage in performance maintenance practices. These are practices that enable successful actualizations of front-stage performances, though they would spoil and stigmatize front-stage performances if they were engaged in on front stages, i.e. if back-stage behaviour became visible to one's audiences. Audiences are not found in back-stage areas. It is essential that the individual segregates front and back stages and their constitutive practices (i.e. by avoiding enacting back-stage practices on front stages). Goffman emphasizes that particular places may function as both front and back stages, depending on whether an audience is present or not.

A concrete example of 'front-stage' and 'back-stage' performances is provided in a recent geographical study by Downing (2008). Downing gives the example of an individual who is HIV positive who is throwing a dinner party for guests in her home, but does not want these guests to find about her HIV status. To present a 'normal' (uninfected) image of her self the individual ensures that her guests are contained within areas of her home that provide no hints of her HIV status, and makes sure that she herself does not reveal any information to them that would indicate that she has HIV. When she needs to take her medication she retreats to an area of the house that her guests will not have access to. As long she can take her medication in one private area of the house (a back-stage area), however, and ensure that her guests do not witness her doing this, she can continue to maintain a positive image of normalcy in front of her guests in the public area of the house (a front-stage area).

When doing back-stage maintenance work, individuals sometimes receive assistance from a select group of other individuals (termed a 'team'). Team members are accomplices in the maintenance of the performance and help to successfully actualize it. Team members need to be segregated from audiences, though, so that they will not 'give the game away' and reveal information that would undermine the performance. It is also crucial that non-team members (the audience) are not allowed to observe what takes place on back stages, or instances of performance slippage. This would ruin the performance and discredit and possibly stigmatize the individual's identity. One important means of managing performance slippage is to segregate audiences, to keep audiences separate in order to ensure that audience members who witness performance slippage in one setting are not allowed to transmit this information to audiences in another setting. The utility of Goffman's framework is later explored and outlined in the Methods and Findings sections.

2. Methods

Ethical approval for the study was received from the following institutional ethics committees: the Royal College of Surgeons in Ireland, the National University of Ireland, Galway, the Irish College of General Practitioners and Galway University Hospital.¹ We utilized a qualitative approach because we wanted to explore

in detail young people's perspectives on where they wanted screening services to be located.

We recruited young adults from six GP (primary care) settings and two family planning clinics: two GPs and one clinic in Dublin, the capital city of Ireland, and four GPs (two urban and one rural) and one clinic in Galway (in the west of the country). These settings were chosen because they would be the types of settings that would offer opportunistic screening to adolescents and young adults. Irish GPs in community healthcare settings can treat STIs, though individuals have to pay to attend these settings for treatment. It is free to attend specialist STI settings for STI care, however.

Young adults were eligible to take part in this study if they were aged 18–29 (those aged under 30 years are most at risk of acquiring Chlamydia infection) and if they had not previously attended a health service for STI testing. All attendees at these clinics (who were attending these clinics for any reason, not just for matters related to their sexual health) were provided with information leaflets about the project by clinic staff. These leaflets invited individuals to text (SMS) 'yes' to the lead author's mobile (cell) phone number, which was printed on the back of these leaflets, if they wished to take part in the study.

The first named author, a Ph.D. sociologist specializing in interview methods, carried out 30 of the interviews. The fourth and fifth authors, female public health specialists who received training in conducting qualitative interviews, carried out five interviews. The fact that the first author was male may have influenced the topics that female respondents were willing to discuss with him. However in practice we believe that respondents were quite open and willing to talk about their feelings about Chlamydia screening. The first named author's training and experience in qualitative research proved to be more important than his gender. Half of the interviews were carried out in person and half by telephone. The average duration of each of the 35 interviews was 1 h. Prior to interviews commencing, respondents were provided with assurances of anonymity and confidentiality and informed that they could withdraw from the study at any point without giving a reason about why they were doing so. Respondents were also provided with an information sheet; on reading this they were asked to either sign a consent sheet or indicate verbally their consent to take part in the interview (verbal agreement was asked for if the interview was being conducted over the telephone). Respondents were then given the landline number of the second author, the project's principal investigator, and informed that they should contact him if they were dissatisfied with any aspect of their interview experience. A non-directive approach was used to allow respondents to shape their own accounts. Interview questions examined where – and reasons why – respondents would accept screening offers (see Appendix for a list of specific questions). Most questions focused on primary care settings, as these were likely to provide a large proportion of settings used in an opportunistic screening programme. We also asked respondents how they felt about specialist facilities, such as Genito-Urinary Medicine (GUM) clinics, which are the main settings that currently offer STI testing. The reason was that individuals might be referred to these settings for additional STI tests if they tested positive for Chlamydia when opportunistically screened; and – if infected – might need to refer their sexual partners to these settings. Knowing how individuals schematize and interpret GUM settings may enable clinicians to address negative concerns, prevent patient drop-out in the handover between screening setting and GUM clinic, and promote appropriate health-seeking behaviour when young people have STI symptoms. Interviews continued until theoretical saturation was deemed to have been reached (the point at which we felt that no new themes were emerging in the interviews).

¹ Because Ireland does not have a single national database containing details of all research studies in Ireland that have granted ethical approval, individuals interested in finding out information about the study's ethical approval should email the Royal College of Surgeons in Ireland's research office at resofficeadmin@rcsi.ie.

Interviews were fully transcribed and the resulting data were thematically analyzed. Significant key words, phrases and themes were marked with summary words or codes that labelled them for subsequent analysis. As each transcript was coded, all codes that were thematically similar were grouped together, and labelled with a summary code, called a category. As categories were developed we began to develop an explanatory framework that could be used to explain how different categories related to each other. Each interview was read and coded by the first, second and third authors. The fourth and fifth authors then provided feedback on these codes, and on emerging framework that these codes supported.

This framework was based on Goffman's (1963) work on stigma and self-presentation. Goffman's work fitted our data well because stigma and concerns about self-presentation were terms that respondents consistently and implicitly and explicitly referred to in their interviews, and because the international literature on STIs as discussed earlier shows that stigma is a significant barrier in STI testing. The concepts therefore had internal (respondents' accounts) and external (international literature) validity, and strong explanatory potential. Respondents made reference to other influencing factors as well when discussing their location preferences (such as infrastructural variables). However, these factors were either less important than the core stigma/self-presentation concept or were used to refine it.

3. Findings

3.1. Discredited settings

Respondents viewed healthcare settings as occupying positions along a continuum of identity risk. Respondents expressed the greatest reluctance about accepting screening tests from, or being seen to attend, *discredited settings*. These were places that respondents felt were publicly associated with STIs. Respondents thought that attending these settings would pose a risk to their identity performances as 'normal' young people. Normalcy for these young people had specific sexual connotations: it meant being 'good girls' rather than 'bad girls' avoiding appearances of promiscuity. Normalcy was enacted and maintained by respondents through careful control of their appearances and practices and by regulating the places that they attended in the course of their everyday lives. Respondents felt that attending discredited settings would be a risky identity practice, as it would suggest to other individuals that there was something 'wrong' or 'deviant' about them; it could leave them labelled, for example with names like 'slut' and 'whore', which were terms these female respondents applied to other females who required and used STI services.

The exemplar discredited setting in most respondents' accounts was the GUM clinic, although STI clinics in GPs and family planning clinics were also mentioned in this context.

I think people would probably be most hindered from going up to a STI clinic. I'd say there's kind of a real stigma attached to going up there. (Female, rural GP attendee, late 20s).

In order to ensure the continuance of their identity performances as 'normals', respondents often felt that STI testing needed to be relegated to back-stage areas and completed in private without an audience around. They felt that attending a discredited setting such as a GUM clinic would, however, be a front-stage action, in that it would take place in public with an audience present to bear witness to the collapse of the normal identity. This would be shameful and threatening, though not

necessarily catastrophic, if the audience was composed of unknown others. Any identity damage experienced as a result of engaging in discrediting actions before unknown individuals would be temporary, and could be compartmentalized, as respondents would not encounter these audiences again. Respondents were more worried about being witnessed attending a discredited setting by someone whom they personally knew. This is an understandable fear, as such audiences would be much more central to respondents' economy, identity, and social and personal outcomes than unknown bystanders. Knowledge about respondents' performative discrepancy could also spread more easily to different audiences (since the 'witness to discreditation' would also presumably know these audiences as well), spoiling respondents' abilities to maintain their normal performances before these audiences in future.

There's such a bad perception of the STI clinic. People would feel like weird walking in if there was a large amount of people outside. They'd be like, oh look, she's going into the STI clinic; she must be dirty. And you might know someone, which would be worse. They'd just be looking at you. You'd be scarlet. And it [knowledge that you had attended the clinic] would just get around. (Female, urban university student, early 20s).

The identity risks of these settings were perceived to be particularly acute for women. The respondents, who were female, felt that male attendees of these clinics would be able to more easily maintain a non-spoiled identity because of the 'sexual double standard' (Marston and King, 2006).

3.2. Discreditable settings

Any healthcare setting that was not considered to be discredited was viewed as being *discreditable*. In other words, a setting that was not visibly and inherently threatening to one's identity might still have the potential to be so, if back-stage practices were made public and visible in it. The mere fact of attending discreditable settings would not threaten respondents' identity performances in the same way as would attendance at a discredited setting. Being asked to take a Chlamydia test in these settings might, however, undermine these performances. Importantly, no healthcare setting was described as being fully 'normal' in the context of STI testing—all healthcare settings posed some degree of identity risk to respondents. Discreditable settings fell into two main categories: front-region settings and back-region settings.

Front-region discreditable settings were community settings where Chlamydia tests were offered in public areas with an audience present. Examples included pharmacies and gyms. The setting itself would not *a priori* be discredited (otherwise respondents would not be attending it) but the screening offer would radically transform the meaning that this setting had for respondents. It would convert it from a site of routine performance enactment into a site of performance risk by inserting back-stage maintenance practices into front-stage areas. Most respondents were wary of the thought of accepting a test in this context as the act of accepting would disrupt their normal 'good-girl' self-presentation. Furthermore, there would be a high risk that the audience present in the front-region setting would be composed of audience members from other settings, which would disrupt respondents' abilities to successfully actualize their performances in those settings in the future.

Interviewer: Would you like to be offered a test from say, what about at say a pharmacy.

Respondent: No. Not so much.

I: How come?

R: Well I know a lot of...I don't know, I don't even like buying condoms in a pharmacy. It's too much. I don't know. You'd bump into your neighbours in there.

I: So they can see what you're doing.

R: Exactly yeah.

I: So you wouldn't accept?

R: Probably not, no. (Female, urban GP attendee, late 20s).

Back-region settings were settings that would offer Chlamydia tests in private without non-clinical audiences being present. Examples of such settings included GP and family planning as opposed to sexual health clinics. These settings were black boxed, i.e. individuals could be attending these settings for any reasons and the screening offer would be confidential. Screening would therefore remain a back-stage practice, protecting the individual's public identity performance.

I think you would actually have a better take up if it wasn't in somewhere like the family planning clinic where it's solely for sexual health. If it was in a general practice people wouldn't know why you're attending. (Female, urban family planning attendee, early 20s).

Respondents had a number of concerns about back-region settings, however. These concerns were generally directed at the clinic staff making the screening offer, notably in relation to any personal connection the respondents might have with the staff. In Goffman's framework, clinic staff offering screening can be conceptualized as members of a team rather than as an audience. Their role is to assist the performer in engaging in back-stage maintenance work while minimizing the risks of this maintenance work to the performer's public identity. Many respondents, though, viewed clinic staff as an audience, rather than as a team, and were concerned about maintaining their performances in front of these staff. They saw their interactions with clinic staff as being front-stage interactions even though they occurred in private. They wanted their performances to dazzle these people, not slip around them, which required them to maintain their 'good-girl' identities in front of them. Many had trouble seeing health facility staff as team members who were there to help them maintain (or at least to guarantee confidentiality and not undermine) their identities on a larger public stage.

These concerns were expressed most strongly by younger respondents in relation to family GPs and GPs who were known, but not known well ('familiar strangers'), and by rural respondents. Two reasons accounted for respondents' concerns about family GPs. One was that respondents had, over the years, learned to play roles as relatively powerless, desexualized innocents in front of their family GPs, who were often represented as older, judgmental, male authority figures. Consequently, they did not want these performances to slip around these individuals, leading to embarrassment and shame. Respondents also felt that there was a high risk that they could encounter their GPs in other settings (i.e. they would be unable to successfully segregate team and audience members). A team member present in a front-stage setting would prevent respondents from unselfconsciously engaging in their public performances.

Young people will usually go to their parents' doctors, which is very difficult to talk to your family doctor that you've known since you were small to talk about your sexual health. You wouldn't want him looking at you (Female, urban students health service attendee, early 20s).

I suppose you could also run into him [GP] when you're out which might get embarrassing (Female, rural GP attendee, early 20s).

Anxieties about GPs who were familiar strangers stemmed from respondents' inability to classify the GP as either a team or as an audience member. As such they were uncertain about the extent to which, and the risks of, letting their public performances slip around them.

If I was very familiar with a doctor it [accepting a test] would probably be alright but if it was someone I went to once or twice and my next visit they asked me if I wanted to take a test that would knock me. (Female, urban University health service attendee, early 20s).

Rural respondents' concerns related not just to their GPs, but to the support staff working in the GP setting. Because of the compact nature of their social networks, these respondents felt that there was a high risk that clinic staff would know, or know of, audience members in other settings. This would undermine respondents' abilities to segregate team and audience members; and they feared an increased risk of information leakage from back-stage healthcare setting to front-stage audiences.

In the country you know your doctor, they know your parents, your neighbours. The nurse who works there is someone else's friend. I suppose you think if the doctor knows you're having these tests the paperwork is there. The nurses or the secretary will know about it or know these tests are being sent off. And any of them could potentially tell anyone else (Female, rural GP attendee, late 20s).

Two settings bear particular mention in relation to the material discussed in this section. The first is the home. Respondents were questioned about how they would feel about doing a Chlamydia test at home themselves. Respondents were interested in the idea, but many of the concerns identified in this section remained relevant. Though home testing avoided the potential minefields of interaction with healthcare professionals that have been identified here, the home was not necessarily a back-stage setting for respondents, particularly for those respondents living with partners or parents. Respondents were still concerned about maintaining their performances as 'good girls' in front of these audiences (particularly parents) and felt that taking a Chlamydia test at home could risk these performances.

Interviewer: How do you think young people might feel if they could do a home test? Either say they could order a kit over the internet or call a phone number and it would be posted out to them.

Respondent: That's good as well but it's not that private is it? Somebody could open it (Female, rural GP attendee, mid 20s).

The second is the specialist STI setting. While, as noted in the previous section, most respondents viewed this type of setting as being discredited, a small minority did not. These respondents saw these settings as *discreditable*. Their attitudes stemmed from the low risk they perceived of encountering an audience member from another setting in this type of setting. A factor facilitating these young people's positive reactions was *setting awareness*. Although they may not have attended GUM clinics themselves, they knew of others in their social networks who had, and who had had positive experiences in these clinics, in that their friends had not encountered anyone that they knew in these settings. Audience segregation was maintained and, ultimately, the identities of the respondents' friends who used these settings did not become discredited.

Interviewer: So am I correct in thinking that you'd like it [testing service] to be located in the STI clinic in [urban] hospital.

Table 1
Study framework.

Type of setting	Example setting	Characteristic	Risk to identity	Measures to reduce identity risk
Discredited	GUM clinic	Public space associated with STIs. Audience present	High	Advertising campaign
Discreditable back region	GP surgery	Offer test in private space without non-clinical audience present	Low/medium	Stress anonymity
Discreditable front region	Pharmacy	Offer test in public place with non-clinical audience present	High	Offer anonymized information leaflet

Respondent: Yeah. You're going into a place like X and there are thousands of people. It's practically totally anonymous, nobody even notices you. I have a friend who went there for testing and she said that it's very low-key. (Female, urban GP attendee, mid 20s).

See Table 1 for a summary of the study's framework.

3.3. Infrastructural characteristics

Infrastructural variables (cost/location/convenience) were mentioned less frequently in respondents' accounts than the identity factors discussed so far in this article, but they were present. Respondents who were students valued screening services that would be located near their university, which would be free.

It's just that some students have a full time table, Monday to Friday 9–5. It [screening] needs to be done at a time and place that they can get to (Female, student health service, late teens).

Other respondents also often expressed a desire for services to be located in a free, nearby setting. When questioned more closely, however, an element of ambiguity often crept into their answers. Free services that were located nearby were likely to attract a larger audience who were more likely to know respondents than a service that had to be paid for and was located further away; the latter service might have more identity-preserving effects.

I suppose I wouldn't go to the local one [GP]. I'd have to go to one further down the road or something, you know what I mean. Just because, like that, you don't know who's standing behind you in the queue. (Female, urban GP attendee, late 20s)

If anonymity could be guaranteed then the first (free) setting would be preferred. These were considerations that respondents weighed; they often concluded that it would be best to have services located in multiple settings rather than have a one-size-fits-all policy regarding screening settings.

I just think the more places it's [screening] available, the better. I think you should be able to get it in your family planning clinic, go see a doctor, see a nurse. (Female, family planning attendee, late 20s).

4. Discussion

The purpose of this paper was to examine where young women who had not previously attended health services for STI testing wanted Chlamydia-screening services to be set up. Most previous studies that have addressed this topic have recruited young adults from GUM clinics. The disadvantage of surveying young adults from these settings is that they have already been proactive about their health, and may have different perspectives on where services should be set up (and less concerns and fears) compared with young adults who have never gone for testing.

We found that respondents were most reluctant to attend what we term discredited settings (specialist STI clinics), finding

that supports the work of authors such as Scoular et al. (2001). Respondents had mixed feelings about receiving tests from what we call discreditable settings. However, they expressed most concerns about being offered tests from discreditable front-region settings such as pharmacies, where they could be offered tests to respondents in public places with audiences present. They were somewhat less concerned about accepting tests from what we call back-region discreditable settings, which offered privacy from the public, though concerns about test confidentiality and embarrassment were still present.

4.1. Situating the results in terms of previous research

The findings of this study contribute to calls by health geographers to conduct more qualitative studies on individuals' experiences of choosing and using health services (Smyth, 2008; Weston, 2003; Takahashi et al., 2001), and to investigate how individuals' commitments to particular identity performances can impact on their sexual health (Downing, 2008; Del Casino, 2007).

The study's findings broadly support the work of previous health geography work on STIs. Concerns about stigma and the effects of Chlamydia testing on personal identity were commonplace amongst our respondents, similar to the stigma-related concerns reported in prior research (Chiao et al., 2009; Takahashi and Magalong, 2008; Goldenberg et al., 2008; Bellis et al., 2007; Anderson and Kitchin, 2000; Takahashi, 1997). Respondents' preferences for screening to be located in settings that would not threaten their identity performances also echoes the findings of previous geographical research on STIs (Chijioko et al., 2009; Petersen et al., 2009; Goldenberg et al., 2008; Mashamba and Robson, 2002). However we believe that this is the first health geography study to identify that 'setting awareness' (personal or proxy knowledge about a particular healthcare setting) can decrease young-adult concerns about attending particular settings for STI testing.

This is also one of the few health geography studies to identify that intensity of concerns about STI-related stigma can vary amongst young women depending on their class, educational and regional background (though, as noted, health geography studies have identified that different sub-groups of a population can have different perspectives on particular healthcare settings). Though stigma- and performance-related concerns were articulated by all of our respondents, these concerns were expressed most strongly by younger respondents, respondents from working class areas and from small towns and rural regions; they were the weakest amongst older respondents, college students and respondents from middle class urban areas. Respondents in the first 'stigma sensitive' group tended to have tighter and more visible social networks than respondents in the latter group. As such they felt subjected to stronger audience surveillance, which required them to more rigidly maintain their front-region performances; because of the compactness of the social networks they also felt that discrediting information about them could easily spread if an audience member was to discover that they had attended a healthcare setting for STI testing. Respondents living at home with their parents appeared to be more worried that their parents would find out about their testing practices than respondents who

were living away from home; however, these latter respondents could have their own performance-related anxieties, for example fearing that their flatmates or peers could find out about their testing practices. We are currently conducting a national questionnaire survey of young adults' attitudes towards Chlamydia screening that will enable us to quantify any differences in the screening location preferences of young adults; the results of that study will be published before the end of 2010.

4.2. Importance of place

Place occupied an important position in these young women's accounts. Respondents used place as a tactical resource to construct particular forms of gendered identity. For example, by refusing to attend places that they believed to be risky for their identities, or by accepting screening only from 'back-region' settings, respondents were able to enact and sustain their front-region 'good-girl' performances. Different places had different symbolic meanings for respondents that respondents could draw on to promote, or avoid so as not to undermine, their front-region performances. In Goffman's terms place was not only a 'blank stage' on which identity was enacted but also a 'prop', something that actively communicated information about respondents' to audience members. By attending identity-supporting places respondents were able to direct a stream of identity accrediting information to audiences, while damming flows of discrediting information. Respondent screening location preferences can be fully understood only in light of these spatialized identity practices, their use of place to manage impression and to develop identity (for more on this process see- [Smith and King, 2009](#); [Balfe and Jackson, 2007](#); [Del Casino, 2007](#)). Locating screening in places that respondents could use to construct, or at least maintain, their front-region performances was more likely to be deemed acceptable to respondents than locating screening in places that would undermine these identities.

It is important to note that place was not a static entity in these young women's accounts. The meanings of particular places could change dramatically depending on whether or not respondents perceived these places to be populated by audience or team members. Different places, then, could vary in the tactical identity-promoting/preserving potential that respondents perceived them to have depending on the category of the non-testing actors (audience or team) operating within them (see [Milligan and Bingley, 2007](#) for another study exploring the shifting meanings that particular places can have for young adults).

Place also influenced respondents' screening location preferences in its role as distance. For some respondents (primarily college students), a screening setting that was located further away from the hub of their everyday lives was less likely to be deemed acceptable than a setting that was positioned close by. Other respondents, however, were more discomfited about screening settings that would be located nearby; for these respondents, the identity risks associated with particular settings demonstrated a distance decay effect; the further away in space a screening setting was, the greater its identity-preserving potential would be. Place, as distance then, was valued for two reasons: for easing respondents' access to settings, and for preventing audiences from easily accessing settings, for convenience and for identity-preserving purposes.

Finally, place influenced respondents' location preferences in its role as a meso-level container of local social networks. Respondents from rural areas, small towns and working class areas expressed greater concerns about stigma and identity spoilage than respondents from urban areas. [Shoveller et al. \(2007\)](#) note that the fears of individuals living in such areas are

understandable; these authors argue that the proximity of social relations within such limited socio-spatial contexts increases the likelihood that stigmatizing labels will be acquired if individuals engage in discrediting practices or attend discrediting places. The social networks of respondents from urban areas, in contrast, are often distributed over a wider socio-spatial context; this appears to be a key reason explaining why respondents in this study who were from urban areas demonstrated diminished STI-related concerns as compared with their rural counterparts.

4.3. Cultural context of results

Geographers have noted that stigma-related attitudes and concerns about sexuality develop within particular cultural contexts ([Weston, 2003](#); [Smyth, 1998](#)). Though we did not ask respondents to explain where they believed their attitudes about STIs and STI testing came from, it is plausible to hypothesize that Ireland's particular cultural context played a part in shaping their attitudes. Ireland has traditionally had quite negative attitudes towards sex and sexuality. Until recently sex was a largely taboo topic within Ireland, an attitude stemming from the Catholic Church's influence over Irish sexuality (though the taboo was enforced by all levels of Irish society; [Inglis, 2006](#)). A 1929 censorship law banned erotic literature in Ireland as well as any information about birth control. Artificial contraceptives were banned in 1935 (and legalized again in the 1970s) and in the same year the Public Dance Halls Act sought to control the threat of unsupervised dancing, considered to be too risky and sexy for the Irish populace ([Inglis, 2006](#)). Many young people still feel embarrassed about being seen to buy or carry condoms and many remain highly discomfited about talking about sex with their parents ([Inglis, 2006](#)). A sexual double standard still exists within Ireland, with women being more likely than men to be adversely affected for having multiple sexual partners ([Inglis, 2002](#)). In this environment it is perhaps unsurprising that many young women would have fairly strong concerns about seeking STI testing.

4.4. Implications for practice

A number of strategies could be used by health and screening programme managers to address the concerns identified in this article. Firstly, to reduce the stigma associated with discredited settings it is likely that a concerted anti-stigma campaign would be needed. This could involve targeting advertising at young adults stressing the normalcy of STI testing and screening and emphasizing the numbers of young adults who are going for STI testing. Secondly, because setting awareness was associated with reduced concerns around stigma in this study, it might also be useful to have young doctors and nurses working in STI clinics to engage in outreach activities with schools and universities to promote such awareness. Thirdly, in the context of an opportunistic screening campaign, discredited settings would become an option or even a necessity after a young person has tested positive for Chlamydia, if they required further or repeat investigation, or they needed to refer partners. In such a situation it would be productive to supply young adults with a list of a range of settings, both local and distant, that they could go to for subsequent testing. This would mean that young adults would have an opportunity to attend settings where the likelihood of encountering audience members from their everyday networks and settings would be low. Respondents would therefore be free to engage in potentially discrediting practices (such as taking STI tests), as the audience members in the STI clinic would be unlikely to be encountered again.

Respondent concerns about back-region settings related primarily to fears about information leakage and embarrassment. To address these concerns clinic staff could explain briefly to young adults the safeguards that staff use to secure patient identities. This information could be printed on a leaflet and handed to respondents while the screening offer is being made. Clinicians could explain that non-clinical staff, such as clinic receptionists, have signed confidentiality agreements and are not permitted to disclose patient information to anyone. Clinic reception staff also need to be trained (if they have not already received such training) to maintain a courteous but distant and dispassionate demeanour when interacting with patients in relation to any aspect of STI screening (handing patients information leaflets, notifying them of results). It is important that this performance is extended to cover non-verbal expression as much as the words that receptionists use. It is also important that this professional performance be maintained outside the clinic if there is a risk of patients and receptionists encountering each other. The GP also needs to maintain a non-judgmental, professional performance in front of the patient.

Based on our findings, front-region settings, such as pharmacies or health clubs, should avoid offering screening when there is an audience present, or should do so in discreet ways. If front-region settings are involved in screening programmes they should hand young people anonymized information leaflets that provide information about the screening programme as well as settings where screening is being offered.

4.5. Strengths and weaknesses

A strength of the study is that by researching the views of young women attending community settings, one is getting the perspective of those who will be the principal targets of opportunistic screening. A weakness is that only two men were interviewed, whose findings were not included here. As far as we have been able to ascertain, this is also the first study on Chlamydia screening in research screening settings through the use of a systematic theoretical framework for understanding stigma. Previous studies have focused on identifying different settings and listing and quantifying the advantages and disadvantages that respondents associated with each.

5. Conclusion

The findings here develop the work of the international studies identified in the 'previous research' section, which have mostly concentrated on the perspectives of urban youth (Goldenberg et al., 2008). They demonstrate that *identity* issues precede and outweigh *infrastructural* issues, when young people are enabled to discuss the factors that would facilitate or inhibit them from taking up STI-screening offers. Identity concerns were the strongest for respondents in rural areas, for younger respondents and for respondents in working class areas. All of these are groups characterized by compact social networks and high levels of peer surveillance. The findings support the idea of extending screening into as many types of back-region clinical settings as is feasible so as to address respondents' performance concerns. Each setting will have its own particular barriers or associations that will prevent a certain proportion of young people from accepting screening offers within it (Ford et al., 2004). We believe the type of research reported here is an essential pre-requisite for investing large levels of resources in piloting, rolling out and only subsequently evaluating STI-screening programmes.

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Appendix. Interview questions

- How do you think young women like yourself would respond to an offer of a Chlamydia test?
Imagine that a young person has just walked in to a place that could offer Chlamydia checkups. What do you think would be the best way to ask this young person if they wanted to take a test? [who should do it, where, when]
- For what reasons do you think a young person would take a test?
- What do you think would discourage young people from taking the test?
- We have just discussed some barriers to testing. What could be done to overcome these barriers?
- Where do you think Chlamydia-screening services should be set up?
 - Healthcare setting vs. nonhealthcare setting

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