

POOR WOMEN WITH SEXUALLY TRANSMITTED INFECTIONS: PROVIDERS' PERSPECTIVES ON DIAGNOSES

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Keywords: Community and Public Health, Health Care, Provider Perspective and Behavior, Health Care, Rural, Marginalized Populations, Poverty, Sexually Transmitted Diseases, Women's Health

ABSTRACT

This article presents results from a study of health care providers, mainly nurses and nurse practitioners, who routinely diagnose sexually transmitted diseases (STDs) in rural low-income populations in West Virginia (WV). A qualitative analysis of eighteen semi-structured interviews reveals that providers who consistently work with low-income populations believe patients undergo a negative change in self-image in response to a chronic STD diagnosis. Providers express concerns about a number of issues related to low-income, rural women's access to sexual health care and see the need for more sexuality education, more funding for free and reduced cost clinics, and more available health insurance. Additionally, despite problems working in publicly funded clinic environments, providers attempt to eliminate stigma attached to diagnoses of sexually transmitted disease.

INTRODUCTION

Sexually transmitted infection (STI) also known as sexually transmitted disease (STD) (Hendricks, 2001) represents a public health problem with massive economic and social consequences for the United States (US) (CDC, 2009a). Viral STDs, such as herpes and human papillomavirus (HPV), the group of viruses that cause genital warts and are associated with cervical, vulvar, vaginal, penile, anal, and head and neck cancers (CDC, 2009c, 2010), are particularly problematic because outbreaks often recur over an individual's life and entail a high level of emotional and physical discomfort. Currently, about 45 million people or about one out of five Americans live with herpes and at least half of all sexually active people will acquire human papillomavirus some time in their life (CDC 2007, 2009c). Providers who routinely diagnose HPV and herpes deal with difficult patient reactions to first time diagnoses of what are often termed "chronic" STDs and the negative stigma attached to having an STD. Some of the characteristics associated with having an STD are "indiscriminate promiscuity, pollution, and uncleanness" (Lawless, Kippax, & Crawford, 1996, p., 1371). Historically, low-income women with STDs have been particularly stigmatized partly because they have been defined as "impure," "undeserving," and "sinful" (Lawless et al., 1996, p. 1376).

Providers who diagnose and treat STDs in public clinics that cater to populations that are both rural and poor deal with a special set of challenges. Issues such as lack of health insurance, transportation problems, inability to pay for services, child care problems, stigma, and lower levels of education make the diagnosis and treatment of STDs a particularly difficult situation for the patients and a demanding undertaking for the providers. Research from the providers' perspective about STD diagnoses in public

clinics is needed to better inform policy that can ultimately benefit both the patients and providers. Although studies on provider attitudes exist (Beatty, O'Connell, Ashikaga, & Cooper, 2003; Danielson, Barbey, Cassidy, Rosenzweig, & Chowdhury, 1999; Lane et al., 1999; Merzel et al. 2004; O'Connell, 1997), many do not focus on rural environments and are narrow in focus. Qualitative research in rural environments that focus on the providers' own perceptions and observations in the field is sorely needed. My research, based on interviews with health care practitioners in West Virginia (WV), begins to address this gap. An analysis of 18 interviews with providers who routinely diagnose low-income patients with STDs addresses how providers describe the diagnostic process within low-income rural populations and the issues they see these women confront.

STDs Diagnoses and Low-Income Women

STDs are often physically more problematic for women than for men. For example, HPV can cause more lasting and difficult complications in women (Weinstock, Berman, & Cates Jr., 2004) because of HPV's link with cervical cancer; it has been identified as the main causal agent in over 95% of cervical cancers (Beatty et al., 2003). Herpes disproportionately affects women, affecting one out of five women versus one out of six men (CDC, 2007). Moreover, adolescent girls ages 15-19 and young women ages 20-24 are most likely to contract common STDs than men or any other age group (CDC, 2009b). Studies like these show the need for more research related to women and sexual healthcare because they underscore the especially high rates of STD transmission in women. A vaccine for HPV for women was approved by the Federal Drug Administration [FDA] in 2006 that prevents against 4 out of the 100 strands of HPV that cause most types of warts and cancer (FDA, 2006). The vaccine is not recommended for women over the age of 26 and can be cost prohibitive for younger women without health insurance (National Cervical Cancer Coalition, 2010).

Socioeconomic status and access to health insurance is often linked to patient health. Persons without health insurance are more likely to report an unmet need for care and are less likely to receive preventive health services (National Center for Health Statistics, 1998). Even with government sponsored Medicaid for the poor, 48% of poor, fulltime workers were uninsured in the United States in 2000 (Waldrop, 2000). Women living below the poverty line are more likely to contract HPV (Women's Economic Agenda Project, 2008) and poor women and women without health insurance have a far more difficult time accessing sexual and reproductive health care than higher income women (Wyn, Ojeda, Ranji, & Salfanicoff, 2004). Frequently, low-income patients or people without health insurance delay seeing a doctor because they cannot afford care. Targeting research in locations where public health care providers treat mostly low-income women without health insurance will allow a greater understanding of providers who serve populations encountering the most difficulty accessing treatment for STDs.

Stigma and Health Care Providers' Perspectives

Some studies claim that receiving a diagnosis of an STD and the treatment one receives during the diagnosis by the health care provider can significantly affect a patient's sense of self (Nack, 2002), particularly because of the stigma attached to an STD diagnosis. Following Goffman's (1963) definition of stigma as "an attribute that is deeply discrediting" (Goffman, 1963, p. 3), I refer to stigma in this study as a perceived label that situates a person apart from those who do not have the "deeply discrediting" attribute, that negatively affects the stigmatized person's sense of self.

Stigma associated with STDs is not likely to decrease without education efforts and is a major barrier to appropriate sexual health care (Fortenberry et al., 2002; Lichtenstein, Laska, & Clair, 2002). Provider attitudes are important to patients receiving sexual and reproductive health care (Lane et al., 1999) and as such are important to studying the STD diagnostic process and stigma. Linnehan and Groce (1999) found that stigma related to how health care providers felt about “promiscuous” patients often prevented patients from seeking out prevention and treatment services. They agree that the overwhelming majority of health care providers see HPV infection as a major health problem for young women, “but only 54% spend at least 10 minutes providing education and counseling to all of their HPV patients” (Linnehan & Groce, 1999, p., 137). Nack (2002) found that women receiving diagnoses of herpes or HPV agreed that providers’ deliveries of diagnoses were key to the symbolic meaning the patient initially related to the STD. Thus, the attitude of providers and amount of time spent in appointments for health education are critically important aspects of care for patients. Often, studies that are dedicated to stigma and patient reactions associated with diagnoses of HPV, herpes, and bacterial infections (CDC, 2000; Chesson, Blandford, Gift, Tao, & Irwin, 2004; Khan et al., 2007; Nack, 2002) do not focus on poor rural women in the United States and typically omit qualitative research about providers’ perspectives informed from the diagnostic setting.

The purpose of this research is to better understand the stigma associated with STDs through health care providers’ eyes and the perspectives of sexual health care providers who consistently serve rural low-income populations in publicly-funded environments. Publicly funded clinics in WV are good sites to explore this phenomenon. WV is a historically rural state with the third highest poverty rate (17.9%) in the country (US Census, 2010a). The median household income in WV in 2008 was \$37,528, well below the national median household income of \$52,029 (US Census, 2010b). Moreover, 21% of all women in WV lack health insurance (versus approximately 17% nationally) and close to 36% of low income women in WV are uninsured (Henry J. Kaiser Family Foundation, 2007, 2004). These findings imply that women in WV are particularly at risk for encountering difficulties accessing care. Research questions associated with my study include: How do health care providers characterize the problems rural low-income populations face with STDs in WV? Do providers demonstrate an awareness of the stigma attached to STD diagnoses? These questions are intended to produce a fuller picture of challenges associated with the STD diagnostic process from the health care provider’s perspective than what has been presented in prior research.

METHODS

In order to address these questions and more fully understand the process involved in working with low-income populations with STDs through the health care providers’ eyes, I engaged health care providers directly in the research process via interviews. Qualitative methodology incorporating interviews is especially pertinent for this study because the emotionality involved in recounting complex situations like STD diagnoses required in depth discussions. I interviewed 18 health care providers from two clinics who give “free” or reduced-cost reproductive and sexual health care to young poor women in WV about their experience diagnosing low income populations with STDs in a face-to-face semi-structured interview format. One clinic mainly serves a student population of ages 18-24, while the other publically funded clinic serves patients of all ages. I targeted providers who work in family planning clinics specifically designed for

poor women without health insurance. Interviews were conducted and recorded in the participants' offices and clinic locations and later transcribed verbatim for analysis.

The health care providers in this study consisted of 4 registered nurses, 7 physicians, a physician's assistant, 3 nurse practitioners, 2 nurse midwives, and one sexually transmitted infections educator. These providers had been working in sexual and reproductive health care for an average of 19 years. The sample included a much higher ratio of female providers (72% female versus 28% male) due to a greater number of female providers in these clinic locations. Providers were recruited based on their practice location, special interests, and also through referrals. I attempted to reach a saturation point of providers by specialty area in these two locations relating to low-income women's sexual health care. I received formal IRB approval to conduct this research, protocol # 16407.

Current research suggests a need for provider sensitivity in clinic care (Nack, 2002; O'Connell, 1997), so interviews focused on issues that may shed light on how providers dealt with delicate patient situations. Literature suggests that low-income women have a more difficult time accessing reproductive health care (Wyn et al., 2004), leading to questions centered around issues involved in treating low-income women. Research (Nack, 2002; Perrin et al., 2006) also suggests that patients react negatively to diagnoses of viral STDs, so providers were asked to explain if they had witnessed any negative reactions to STD diagnoses. Other examples of interview questions included: What are the most recurring issues you see involved in low-income women's sexual health care? What are some goals you have in working with this population? What policies would help you do your job better?

The responses to the interview were analyzed in transcript form using line-by-line coding, labeling of recurring concepts, incident to incident comparison, and cross referencing of codes and memos. Examples of codes include "provider sensitivity to stigma" and "issues with at-risk populations." After initial coding, I used operational definitions to further the analysis process. The analysis yielded the categories of 1. *The Process of STD Diagnosis*, which included examples of codes such as "provider sensitivity to stigma" and 2. *Providers' Views of Barriers to Care*, which included codes such as "issues with at-risk populations." The scheme provided the basis for discussing patients' reactions to STD diagnoses through the providers' eyes including patient emotional responses like anger. After determining how providers perceived patients and their reactions to the STD diagnoses I was able to better understand the degree of awareness providers exhibited surrounding stigma and specific problems they associate with low-income populations.

FINDINGS

Providers' Descriptions of Patient Reactions to Diagnoses

Anger and sadness are the two most common patient reactions to STD diagnoses that providers spoke about, although denial was also a significant reaction. Thirteen of the eighteen providers interviewed mentioned sadness, anger, or both as the most prominent factors after initial diagnosis. Providers revealed that sadness or crying after the initial clinical diagnosis is a common occurrence in patients diagnosed with STDs, but specifically with chronic STDs. Patient responses to providers included phrases like, "Nobody will want to go out with me."

One registered nurse (RN) describes that she has seen a lot of tears...[from patients] thinking... 'How am I going to tell my partner now? What am I going to tell my partner?'" She explained that a patient is typically upset during the diagnosis because they

are wondering about the changes they will have to make in their interpersonal and sexual lives. Sometimes, the fear and uncertainty elicited after receiving a diagnosis contributes to a patient denying the existence of the STD or reacting angrily, often directly at the provider giving the diagnosis.

According to providers, patients sometimes deny they have the infection or might not believe a provider is correct about their diagnosis. One physician remembers a patient who refused the diagnosis because the patient did not realize her symptoms, like headaches or neck aches, could be linked to herpes. According to him, many patients “are very angry, defensive, and unwilling to accept that they have [an STD],” especially when they come to the clinic with a lack of information on STDs. Another way patients deny the existence of the STD might be to get a second opinion days later after symptoms have subsided. One physician described his experience of diagnosing a patient with herpes who was very angry with him and refused to accept the diagnosis. When her symptoms had cleared after the outbreak she went to a different clinic where she was told she did not have herpes and actually came back specifically to tell the physician that he was “out in left field;” or wrong about the diagnosis. It is possible that the provider could have misdiagnosed the patient, but instead of requesting a blood test to be sure, the patient waited until symptoms had disappeared to be told at a different clinic that she did not have herpes.

Patients might also react angrily toward their partners. Providers described many instances when anger at a partner was the first response a patient elicited because the patients immediately assumed a partner had been unfaithful and/or was the source of the infection. “Finger pointing” or phrases like, “Just wait until I get home” were frequently said by patients. The assumption that a partner has been unfaithful could be correct, but one provider emphasizes to her patients that “this doesn’t [always] mean that your partner has been unfaithful. It means that you probably need to sit down and talk about it and find out.” When assumptions like these are made by patients, the provider must compensate by being emotionally supportive and educate the patient about STD transmission. Additionally, if providers are actually simultaneously diagnosing infidelity in a partnership, they are the first point of contact. The emotional reactions from patients can prove tricky for providers to counter, while maintaining a balance between professionalism and empathy.

In addition to questions of infidelity, the type of STD diagnosed also affects a patient’s reaction. In the interviews, providers noted that patient reactions to STD diagnoses vary and are often more pronounced with chronic STDs such as herpes than with curable STDs like Chlamydia. STDs other than HIV were put into two consistent categories by health care providers; bacterial, curable and viral, incurable. When providers spoke about giving STD diagnoses to patients, they referred mostly to the level of difficulty they saw a patient present after receiving a diagnosis and always rated viral STDs as being more emotionally difficult to diagnose from the provider’s perspective. A female RN discusses the difficulty of diagnosing a viral versus a bacterial STD:

Patients tend to get much more upset about [viral STDs] than about something that they know they can take a pill or drink something and then it’s gone. So, that’s a lot more education talking to them about the long term...And some patients take it very well and other[s] are very upset and sobbing...From an emotional standpoint, [diagnosing viral STDs is] harder on both the clinician as well as the individual that’s receiving the diagnosis.

Since viral STDs are incurable, the provider acknowledges that the diagnostic session might be harder on both the patient and the provider. Viral STDs require more educational counseling from the provider to the patient about the long-term effects of having a disease that will be with the patient for their whole life and the provider must respond to patients' questions and explains treatment options. The necessary additional counseling from the provider increases appointment times and might cause already tight schedules in underfunded clinics to run behind which has negative consequences for others in the waiting room, in addition to providers' schedules. Viral STDs also carry a larger social stigma.

Providers are aware that a chronic life-long illness, such as recurrent herpes, often changes a patient's view of their sexuality. They also generally agree that "the majority of patients are totally devastated by the news that they have HPV or that they have herpes. It's chilling and horrifying for most of them. They feel dirty. They feel totally unclean." Providers in clinics who consistently work with low-income populations recognize that a patient could feel stigmatized and understand that patients might feel vulnerable disclosing personal histories or that patients are likely to judge themselves and say phrases like, "No one will ever want to have sex with me again."

Providers are often aware that the social stigma associated with STDs can be damaging to a patient's sense of self, although patients might not be aware of the provider's recognition of this. One RN describes patients feeling they might be "scarlet letter[ed]" for life, after a chronic STD diagnosis. Providers spoke of consistent labels patients put on themselves such as "shame, dirty, slut...and almost always you hear, 'I feel so ashamed, I feel so gross.'" Some providers make stigma-removal a primary goal.

The main thing that I'd like to do is get the stigma of STDs removed...I tell my patients, "No virus, no bacteria, is a judgment of character, right? Can they [the viruses] tell who's a good person and who's a bad person?" So I think the sooner we all get to that point, the better. Because it's all that moral stigma that makes people not come in; makes them afraid to talk to their partners. It's really the moral stigma that causes all of the emotional sequelae. It's really not medical. Like herpes. I always tell my patients, "Herpes is the most overrated disease on the planet, I think. Whoever cries over a cold sore? Nobody! This is the same thing." And yet, genital herpes...It's like the end of the world. At some point I wish we could just all get over that.

It is evident from this nurse practitioner that she believes the social stigma attached to STDs is damaging to a patient's view of themselves and their sexuality. She views this stigma as extremely problematic and works to remove stigma by likening herpes to having a cold sore. This nurse practitioner helped to navigate some of the patient's emotional response to herpes by using terminology like "overrated disease." In the emotionally charged diagnostic appointments, patients might not realize that the provider is attempting to support them as some professional distance must be maintained.

Providers' Perceptions of Barriers to Care for Low-Income Populations

Providers highlight that emotionally-charged reactions from patients, including denial of their infections, anger at the provider or "finger pointing" at their partners, crying, and a change in sexual self-identity, often ensue during the diagnostic session. The difficult process of diagnosing an STD is intensified when added to issues of economic insecurity. Five providers pointed out that low-income patients will have a difficult time paying for medication. Moreover, those in rural areas might have a tough

time finding transportation to pharmacies to obtain these medications or to the clinic for the appointments themselves. Other problematic issues for low income populations providers identified included lack of child care and the inability to get time off work in low paying jobs. Because of problems accessing care, low-income patients will frequently miss appointments. One provider explained she thought missing appointments could negatively affect how providers view low-income patients because they are labeled as “no show” and “some providers are put off by people who are repeatedly ‘no show’ without finding out why.” This is just one of the ways low-income patients might be stigmatized, even by their health care providers.

The presence or lack of health insurance often dictates what kind of care someone will receive. If a patient cannot pay for care, they will most likely choose not to have a test done or the provider must give less desirable options. For example, one nurse mentioned that a colposcopy, a test that looks for cervical cancer and/or HPV after an abnormal pap smear, typically costs between \$400 and \$500 dollars in the state of WV without health insurance. Many times, a patient has to choose between some essential item such as food or the colposcopy, according to this nurse. Thus, the patient cannot get the care he or she needs or deserves. The patients might flat out refuse necessary blood tests or ultrasounds because they cannot pay for it. Even when a patient has access to free tests, such as pap smears, the tests are often not as good as pap smears for higher income women. One RN indicated that pap tests given at “free” clinics do not always test for HPV because those tests that do test for HPV are much more expensive. She said that state clinics that offer free and reduced-cost health care often do not have the funding to provide the most up-to-date tests.

The kind of health insurance a patient possesses can also influence how a patient is treated. Although I asked outright if providers thought that lack of health insurance was a barrier to care, a third of the providers volunteered that government sponsored Medicare and Medicaid in WV had serious defects inhibiting providers from adequate job performance. One physician mentioned that reimbursements for certain procedures were often unequal, such as the Prostate Specific Antigen (PSA) for men, because it is reimbursed at much higher rates than a more labor intensive pap smear. This gender-bias from Medicaid towards men’s health care is also shown via contraceptive inequality. Another provider mentioned that many private forms of health insurance cover Viagra for men, but not birth control pills for women. Medicaid also reimburses much less for health care than private health insurance and providers pointed out that they were forced to see a greater number of patients to offset the cost. Providers who see more patients with private health insurance might not need to rush through seeing as many patients as possible to make enough money to cover the cost of operating a clinic. One nurse midwife mentioned that she could not give free care without getting charged for it or fired. This same nurse midwife noted that lack of insurance can also mean that low-income women will have more frequent STD outbreaks because they cannot afford to pay for medicines, such as suppressive therapies. She said that some medications used in the suppression of herpes might cost around \$9 a pill without insurance. So an uninsured patient who cannot afford to pay \$9 a pill for suppressive therapy has to, in her words, “just tough it out.” She commented that she tries to give out the free samples that pharmaceutical representatives bring, but pharmaceutical representatives typically do not give out samples to places where uninsured patients are treated, like the clinics in this study.

In addition to being underinsured or not insured, times that clinics are open also pose as obstacles for rural low-income populations, according to another nurse practitioner.

Clinics can take all day.... Low-income women have to go into clinics and they have to take a whole day out of their life because they have to come in, they have to skip class, they have to do this, they have to do that, and then, they all get seen by medical students. I don't think it's fair. It just isn't very sensitive to people's needs. It shouldn't be 8-4, rigid hours. WV, we have such a high cervical cancer rate, but a low rate of women who get pap smears. Because places where you can get free pap smears are not open at times when women who work for McDonald's can get to...Clinics should be open seven days a week. It should be in Kroger's [a typical grocery store in WV].

This provider is clearly aware of the difficulties poor women face when trying to get access to health care. The viral STDs such as herpes and HPV often require many treatments, which increases transportation difficulties. Repeatedly having to go to a clinic can cause stress and financial hardship in addition to the emotional impact of the diagnosis of an STD.

Providers who work in clinics catering to low-income populations also see instances of abuse that complicate the emotionality involved in diagnosis. One female nurse midwife, who mainly works with young low-income women, felt many of her patients were emotionally abused at home. She discusses one young female diagnosed with genital warts.

Well I had a patient, young girl, 16. Just a terrible life history. A lot of abuse. And took care of all her siblings...She was pretty hysterical...I went in to talk to her and she said, "I have something down there. And all I've done is sit in the bathtub. And cry for three days." It just told me how difficult it was for her to come in and how ashamed and she knew it was something; she just didn't know what. It was truly the worst case of HPV I've ever seen...She was just absolutely devastated and hysterical that she had given it to her little sister that she had taken a bath with. And it was very traumatic for her. And I ended up having to treat her with multiple office visits with acid to take them off.

Using phrases like "it just told me how difficult it was for her" and "devastated" shows the empathy with which the midwife discusses her patient and provides some evidence that during the diagnosis this particular provider might be aware of the complexity of the diagnosis for the patient.

Most providers revealed that they are paid less money working for public clinics and admitted they could get higher paying jobs elsewhere. Yet all the providers interviewed chose to stay in their current job situation. This suggests that providers receive some level of satisfaction from working in clinic environments, helping those without resources. One RN spoke about finding satisfaction in her job, even with the difficulties in treating low-income patients.

90% of the time when I leave work and I go home I feel like I've done something worthwhile and that in itself is enough. Even though sometimes when you work for a [public clinic] your pay is not going to be as good as a lot of the other places where I could go and probably make \$10 more an hour...I don't know that I would have that sense of satisfaction. And sometimes we don't have that sense of satisfaction. We fail sometimes...But at the same time, you still feel like you've at least been

able to impact some one's life in a positive way.

This provider notes that she feels good about her job performance, even in the midst of difficult conditions. Not all providers reflected on their occupation as positively as this nurse, but none of the providers indicated that they wanted to change positions to work with higher income populations.

DISCUSSION

Studies have shown that stigma related to how health care providers feel about “promiscuous” patients and fear of being “scarlet lettered” often prevents patients from taking advantage of prevention and treatment services (Lichtenstein et al. 2002). One study found that almost half of women ages 18-49 had never discussed STDs with their provider (Henry J. Kaiser Family Foundation, 2003). One of the most commonly reasons cited for women not to speak to their providers was “embarrassment or fear of judgment on the part of the provider” (Henry J. Kaiser Family Foundation, 2003, p. 7). Although there were some health care practitioners I interviewed who appeared less empathetic, most of the providers were in touch with the degree to which their patients stigmatize themselves and attach a greater symbolic meaning to the disease. The providers in this study highlighted that an STD diagnosis was “chilling and horrifying” for their patients and acknowledged that the stigma attached to a chronic STD diagnosis might cause a patient to feel “dirty” or “unclean.” Although my study is not necessarily generalizable, the acknowledgement of stigma and the willingness to discuss stigma by providers working in the two clinics in my sample suggests that providers in low-income clinics do actually work to avoid perpetuating the stigma attached to STDs. Fortenberry et al., (2002) found that individuals who had received a gonorrhea test in the past year felt less shame than those who had not been previously tested. In other words, testing for STDs helps to alleviate stigma surrounding STDs in general. This suggests that “embarrassment or concern” about being judged (Henry J. Kaiser Family Foundation, 2003, p. 7) rests more in the overarching negative symbolic meaning of sexually transmitted diseases and less on that of the actual behavior of health care providers. Some providers in this study even mentioned that stigma removal was a primary goal of theirs.

Having health insurance has been shown to be a large predicator of whether or not a person will have access to care and persons without health insurance are more likely to report an unmet need for care (National Center for Health Statistics, 1998). Medicaid covers only 1 in 5 low-income women and those women who are on Medicaid are dissatisfied with their quality of care (Wyn et al., 2004). This trend reflects a need for not only greater health insurance coverage, but an increase in the quality of care for those who have Medicaid, especially in WV since 33% of West Virginians receive their insurance through Medicaid or Medicare (Henry J. Kaiser Family Foundation, 2010). The providers in this study noted they are often forced into a bind to make health care decisions based on a patient's ability to pay, rather than the most medically appropriate decision.

There are considerable time and funding constraints in most clinics that cater to underinsured populations. For instance, the waiting list to get an appointment at one of the clinics in my sample can be anywhere from three-eight weeks. Because of limited availability and scheduling, providers must try and see many patients in one day. Moreover, providers in this study pointed out that a significant amount of time is spent counseling patients who are misinformed about STD transmission and complications. Consequently, patients might have to endure a much longer waiting period in public

clinic environments in order to account for this time lag. The inconvenience of spending hours in the waiting room for an appointment followed by an hour or more appointment is problematic for rural low-income patients with children or for those who might have transportation issues. The inconvenience is exacerbated when repeated follow up diagnostic or treatment sessions are necessary. This suggests that longer appointment times, in addition to more sufficient and labor-appropriate reimbursements from Medicare, might help both providers and patients negotiate a first time STD diagnosis and provide more little breathing room for practitioners to offer adequate counseling.

The providers I interviewed had been in medicine for an average of 19 years. The views of these seasoned providers may not be equivalent to those of the broader provider population and thus could be a limitation to this study. Also, providers who voluntarily work in less desirable conditions are more likely to be empathetic to the needs and difficulties faced by disadvantaged populations. Further research should include private practice locations to get a wider range of providers with differing orientations. Additionally, there are logistical limitations in this study. The interview sample size is small at 18 participants and the research locations are not representative of all providers in WV, nor of those in the United States and the study is thus not generalizable. However, this qualitative study provides insight into the experiences of these providers and offers a unique perspective on those who work in publicly funded clinics with rural populations.

CONCLUSIONS AND IMPLICATIONS

My research has shown that providers who treat rural low-income populations deal with issues of lack of proper health insurance which necessitates more creativity in terms of treatment options, Medicare/Medicaid reimbursement problems, screening and contraceptive inequality, partner treatment and cost, medication cost, transportation and child care, inconvenient clinic hours, and lack of comprehensive sexual education in the populations they serve. Policies that providers supposed might better address issues involved in treating low-income populations include more sexual education in our school systems, STD screenings at every annual appointment, more clinics designed specifically for low-income populations, universal health insurance, and separate counseling appointments for patients who have recently been diagnosed with an STD. Further research on low-income populations with STDs would help inform better policy and give a fuller picture to the effectiveness of sexual education and treatment of STDs in publicly funded clinics.

Providers who treat low-income women on a daily basis must deal with patients missing appointments and understand that it is not always the patient's fault. They make less money and have fewer supplies and resources. Providers routinely work with patients who might be more emotional during diagnostic sessions and who may have fewer emotional support systems at home. Low-income patients rarely have had provider consistency or medical counseling. Less medical counseling means that patients will have more medical problems in the long term. In addition, the provider might have to take more time finding out what is wrong with the patient because the patient may not have the educational background to fully understand the implications of their disease, making appointment wait times much longer for others. Low-income populations are also historically more stigmatized (Lawless et al., 1996).

The number of years that each of the study participants worked in health care (average of 19 years) suggests that these providers are willing to continue their work despite the problematic aspects of care with low-income populations. It also indicates that

they receive satisfaction from their occupations and working with low-income populations. Despite studies that have documented the need for greater provider sensitivity and asserted that providers often exacerbate the stigma attached to STDs (Nack, 2002; O'Connell 1997), this study suggests that some providers who consistently work with rural low-income patients are very much aware of the problematic nature of stigma attached to STDs and try to effectively limit the amount of perceived stigma accompanying an STD diagnosis.

ACKNOWLEDGEMENTS

The author wishes to thank the providers who donated their time in order to be included in this study and Melissa Latimer, PhD, Heather Turner, PhD, Michele Dillon, PhD, and the reviewers who provided excellent and helpful feedback.

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