‘Dirty’ and Infertile: the Underdiagnosis and Impact of Chlamydia

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Personal identity is shaped as we navigate our social world and perceive our experiences. Human reproduction and motherhood have come to be associated with womanhood in immeasurable ways, to the extent that some consider pregnancy and motherhood to be the essence of womanhood. Therefore, complications such as infertility can have a huge impact on a woman’s identity. The World Health Organization estimates that everyday more than 1 million people are infected with a sexually transmitted infection (STI) (“Sexually Transmitted Infections). When left untreated, STIs can pose serious complications for women planning to become pregnant. Chlamydia, the most common STD in the United States, can result in urethritis, cervicitis, pelvic inflammatory disease (PID), infertility, ectopic pregnancy, and chronic pelvic pain (Paavonen et al., 1990). The Center for Disease Control and Prevention (CDC) estimates that 2.86 million Americans are infected with Chlamydia annually, however as many as half of these cases go unreported; a frightening statistic considering 10-15% of the untreated infections develop into Pelvic Inflammatory Disease (PID) and PID results in infertility 10-15% of the time (“STDs &Infertility”; “Pelvic Inflammatory Disease”). The Institute of Medicine estimates that PID is the etiology of infertility in at least 15% of infertile American women, yet less than 50% of sexually active young females, the most at-risk group, are tested annually. In 2000, 25.3% of young women were tested (“The Hidden Epidemic”). By 2007, it jumped to 41.6% (U.S Preventative Services Task Force). Historical failures of the medical community, current health disparities, and female-specific social pressures explain why so many cases of Chlamydia go undiagnosed, but the potential implications of Chlamydia and infertility on female identity are evidence that continuous efforts must be made to ensure all women are able to utilize preventative health services.
Biological Mechanism of Chlamydia and Pelvic Inflammatory Disease:

Pelvic Inflammatory Disease (PID) is an infection in the upper reproductive tract of women that is most commonly caused by sexually transmitted microorganisms, but it can also be spread by surgery, abortion, or childbirth. Typically, Chlamydia presents without symptoms. However when symptoms are present, the infection is marked by any combination of lower abdominal pain, fever, unusual discharge, unpleasant vaginal odor, pain and/or bleeding with intercourse or between periods, and a burning sensation with urination (“Pelvic Inflammatory Disease”). Unfortunately, even though this is a common condition much information regarding incidence and prevalence rates, risk factors, microbial etiology, and pathogenesis are unknown due to a lack of diagnoses and subsequent reporting, ethical concerns, the spectrum of clinical manifestations, and the associated lack of standardized diagnostic criteria.

A general understanding of the pathogenesis of *Chlamydia trachomatis*, the most commonly associated bacterial strain with genital Chlamydia infections, is crucial to understanding how the infection can lead to infertility. During vaginal intercourse, *Chlamydia trachomatis* enters a woman through the vaginal canal and is transmitted through penetrative sex with infected fluids. Chlamydia can linger asymptptomatically for years or present physically as painful urination or unusual vaginal discharge (Sweet, 1986). Occasionally without treatment the infection has been shown to resolve itself spontaneously, however this mechanism is not fully understood and cannot be expected to occur in most women. For PID to occur, the bacteria must ascend into the fallopian tubes by permeating the cervical mucosal membrane. Cervical mucus is considered to be a component of our body’s nature defense against microorganisms, although once again at this time the mechanism is unclear. It has been speculated that the mucus acts as a physical barrier creating a dense, impermeable layer. This is supported by evidence
showing that endometrial Chlamydia infection is more common slightly before and during ovulation when the cervical mucus is thinner. During this time the mucus is thinner to make it easier for the sperm to enter and gain access to the egg, thus facilitating fertilization. Likewise it appears the bacteria also benefit and find it easier to enter the uterus when the mucus is thinner (Taylor-Robinson et al., 2012; Darville et al., 2010). Other evidence suggests that the mucus contains antimicrobial substances that kill bacteria on contact providing an innate immune defense (McCormack et al., 1979). Genetic differences amongst women are also being explored to discover why the infection presents and progresses differently. Major histocompatibility complex 2 (MHC-II) cells are being investigated as a source of the differential immune response in women. These cells are important in disease prevention. They recognize foreign invaders and stimulate the adaptive immune system (Geisler, 2010).

Regardless, once in the fallopian tubes the body’s immune system recognizes the invader and elicits the innate immune response, a necessary and beneficial inflammatory process to fight off pathogens. Infected epithelial cells elicit the release of chemokines to recruit inflammatory leukocytes (white blood cells) and cytokines to clear the infection. Upon reinfection, the adaptive immune system is activated and Chlamydia-specific immune cells are released. The body’s natural response elicits inflammation to ward off the bacteria. Although the inflammation is protective against the microorganisms, it can lead to scarring and damage of the fallopian tubes (Chlamydia Infections CDC). This scar tissue can prevent sperm from entering the fallopian tubes (blocking fertilization) or it can prevent the zygote (fertilized egg) from traveling to the uterus for proper development. The later, known as an ectopic pregnancy, is especially dangerous for women and in extreme circumstances can lead to death.

**Prevention and Testing:**
There is no good estimate for how long it takes for a vaginal Chlamydia infection to progress to PID. More information is needed to understand this timeline as well as spontaneous resolution, persistence, and complications. McCormack et al. (1979) evaluated C. trachomatis clearance and found that 57% of the women who chose not to take antibiotics to clear the infection were still infected 15-17 months after their initial positive testing. This study is limited by a small sample size and lack of knowledge of the time of infection, but due to ethical considerations of withholding medication and inherent challenges associated with finding women willing to test but not wishing to receive treatment it is currently one of the best estimates of spontaneous resolution and persistence. Similarly, a 2010 review found that approximately half of the infections resolved themselves a year after initial testing and continue to clear themselves as time progresses (Geisler, 2010). It is unclear what clinical factors help resolve the infection. Because the probability of the infection clearing itself increases as time progresses it has been suggested that this process is mediated by an immune response.

Clearly, the safest option is to avoid infection at all by practicing abstinence or safe sex including monogamy, using condoms or other barrier methods to prevent transmission, discussing sexual histories with new partners prior to sexual interactions, and using lubricants if necessary. As an additional preventative measure, the CDC recommends that all women under the age of 25 get tested for Chlamydia every year. Testing is relatively simple and pain free; it requires just a sample of the potentially infected body fluids. The five most common tests are nucleic acid amplification tests (NAAT), nucleic acid hybridization tests (DNA probe test), enzyme-linked immunosorbent assay (ELISA), direct fluorescent antibody test (DFA), and a Chlamydia culture. Treatment is easy as well. A single course of antibiotics (Azithromycin, Note:
Doxycycline, Erythromycin base, Erythromycin ethylsuccinate, Levofloxacin, Ofloxacin, or Amoxicillin) will kill the bacteria, alleviating the infection (Chlamydia Infections, CDC). There is speculation that because antibiotics by nature disrupt the microbial colony, normally nonpathogenic bacteria could overgrow and ascend into the upper genital tract and lead to vaginosis, the most common vaginal infection characterized by a disruption to the normal bacterial colonies. If this occurs another round of antibiotics will be necessary and should be monitored by a health professional (Warkowski and Berman, 2010).

Since testing and treatment are relatively simple, it becomes interesting to consider why then half of these infections are going untreated. The most obvious explanation rests in chlamydia’s primary manifestation, or lack thereof. Chlamydia is known as the silent killer because it typically is asymptomatic. This means that infected women will not experience any discomfort such as burning with urination, bleeding, or pain. But this explanation to account for all the undiagnosed cases is too simple. The history of the medical community, current health disparities, and cultural pressures imposed on women will be used to explore this unsuspecting relationship.

1 NAATs and DNA probe tests assess for the presence of the bacterial DNA, whereas ELISA and DFA test for Chlamydia antibodies. An example of a NAAT is a polymerase chain reaction (PCR) in which a primer is used to facilitate amplification of C. trachomatis DNA for easy identification. The DNA probe test works similarly except for amplifying the entire strand of bacterial DNA it will only synthesize a segment of it. This is faster and more cost effective, although less sensitive. When testing for Chlamydia both tests are effective. To fight an infection, the immune system produces antibodies to recognize specific proteins, antigens, on the surface of the invading pathogen. A single antibody specifically recognizes each antigen. Therefore, scientists can add a known antibody to detect the presence of the antigen or pathogen. ELISA uses antibodies tagged with enzymes that elicit a color change if they bind to their respective antigen. In this case a color change would indicate the presence of C. trachomatis. Similarly, DFA uses antibodies tagged with florescent dye that changes color upon binding with the antigen on the surface of C. trachomatis. The culture assay must be done in a lab and takes longer (5 to 7 days) so it is not the preferred method.
Historical Role of the Medical Community in Underdiagnosis:

The idea that social deviances such as prostitution, homosexuality, or other socially unacceptable forms of sexuality could be attributed to biology is a belief that began in the early modern period in western societies and continues until the present. When female bodies are disregarded in medicine, women become socialized to be passive recipients of health care. In the nineteenth century there was a theory that lesbian tendencies were the result of enlarged clitorises. Dr. Alexandre Parent-Duchâtelet attempted to uncover the truth and in a detailed study of 3,250 prostitutes in Paris, he failed to show any correlation between clitoris size, sexual orientation, breast size, or even prostitution (Zacks, 1997). However, the underlying assumptions of Parent-Duchâtelet that clitoral size could somehow determine or at least influence one’s sexual orientation emphasizes with fervor the tendency to attribute behaviors to biology or something innate within us thus taking away personal agency. What these women loose when scientists blame their genes is an understanding of how we are shaped by our environment. As research methods progress, scientists may find a gene that predisposes a person to experience same-sex desires, but that gene will not and cannot be fully responsible for determining a person’s identity. We have a voice outside of our genetics, a voice that gets silenced when we fail to consider the whole picture. Parent-Duchâtelet’s study is just one of the early examples of the medicalization of female sexuality, a practice still prevalent today as observed with the push for a female impotence drug. This teaches women that there is a ‘correct’ form of sexuality, a norm to strive for. This leads to the increased stigmatization of deviances, including STDs and infertility.

Women have also been excluded from medical trials; a costly practice that has lasting impacts on sexual and reproductive health utilization today. In 1977, based on the FDA's 1977
"General Considerations for the Clinical Evaluation of Drugs" women of reproductive age were excluded from phase 1 and early phase 2 clinical trials for non-serious diseases (Evelyn et al., 2001). However, applying data based on a male model to women is a dangerous process because men and women can respond differently to treatments. According to the Society for Women’s Health Research men were the preferred participants because people believed that men and women were biologically identical minus their reproductive organs, women were more expensive to recruit and include in trials, women’s potential fetuses needed protection, and women’s hormonal changes would impact data. However, women of reproductive ages need to be included for targeted prevention methods to female health conditions. Women have different needs and their specific physiology (hormonal fluctuations throughout menstrual cycle) and ability to conceive make it more important to observe how their body and reproductive capabilities respond to treatment before a drug is widely available. Beyond this there are many biological sex differences that are yet to be understood. Without knowing what they are, they cannot safely be controlled for (“Issue: Inclusion of Women and Minorities in Clinical Research”).

The residues of these failures present themselves in medicine today. In an article descriptively titled “I’ve been crying my way through” female patients recount their experiences as patients with biomedically undefined conditions. The title itself conveys the frustration and agony experienced by these women. Expecting to be taken seriously, receive relevant health information, and guidance and support the women instead were ignored, disregarded, and rejected (Johansson et al., 1991). The doctors were more likely to prescribe antipsychotic drugs than consider the source of pain from the woman’s perspective. Once again, the woman’s body and her own ability to understand her body were disregarded. Physicians have been shown to
attribute women’s health complaints to emotions with a greater propensity than men’s (McMurray et al., 1991). Too frequently, a woman’s voice is silenced by the belief that women are incapable of rational thought. Women’s health has been pushed aside, ignored to the expense of the female patient; that is exactly what is still going on in regards to sexual and reproductive healthcare. It simply is a reflection of the mainstream dependence on medical diagnostics for explaining social aberrancy. The current underutilization of sexual and reproductive health services is in part an extension of women’s role as medical patients through history, a reflection of their second-class citizen status. However, history is never fully responsible for current injustices. There are other structural and demographical barriers to healthcare.

Role of Health Disparities in Underdiagnosis:

Each person has their own reason or explanation for the things they do. We are all motivated, influenced, and shaped by different factors. In a perfect world health equity would exist and all people would have equal opportunities to live a healthy life. However, there are some structural barriers to utilizing services that are observed across populations. Factors such as race, ethnicity, class, and income can interfere, leaving certain groups of people more susceptible to disease. The structural inequalities that influence risky behavior need to be identified, dissected, and deconstructed to empower women so they can control their health.

Chlamydia rates are higher among certain racial groups compared to whites in the United States because of the restrictive existing social conditions, not color or ethnicity. Black women have six times the rate of infection than white women, black men have nine times the rate of black men, American Indians/Alaska Natives have four times the rate of whites, and Hispanics
have two times the rate ("STDs in Racial and Ethnic Minorities," CDC). A matrix of factors contribute to these elevated rates.

Once again historical injustice projects itself in current behaviors. Many African Americans share a mistrust of the medical community that stems back to a history of exploitation and racial discrimination preventing them from seeking necessary medical services today. The Tuskegee Study, the longest nontherapeutic experiment on humans ever, symbolizes the exploitation of any vulnerable group in medicine. In this trial 400 black men with clinical syphilis were monitored for forty years without being informed, treated, or educated about the transmission or prevention of their condition. By the time the study ended, 100 of the men had died from syphilis or syphilis related complications (Corbie-Smith et al., 1999). The implications of this study are so grave that they have been extrapolated to show that any minority population can be vulnerable whether grouped by race, ethnicity, gender, disability, age, or social class.

Additionally, race can be used as a proxy for class. Black Americans are overrepresented in socioeconomically disadvantaged groups. In fact, they are 2.5 times more likely to live in poverty than white Americans. Often times, the results are the same when statisticians substitute race for class when determining health indicators (Kawachi et al., 2005). Living in poverty is connected to many things besides race as well such as education level, incarceration, use of illicit substances and alcohol, and limited access to health services and treatments. Based on sexual networks influenced by contextual factors, such as poverty, discrimination, epidemiology of illicit drug use in the community, ratio of men to women, incarceration rates, and racial segregation these individuals may also be more likely to sexually engage with an infected partner (Adimora et al., 2005). These all combine to impose more systematic barriers. Not only are
these individuals less likely to be tested, but also they are less likely to be aware of their risk.

A few theories have been presented to explain why certain groups are more vulnerable to adverse health outcomes. These models can also be used to show why Chlamydia goes undiagnosed and untested. The first premise, the health-behavior model, assumes health outcomes are the result of voluntary actions (Johnson and Owen, 2012). This model suggests that infertility from PID is the result of women voluntarily choosing not to be tested, without any additional influencers. The second, the socio-economic status model, posits that racial and ethnic health disparities are associated with financial disparities and it is a coupling effect that restricts health services. According to this theory, race and socio-economic status combine to prevent access to testing centers (Johnson and Owen, 2012). This model suggests that a black woman might have a limited income because of her race (she had difficulty getting hired or has a smaller salary because of her skin color). As a result, she is forced to live more than forty minutes away from her nearest health clinic. This increases the burden so she does not attend. Additionally because of the demographics associated with the neighborhood she lives in, her sexual network may have higher rates of STDs putting her at greater risk of infection. The psychosocial model takes it a step further and acknowledges that all interactions from the social world have an impact on our health. In particular, this model postulates that the stress associated with institutionalized racism is responsible for adverse outcomes in certain groups (Johnson and Owen, 2012). According to this theory, if an African American woman can find a way to get to a clinic, her doctor’s stereotypes about her race may lead him or her to give her less comprehensive advice about protecting herself. Hearing that she is sexually active, he or she recommends she take oral contraceptives to prevent pregnancy, but he fails to mention the necessity of using a condom to prevent against STDs. His preconceived notions that it is more
important to prevent pregnancy in black women than protect their fertility prevent him or her from seeing her as an individual with personal concerns

Role of Gender Stereotypes in Underdiagnosis:

The social construction of gender serves as a barrier to receiving adequate health services. Women are exposed to gender specific pressures that impact their awareness and agency. While adolescent girls have been found to be slightly more aware that STDs could impact reproductive capabilities than boys, the rates were far less than optimal. Only 72% thought infertility could occur, and even more troubling only 42% believed they had any control over contracting a STD or preventing any potential sequelae (Trent et al., 2006). It is unclear why adolescents feel inadequately prepared to mitigate the effects of STDs or prevent them in general, but we can speculate. A number of scholars have argued that unequal gender relations make the young women feel helpless, unable to reject sexual advances, or request condom use (Peasant et al., 2014).

Unequal power relations between adolescents and both parents and doctors could also minimize the control adolescents perceive having regarding their health decisions. Studies show doctors are unwilling, inadequately prepared, and unaware of the responsibility to test young women. Evidence also suggests that adolescents are unwilling to disclose sexual practices unless their provider asks targeted questions (Blum et al., 1996). This unwillingness stems from psychosocial factors that have become associated with STDs. As discussed previously, Chlamydia in and of itself is a bacterial infection; it results from natural, normal behaviors and can be easily treated. In this sense, it is not much different than strep throat or the flu, so why
does society identify STDs in a category all of their own?

Literature shows that with STDs come stigmas, shame, and embarrassment (Hood and Friedman, 2011). They expose our sexual tendencies, behaviors that are considered taboo, personal, certainly not to be discussed. In the public sphere euphemisms are used to discuss sexuality, it is hinted at and used to market products, attract interest, and draw attention but it is never shown in its full rawness. At the same time, disease contradicts everything we consider sexual; pleasure, fantasy, intimacy. So the movement from intercourse to disease is an uncomfortable transformation that alters our perception of sex, something so deeply engrained in us we forget to question it.

STDs have become inseparably associated with social attitudes and values. They are believed to reflect personal hygiene and represent morality, sin, punishment, blame, and retribution. According to historian Hillary Piercy, when syphilis and gonorrhea were first identified, discharge was considered the source of infection. Vaginal secretions and menstrual fluids were considered a source of contamination to men. In the eighteenth and nineteenth centuries, infection was considered unfortunate but inevitable in men, while women were either innocent victims or dangerous sources of infections. These two groups of women were juxtaposed against each other. As cultural norms dictated, ‘good’ women were sexually subordinate to their husbands, lacking the ability to resist sexual advances and thus prevent transmission. Prostitutes, on the other hand, were the sources of infection, disrupting the family and contributing to economic instability. This put them in the realm of ‘otherness,’ associated with people and behaviors outside the moral code and thus seen as a threat to society. They posed such a risk to society that The Contagious Disease Act of 1899 determined that prostitution was sufficient evidence of disease. With this, STDs became synonymous with
women of lower class, prostitutes, and immoral behavior. This association permeates into our current perceptions of STDs and affects not only the way we view our sexuality and determine acceptable behaviors, but also our health outcomes (Piercy, 2007).

In addition to these psychosocial barriers that disproportionately affect women, women are also disadvantaged because society is reluctant to discuss sexual practices and this prevents social progress. Part of this stems from the stigma discussed above, but other feminist scholars have criticized components of the women’s health movement and specifically post-feminism for contributing to a decline in sexual agency. Angela McRobbie and other post-feminist scholars dismiss sexism, claiming women have transcended traditional gender and sexual inequalities to appear as rational agents constructed as the modern idealized woman capable of making her own decisions (Gonick et al., 2009). However, with this comes a new set of challenges and problems that still warrants the need for a classed, raced, and gendered analysis of sexual agency. In an analysis of the advertising campaign and mandate for Guardasil, a vaccination for Human Papilloma Virus (HPV), Tasha Dubriwny highlights flaws associated with the message of female empowerment that was brought along with post-feminism. The media campaign disguised the mandate as female empowerment, allowing women to control their sexuality, and remain safe. However, Dubriwny claims this was more of a façade than anything else. Still bound by gender and sexual differences and rather than being empowered, the Guardasil girl is constructed through a paternalistic lens to be vulnerable and in need of protection. By mandating the vaccination, the implied narrative suggests that all girls will put themselves at risk and parents, doctors, and legislators are the only ones who can protect them (Dubriwny, 2013). HPV is a noncommunicable disease; it can only be spread by unprotected sexual contact. Therefore, mandating the vaccination suggests that young women cannot or will not take other
precautionary measures, such as condom usage, to prevent infection. Full sexual agency is achieved through informed consent. The young women should been provided with resources and information to decide the best preventative measure for themselves, but instead the government made the decision. This shows that society is reluctant to provide comprehensive sexual education and services for children and teens. The social context of disease is extremely important to understanding health behaviors and without an open, honest dialogue we cannot expect or even hope for health equity. When it comes to STDs, women are bombarded from every angle with conflicting messages.

There are many reasons why sexually transmitted diseases, Chlamydia in particular, are surviving undiagnosed, but the overarching theme associated with each plausible explanation is stigma. Unfortunately, sexuality and identity are so closely linked they are often inseparable by society’s standards. Since these diseases are transmitted sexually, they are considered representative of one’s sexuality, thus linking the individual’s identity with the disease. Therefore, the positive diagnosis itself can have serious emotional implications that extend beyond the gender inequalities associated with underdiagnosis. Being infected with Chlamydia can challenge a woman’s identity.

Chlamydia and Femininity:

Upon a diagnosis of Chlamydia women report feeling shame, embarrassment, horror, and disgust generating a sense of bodily pollution and discomfort. Perhaps the most prevailing notion is the concept of ‘dirt.’ Hilary Piercy describes dirt as “matter that exists outside of, or which confuses and challenges, the existing structures and classifications within society” (Piercy,
2007). According to this theory, part of the distress arises from the discordance between one’s perceived identity and one’s actual identity. Piercy explains that because STDs are associated with immoral behavior and prostitution, they are situated in the realm of otherness; STDs happen to other people. This also means the diagnosis is typically unexpected and unanticipated. Even women practicing high-risk sexual behavior do not expect to contract an STD. A positive diagnosis challenges a woman’s sense of self by imposing stigmas and notions associated with STDs onto one’s individual sexual identity. Discrepancies between individual sexual identity and notions of STDs force women to reassess their personal perceptions of STDs. In a sense they need to transcend an imagined barrier or acceptable moral code. They can either accept that as an infected carrier they are less human, less worthy of respect, or they can redefine their situation in their own terms.

Part of the emotional turmoil associated with an STD is the threat to a woman’s moral reputation. Social identities based on sexual behaviors are different for men and women. Gendered and derogatory terms such as ‘slut’ and ‘whore’ do not exist in the male arena. Acceptable expressions of sexuality are extremely different for men and women. While engaging in sexual activity with multiple partners is a source of shame and ridicule for women, men are praised and deemed more powerful (Tanenbaum, 2000). The sexual double standard has grave implications for the emotional processing and understanding of an STD since STDs are incorrectly associated with promiscuity. It impacts health behaviors such as conversations individuals are comfortable engaging in with doctors, peers, and parents. This impacts the quality of health information and accessible resources, putting women at risk.

As a result of this double standard and associated with promiscuity, which society looks down upon, women are more likely to feel guilty about a positive diagnosis than men. They feel
guilty because society tells them they did something wrong. They contracted the disease because they behaved poorly. They put themselves at risk by being promiscuous. Therefore, through society’s lens the infection is a punishment for poor behavior. But this is the wrong way to look at the situation; this reflects what is wrong with society’s perception of female sexuality. There is nothing inherently immoral or wrong for engaging in sexual activity. A woman’s sexual interests and actions belong to and should be guided by her personal moral code and sense of self. Allow negative health consequences to shape our perceptions of human sexuality is a dangerous practice that will continue to ostracize and mistakenly, since promiscuity may be the biggest myth related to STDs, judge people contributing to poorer treatment plans and an increase in pelvic inflammatory disease and ultimately infertility.

Infertility and Womanhood:

The way a woman perceives her infertility greatly affects the impact it has on her life, access to social support, coping mechanisms, and emotional well being (Mindes et al., 2003). The experience is different for every couple. Some feel anxiety, fear, isolation, depression, guilt, frustration, and helplessness, while others feel inadequate or defective. Many studies have focused on gender differences in response to infertility. Although, it has been well documented that the root cause of infertility is evenly the result of than man, the woman, or a combination, cultural norms, American society, and medical tests reinforce the notion that infertility is a female problem. This results in an additional burden and increased stress on the woman, regardless of the source of the biological problem (Exley and Letherby, 2001; Abbey, 2000). Women and men also experience infertility related stigmas differently. Women with less social
support perceive negative stigmas to be stronger than their counterparts with greater support systems. While low social support is an indicator of increased rates of anxiety, depression, and distress, high social support does not indicate an increased willingness to disclose the condition with their friends and family. Rather, the women who were more likely to communicate with their social networks were the women who reported feeling higher levels of distress (Parry et al., 2005).

Infertility illustrates a complex conflict: the collision of one’s private and public life with regards to gender equality and role of the state. On the one hand, reproduction is an extremely personal and private affair. It is an intimate issue between a woman and her partner, their bodies, and their desire to procreate. When infertility is medicalized and becomes a public issue, women risk losing reproductive agency and personal decision making. However, the separation between the public and private spheres can also be harmful to women. If the public sphere is separated from the private sphere, it allows the state to withhold funding for reproductive services for ‘personal’ issues such as contraceptives and abortion. It also allows the state to take a back seat approach to reproductive rights.

Society’s intrusive obsession with reproduction is marked by unsolicited advice, invasive questions, and unwanted scrutiny. It is as if infertility grants others the permission to claim a woman’s autonomy. As a public matter, infertility is associated with childlessness regardless of intent. If the desire for children is the socially desired norm, than not having children is ‘deviant’ (Parry, 2005; Rosenblatt et al., 1973). According to this theory, unless the woman communicates her intimate struggles, thus making her individual health records public, she will be perceived much like the women who choose to be childless.
However, placing reproduction in the public sphere is difficult for women. A study from 2009, appropriately titled “Nobody Thinks Twice About Asking,” discusses the various means strangers and individuals within one’s social network request information regarding a woman’s plans to conceive. The questions range from caring and a chance to talk, to insensitive, to a threat to one’s identity, to an invasion of privacy, all the way to a reflection of pronatalist beliefs. Pronatalism is a gender narrative that assumes women are made for motherhood and should bear children. The range of responses can be evasive (dismissing the questions), indirect (hinting at the problem without providing any specific information to confirm), to revelations (disclosing infertility in a firm, almost rude manner to either protect her identity as a woman who desires a child or to let the asker know he or she is overstepping boundaries) (Bute, 2009). With the wide variety of responses, it makes sense that social networks would have inconsistent associations with infertility disclosure and perceptions of infertility related stigma. Social networks were not found to be associated with rates of disclosure, rather the women more willing, perhaps more in need, of sharing their struggle were the women who perceived their situation to be more distressing (Parry et al., 2005). This further supports the notion that infertility and the impact on a woman’s identity is truly dependent on the individual and her unique situation. As a result, society needs to be more sensitive to these unique characteristics and recognize its role in infertility distress. Individual medical records should always be considered private and even the closest friends and family need a heightened awareness to properly assist their loved ones. Women should not be approached with inappropriate questions, even if they are well intended.

The gendered stigma around infertility can also explain why women may experience infertility differently than men. In an infertility study, women equated fertility with the ability to nurture. Their self-identification as ‘nurturing beings’ diminished as they grew to accept their
infertility (Becker et al., 1997). Similarly, childlessness also challenges one’s initiation into adulthood. Becoming a mother is a milestone, a marker of success if you may. Disrupting this stage can place a woman’s life in emotional turmoil where she must reassess where she wants to go (Exley and Letherby, 2001).

The stigma a woman experiences as a result of infertility may be increased if the source of infertility is associated with its own array of stigmas. A woman’s psychosocial response to infertility is closely linked to the medical embodiment of infertility, or the process in which a woman is identified as infertile. Although it has been well documented that the root cause of infertility is evenly the result of than man, the woman, or a combination, cultural norms, American society, and medical tests reinforce the notion that infertility is a female problem. This results in an additional burden and increased stress on the woman, regardless of the source of the biological problem (Exley and Letherby, 2001; Abbey, 2000). When a woman’s actions are actually identified as the source of her inability to conceive, she may experience a more immediate, personal sense of bodily failure, which is confirmed and legitimated by medical professionals. Literature suggests that the cause of the infertility as well as the links between impaired body, self, and identity affect a woman’s fertility related distress (Meyer, 2001).

Women who self identify to be the cause of infertility, compared to those who consider the biological problem to be male-factor based, report heightened levels of distress than those who do not (Songer et al., 2004). This is a crucial fact to remember when considering the emotional processing of STD related infertility. There are no studies solely looking at role of Chlamydia and how women respond to the diagnosis, but we can speculate based on typical responses to fertility and guilt. As previously mentioned, women may feel guilty about a Chlamydia diagnosis; they feel responsible for the infection since it is a ‘punishment’ for
immoral, socially damaging behavior. Thus it is logical that infertility could be an extension albeit more severe punishment as well. With regards to a woman’s self-identification perhaps she will internalize her infertility as a sign that she was not meant to bear kids, she has made mistakes that make her a poor candidate for motherhood.

Looking Forward:

Infertility treatment such as in vitro fertilization and intracytoplasmic sperm injection (ICSI) focuses almost exclusively on the woman, even when the cause is male based, reinforcing the assumption that infertility is the woman’s problem. This leads to an increased in her perceived burden and a decrease in self-worth (Songer et al., 2004). Because STD related infertility can be attributed to a specific action or set of behaviors the woman engages in, it is logical that it could increase the associated guilt and responsibility. This is a bad combination for a woman’s sense of self, one that does not put her in a position to own her sexuality and one that needs to be eradicated. While more data is still needed to fully understand the implications of infertility resulting from untreated sexually transmitted diseases, we can be certain that stigmas against women engaging in sexual activity need to be challenged. Public health professionals and doctors can work to educate people, men and women alike, on safer sex practices. They also need to be better about increasing testing and spreading awareness about the long-term risks of sexually transmitted infections. Perhaps emphasizing the impact on fertility or fertility preservation campaigns could be an effective method of STD prevention. The social stigmas surrounding STDs and infertility need to change as well; they benefit no one and only serve to disgrace women. The social context of STDs that make women feel guilty or worthy of
their infection ignore the most fundamental concept of infection: bacteria do not discriminate. Therefore it is incorrect to assume an STD can shed light onto a woman’s sexual or individual identity and even if it did that would not serve to support discrimination. A woman may be more likely to contract an STD if she has unprotected sex with more partners, but that is simply because her exposure is greater. It only takes one exposure to the bacteria to become infected. As a society we need to be more tolerant of differences. Human sexuality, in all of its variations, is a natural phenomenon that can increase one’s quality of life when it is embraced. Sex positivity can change the stigmas associated with STDs and subsequent infertility.

Sex positivity embraces sexuality and celebrates differences. As a result, it separates the flawed assumption that sexual differences are based in biology. Unlinking these two concepts is important to allow for a more fluid sexuality and thus improve health outcomes. If as a society we can recognize that STDs are not characteristic of sexual behaviors, and do not imply that one is dirty we can transcend this imposed barrier, lead healthier lives, and reduce the incidence of female factor infertility.
References:


