Vaginal thrush: perceptions and experiences of women of South Asian descent

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Abstract

It is estimated that 75% of all women will, at some time in their lives, experience at least one episode of vaginal thrush. This paper reports the perceptions and experiences of women of South Asian descent living in England, who were suffering or had suffered from thrush. The paper draws upon data collected during 20 semi-structured interviews. The women reported that thrush sometimes had a considerable impact on their lives, making some of them feel ‘dirty’, embarrassed, depressed and stigmatized. Some women delayed seeking professional help even if they had access to a female General Practitioner. Access to professional care was sometimes hampered by language barriers, but more often by structural factors of gender and social class. Although almost all the women came originally from Gujarat (or had parents who were born in Gujarat), they reported a wide range of experiences. Since vaginal thrush causes much distress and since it is often preventable, the findings presented here have implications for clinical practice. The paper concludes with suggestions for future developments.

Introduction

There is a paucity of data on the sexual and reproductive health needs of ethnic minority groups living in Britain (Kubba, 1998). In particular, little is known about the needs and experiences of women of South Asian descent, who suffer from candidiasis, also known as thrush. While the reproductive health needs of South Asian women living in Britain have been considered to some extent (Firdous and Bhopal, 1989; McAvoy and Raza, 1991; Bowler, 1993; Parsons et al., 1994; Bowes and Domokos, 1996; Chapple, 1998; Chapple et al., 1998; Starkey, 1998), research has tended to concentrate on maternity services and cervical smear uptake, and not on sensitive subjects which may carry a social stigma.

Morbidity is difficult to estimate

Thrush is caused by yeast, usually Candida albicans, which may be present in the vaginas of up to 20% of sexually active women. Candida is harmless initially, but may become pathogenic when conditions in the vagina change, particularly when there is a rise in vaginal pH or an excess of glycogen that has not been converted to lactic acid by lactobacilli. Factors that may cause a change in vaginal pH include semen, menstrual blood and perfumed soaps (McGroarty, 1993; Greer, 1998). Symptoms of thrush include white discharge, pain and irritation. Although thrush may clear up rapidly when treated, it may recur repeatedly and thus become chronic. However, measures may be taken to try to prevent further attacks.

It is estimated that approximately 75% of all women will, at some time in their lives, experience...
at least one episode of vaginal thrush and that some women experience recurrent episodes (Irving et al., 1998). Morbidity is difficult to estimate, because although many women in the general population consult their doctors every time they experience vaginal symptoms, women frequently buy over-the-counter products or use alternative therapies to manage their symptoms themselves (O’Dowd et al. 1996). Although vaginal thrush is a common condition in parts of India (Bang et al., 1989; Bang and Bang, 1994), it is not known how many women of South Asian descent living in Britain suffer from this condition.

Before using over-the-counter vaginal anti-fungal drugs women are advised to consult their doctors if it is the first time they have experienced symptoms of thrush or if they have had more than two infections in the last 6 months. The leaflets that are sold with anti-fungal products also advise women to consult their doctors if they have ever had a STD, if they are under 16 or over 60 years old, if they are pregnant, or have had an allergic reaction to any other anti-fungal drug.

The need for more qualitative research
In Britain, research in this area has been mainly quantitative in design. Women’s ideas about the cause of thrush have received scant attention and little is known about women’s personal management of the condition, and the way in which thrush may affect women’s lives and perceptions of themselves. Moreover, in Britain, the little qualitative work that has been conducted in this area has focused on the experiences of educated middle class white women (Irving et al., 1998; Chapple et al., 2000) and not on the experiences of women from minority ethnic groups.

This paper reports the results of a study conducted in the Northern England in 1999. The aim of the research was to explore the perceptions and experiences of women of South Asian descent suffering from thrush, and to identify factors which might impede the early diagnosis and treatment of this common condition. Although some areas of Britain have relatively large South Asian communities, this exploratory work has not been done before. Feminists working in other fields of interest have frequently emphasized the importance of listening to women’s voices [see (Reinharz, 1992)], but as Ramazanoglu (Ramazanoglu, 1989) has pointed out, relatively little attention has been paid to distinctions of race and class within the category ‘women’.

Various models, such as the Health Belief Model, have been developed to try to explain help seeking behaviour [see (Hassell et al., 2000)]. However, it is now clear that no simple explanatory framework can explain health care utilization and some models have serious limitations (Good, 1994). Indeed, as Bury (Bury, 1997) points out, the study of health beliefs has turned, in recent years, ‘from a focus on the gulf between lay and scientific modes of thought to one where each is considered in the context of rapid social change’. He suggests that there is now a considerable overlap and erosion of boundaries, and that today people’s lay knowledge of health and illness is likely to be studied as much as their lay beliefs. This should be kept in mind when looking at the data presented below.

The analysis of the data also relies heavily on themes and concepts identified some years ago by Goffman (Goffman, 1963), Schneider and Conrad (Schneider and Conrad, 1983) and Scambler (Scambler, 1984). For example, the concepts of stigma, self and spoiled identity were highly relevant. People may not seek advice if they fear they have a stigmatizing condition.

Method
Face-to-face interviewing was chosen as the best method for this research. Although Chapple (Chap-ple, 1999) successfully conducted interviews by telephone when exploring the experiences and perceptions of vaginal thrush amongst a group of middle class white women, this method was judged inappropriate for research that included women not fluent in English. Thus although three of the interviews for this study were conducted by telephone with women who were fluent in English, the other 17 interviews were conducted face-to-face in the respondents’ homes.
The sample

According to Bhopal [(Bhopal, 1995), p. 156], Asian families are one of the most ‘...closed and private of all social groups’ and the author suspected that she would find it particularly difficult to recruit women of South Asian descent for research about vaginal thrush, a condition that some associate with STDs. When Jaswal and Harpham (Jaswal and Harpham, 1997) were conducting research in India they found a culture of ‘silence’ surrounding all gynaecological conditions.

Finding the sample was particularly difficult because in order to recruit women who had treated themselves, as well as those who had consulted a General Practitioner (GP), the author did not want to rely on National Health Service records. Recruitment started with the help of a colleague who spoke Gujarati and Urdu. She introduced the author to a local community leader, who invited the author to talk to a group of Muslim women about dental health. This woman argued that if women who attended her group were going to help with the research the author should give something back in return. Having obtained up-to-date information and leaflets in appropriate languages the author conducted a session on dental health with about 30 women and children. At the end of the afternoon the author told the women about her research on thrush and four women volunteered for the study. Some women were subsequently recruited via a colleague and others were recruited via a linkworker who lived in another town. Two were also recruited via word of mouth, the ‘snowball method’ (Grbich, 1999). Woman suffering from thrush, and who had already been interviewed, spoke to close friends and suggested that they should also take part in the research.

Twenty Muslim women of South Asian descent, who had suffered one or more episodes of vaginal thrush, were finally identified. Most respondents lived in one of two towns, situated in Northern England. However, most of their families came originally from Gujarat in India.

Table I. Sample characteristics of 20 Muslim women interviewed about thrush

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>No. of women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td></td>
</tr>
<tr>
<td>&lt;19</td>
<td>1</td>
</tr>
<tr>
<td>20–30</td>
<td>6</td>
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<tr>
<td>31–40</td>
<td>10</td>
</tr>
<tr>
<td>41–50</td>
<td>2</td>
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<tr>
<td>&gt;51</td>
<td>1</td>
</tr>
<tr>
<td>Born</td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>8</td>
</tr>
<tr>
<td>Gujarat</td>
<td>6</td>
</tr>
<tr>
<td>other (e.g. East Africa)</td>
<td>6</td>
</tr>
<tr>
<td>Parents born</td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>0</td>
</tr>
<tr>
<td>Gujarat</td>
<td>18</td>
</tr>
<tr>
<td>other (e.g. Pakistan)</td>
<td>2</td>
</tr>
<tr>
<td>Languages</td>
<td></td>
</tr>
<tr>
<td>good English + Gujarati, Urdu, etc.</td>
<td>16</td>
</tr>
<tr>
<td>poor English and Gujarati</td>
<td>3</td>
</tr>
<tr>
<td>Gujarati only</td>
<td>1</td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>further education (e.g. degree)</td>
<td>9</td>
</tr>
<tr>
<td>left school at 18 (after A levels)</td>
<td>2</td>
</tr>
<tr>
<td>left school at 16 (after GCSE)</td>
<td>5</td>
</tr>
<tr>
<td>left school before 16</td>
<td>4</td>
</tr>
<tr>
<td>Employment status</td>
<td></td>
</tr>
<tr>
<td>employed</td>
<td>5</td>
</tr>
<tr>
<td>unemployed</td>
<td>11</td>
</tr>
<tr>
<td>student</td>
<td>4</td>
</tr>
<tr>
<td>Low income and benefits (e.g. family credit)</td>
<td>14</td>
</tr>
</tbody>
</table>

Some of these women were very well educated, but at the time of the study most were unemployed and caring for children. Their husbands were mainly skilled manual workers, such as taxi drivers. However, some were unemployed (see Table I for sample details).

The interviews

The author was aware that as a white woman she might find this research difficult and that ‘gender might not be enough to create the shared understandings necessary for a successful interview’ (Bhopal, 1995). However, like Edwards (Edwards, 1990), who debated whether or not to interview black women as well as white women during her research, the author decided that to ignore the voices of South Asian women would be a mistake,
because these women might have important concerns that needed to be addressed. Eventually, like Bowes and Domokos (Bowes and Domokos, 1996), the author decided that she would do the best she could in the circumstances, maintaining a ‘reflexive, critical evaluation of those circumstances’ and the way they might influence her work.

Data were collected using an interview guide that was developed as the result of earlier work (Chapple et al., 2000) and colleagues acted as interpreters when necessary. The interviews lasted from 30 to 60 min. They were tape recorded, with written consent, and transcribed in full.

Data analysis, validation and trustworthiness
Analysis started as soon as the first interview had been transcribed. Although the interviews were semi-structured, they were interactive and questions were not always asked in the same order, and some interviews focused more on some topics than others. Thus it was not appropriate to ask anyone else to code the transcripts to obtain inter-rater reliability scores (Morse, 1997). Participants in later interviews were used to verify information gained from earlier interviews. Findings were also discussed with the linkworker, who had worked with women of South Asian descent for many years. She became a ‘key informant’ (Plummer, 1983) herself, having known other women who suffered from thrush. Transcripts were returned to those women who wished to see them. Women were then contacted again to discuss points that had not been fully understood and to see if they had anything else to add. Transcripts were coded, analysed and read ‘horizontally’, using Microsoft Word computer software (Tesch, 1990). The author conducted a thematic content analysis, developing core categories and sub-categories as the study progressed (Burnard, 1998). A summary of the results was then sent to most of the women. (Those who did not speak good English assured the author that they knew someone who could help with translation.) All those who commented on the results spoke positively about the findings, which are grounded in the data.

Results

Perceived causes of thrush
People’s views about the cause of any particular disease may determine whether or not a health problem is thought to be preventable (Smith et al., 1999). Views about disease causation will also affect the actions that people may or may not take to try to cure their illness. Although some of the women in this study said that they did not know what had caused their thrush, others offered explanations.

Some women blamed themselves and thought that poor hygiene was to blame:

I thought maybe I hadn’t cleaned myself properly. [Interview 13, aged 32]

Some of the older women suggested that the white discharge associated with thrush was due to a serious disease affecting the whole body:

If you get a bit of white discharge everybody thinks that your bones are wasting away, and they believe that very, very strongly in India...that its a very bad disease in your body..., and you are wasting away. If you get that discharge they think you are losing something very vital in your body and its not something that you’ll ever be able to replace easily. [Interview 12, aged 36, via interpreter]

This belief is understandable, since in parts of Gujarat State some women regard white discharge as a serious illness. When a group of Gujarati women were asked to rank the 10 most commonly mentioned illnesses according to relative severity, they ranked white discharge as the most serious (Patel, 1994). Women ranked white discharge as a serious condition because it was seen as painful, difficult to cure and it affected their physical work. One woman in this study mentioned witchcraft as a possible cause of thrush:

Most of us will point towards witchcraft (...) it’s sort of spoilt your inner intestine and that’s why you’re having this discharge because its smelly (...) it’s probably somebody’s put a curse
on you like magic, that’s why we’re having this, because how can your body discharge such an odour whatever, so it must be something to do with black magic. It’s as if somebody’s put a curse on you or evil eye or whatever. [Interview 16, aged 50]

In Gujarat, women also associate white discharge with bewitchment and possible death (Patel, 1994). Patel suggests that women are reluctant to discuss the cause of white discharge because they believed that discussing health problems with other women makes them even more vulnerable to witchcraft.

Some women in this study were concerned that thrush was a STD:

It was a taboo subject. It was very difficult for me to divulge any information to anyone. It’s quite sexually transported. This is an area that I was really worried about. Because you never know your partner. You trust them, but you don’t... [Interview 16, aged 50]

The belief that thrush is sexually transmitted is also common in parts of India (Bang and Bang, 1994).

Bang and Bang (Bang and Bang, 1994) also reported that in India they found that women believed that consumption of ‘hot’ food could aggravate ‘heat’ in the body and thus lead to white discharge. Five women in this study suggested that too much ‘hot’ food might cause white discharge and one woman said that her mother firmly believed that too much ‘hot’ food might make matters worse:

The bones rub against each other and then it leads to discharge, you know the tissues to rub against each other, and it would cause discharge. The extra fluid, unwanted fluid inside the vaginal area would get discharged, and the more you eat hot food, the warmer you get inside there, due to the hot food. [Interview 6, aged 37]

Explanatory models may change with time (Davison et al., 1991) and some of the younger women interviewed in this study suggested reasons for thrush that might be regarded as more ‘scientific’ than those discussed above. For example, the 37-year-old woman who said that her mother firmly believed that too much hot food caused thrush, said that she had been given a different education here in England and she said that her soul believed something different, i.e. that:

Hormones develop different variations, and therefore come out in pimples and spots or thrush. [Interview 6]

Two women suggested that thrush had been caused by the previous use of antibiotics and two others mentioned fungal infections caused by yeast. One woman said that she was aware that antibiotics might cause thrush because she had read the leaflet that is supplied with the anti-fungal drug Canesten®. Another woman had read about thrush in a Reader’s Digest Family Medical Advisor.

The impact of thrush on women’s lives

Having heard that many of the women associated thrush with poor hygiene, promiscuity or witchcraft it is hardly surprising that some of them felt a strong sense of stigma. One older woman recalled:

I thought it was quite stigmatizing so I couldn’t talk to anyone. [Interview 16, aged 50]

In Goffman’s (Goffman, 1963) terms, these women were ‘discreditable’ rather than ‘discredited’, because thrush is not immediately visible and it appears that stigma was largely ‘felt’ rather than ‘enacted’ (Scambler and Hopkins, 1986). Clearly some women felt a sense of shame and spoiled identity. Many of the women said that thrush made them feel extremely ‘dirty’. One elderly woman said that she could not go out and she was unable to pray because she felt dirty all the time. Another young woman also recalled that for her thrush was a ‘very, very, dirty experience’. She explained:

No matter what culture, anything down below is associated with being dirty, because you wee from down below. [Interview 6, aged 37]

Some women told the author that they found it hard to discuss their problem with family or friends. One young woman explained that she was afraid of other people’s reaction.
It’s embarrassing. Its like Ahhh, you’ve got the plague! You’ve got thrush. [Interview 4, aged 34]

This woman was worried that she would be blamed for having thrush, in the same way that people with spots are sometimes wrongly blamed for their skin condition:

It’s like, you know, it’s like spots. You think people who are greasy or who don’t wash get a lot of spots, but that’s not true is it?

Some women felt a constant need to scratch, which made it difficult for them to conceal their condition in public situations. They described their difficulties and their attempts to hide their problem.

It can be embarrassing because sometimes you really want to itch, and then you’ve quickly got to go to the toilet. [Interview 2, aged 33]

It’s very uncomfortable, and you can’t itch, and you can’t have a jolly good scratch. [Interview 4, aged 34]

Two women said that they were afraid to go out of the house because their condition might be noticed:

She’s saying, ‘During the week that I had it, it was the most terrible week of my life, because I’ve never had it before. And it came suddenly, I couldn’t do anything, I couldn’t walk properly in case people knew what was happening to me, and I got really depressed’. [Interview 12, aged 36, via interpreter]

Some women said that thrush affected their sex lives. Others reported that the symptoms kept them awake at night, and some mentioned their pain:

I couldn’t even walk. I couldn’t even put my legs together (...), It was so painful. [Interview 17, aged 26]

Those who thought that white discharge was due to serious disease said that thrush made their bones weaker and that this caused other significant problems:

Asian women think that when discharge comes it weakens your bones. Your bones will get weak, and because of that you get so many other problems, aching, losing weight, not sleeping, not eating properly, and all these problems because of that. [Interpreter for Interview 15, aged 44]

Self-management of thrush

Women’s self-management of thrush varied greatly.

A few women bought Canesten® directly from the chemist without a prescription, even though they could have obtained a free prescription had they consulted their doctors. They preferred to avoid possible embarrassment.

Other women used alternative treatments such as natural yoghurt, which they found cool and soothing. This is a good example of the use of ‘lay knowledge’, passed informally from one person to another.

I’ve tried yoghurt. I used it and it [the thrush] went. [Interview 3, aged 34]

One young woman said that she only used yoghurt externally. She explained that it was against her religion to use tampons so she had not thought of using a tampon as a means of getting yoghurt inside the vagina. However, she said that it would be acceptable to put yoghurt inside the vagina because in this case yoghurt could be regarded as a necessary medicine. It is interesting to note that another young woman said that since yoghurt is a food, it should be respected and should never be inserted into the vagina, which she regarded as a ‘dirty’ place. Both these women were Muslims and both had parents who had come originally from Gujarat. However, they had quite different views about the use of yoghurt as a possible cure for thrush.

Many women washed more frequently in order to try to alleviate symptoms and one woman probably made the situation much worse by taking ‘piping hot baths’, containing Dettol.

I was changing my underwear four or five times a day... Every time I got a discharge I’d fill the
bath up, and put piping hot water in, and I’d put Dettol inside and sit in it. And I suffered that for a long time until I had the guts to go to the doctor and tell. [Interview 17, aged 26]

Some women changed their diets, and ate fewer ‘hot’ foods during an attack:

When I have an attack of thrush then I usually change my diet from hot foods to cold foods, like milk and bananas. Oranges and fruits are good as well. I would avoid foods like chicken, which is hot, and aubergines, and pickles... Fish is hot. (...) My mother told me that I should eat cold foods because they are good, good to cool the body down. [Interview II, aged 25]

In Gujarat it is common practice to reduce the consumption of ‘hot’ foods to cure various ailments (Pool, 1987) and it is known that some women of South Asian descent living in Britain also change their diet to control symptoms associated with other gynaecological conditions (Chapple, 1998). It is interesting to note that the 37-year-old woman (discussed in the earlier section), who said that her mother believed that hot foods were the cause of thrush, but who said that she herself believed that hormones were to blame, also avoided tea and coffee. She said that tea and coffee were ‘hot’ and that her mother had always told her to avoid hot foods [for a detailed discussion of ‘hot’ and ‘cold’ foods and associated theories, see Pool (Pool, 1987)].

Access to professional health care

While some women reported that their GPs had successfully treated them with Canesten®, others reported that this treatment was ineffective and some women perceived that their GPs had not taken their problem seriously. Many women delayed seeking help, even if they had female GPs, because of acute embarrassment and fear of an internal examination. As one woman said:

I was even born here and I found it embarrassing to go to the doctor. [Interview 17, aged 26]

When asked why seeing a female GP was so embarrassing, she replied:

I don’t know, I’ve always been. Well, the same with all Asian girls. I think ‘cos they’ve been brought up to sort of cover themselves all the time.

This woman also said that she delayed seeing medical help because she was afraid she had contracted a STD:

I’d rather not know about it. If I go to the doctor and she says there’s something like HIV or something like sexually transmitted disease, I’d rather not know about it.

Women much preferred to consult female doctors, but the latter were not always available. Respondents said that they particularly disliked consulting male Asian GPs, either because the latter were family friends or because (in their view) male Asian doctors (particularly older ones) treated them in a patronizing way:

But male Asian GPs, they’ve got this status problem. They think we don’t have a voice, we shouldn’t voice our opinions at all. If we voice our opinions then we’re a loose woman or something. They are like demi-Gods and we have to accept it. [Interview 16, aged 50]

One woman found it particularly difficult to consult older Asian GPs. She explained that their attitudes and ‘style’ affected communication with their Asian patients. She said that she preferred to consult a white doctor:

The older [Asian ] GPs, they suffer from this social peer thing, peer class. ... Generally they look down on you. They think, ‘She’s brought up in this country, she belongs to this society, why is she behaving like this?’ You can see this from their face (...), and because they’ve gone a step ahead, because they’re doctors, you know, they’ve overcome this cultural barrier, they feel all Asian people who are living in England should teach their children, educate their children to get out of this, but it’s not that easy, you know. [Interview 6, aged 37]

One woman said that when she and her friends
wore traditional clothes (such as veils), doctors (Asians included) tended to make unwarranted assumptions about them. This woman also reported that she felt intimidated when she consulted her GP wearing her traditional clothing:

If I walked into a situation and I had power dressing I’d be treated different to the way I’d be treated if I wore traditional outfit. [Interview 3, aged 34]

Bowes and Domokos (Bowes and Domokos, 1996) also reported that some of the Asian women that they interviewed experienced similar stereotyping. For example, one woman said that she was treated as an ‘idiot’ when wearing traditional Punjabi dress. However, although Bowes and Domokos concluded that such stereotyping was due to racism, in this study (of thrush) it appears that the women were treated in this humiliating manner because of their social class rather than their cultural background. The women who complained so bitterly about their male GPs were referring to doctors of South Asian descent.

Some women said that they preferred to see a white GP (male or female) rather than an Asian GP because of issues of confidentiality:

I think it’s easier for us to discuss [thrush] with a white woman than to discuss it with our own people because I think we feel there is not much confidentiality in our folks, because its such a tight knit community and the word goes round and it is true, our people are very lax at confidentiality, so if you tell someone, you know, you’d find somebody else in that district talking about it. [Interview 16, aged 50]

Communication between the respondents and their GPs was sometimes hampered by language difficulties, but since most of the women in this study spoke English, this did not appear to be a major problem for this particular group. However, one woman asserted that others had difficulties:

Women are not being treated properly, because they can’t speak the English language, and some locum doctors, or their own GPs are just fobbing them off. [Interview 3, aged 34]

As others have noted (Bowes and Domokos, 1995; Yee, 1997), communication difficulties go well beyond language, and data collected during these interviews suggest that the structural factors of gender and class affected communication more than language barriers.

**Preventing future attacks of thrush**

Most of the women had no idea how to prevent future attacks of thrush. Having explored women’s ideas about the various causes of thrush (see earlier section), this was hardly surprising. If women believe that white discharge is due to serious incurable disease or due to witchcraft they are unlikely to feel in control of events. One woman wore a ‘cotton’ (a cotton necklace), which had been blessed by a priest in India, in order to prevent further attacks of thrush. Only three women said that it was important to avoid hot, tight trousers and only two women avoided antibiotics because they feared another attack. One woman knew that she could reduce the likelihood of thrush by wiping herself from front to back after urination.

**Discussion**

This study has shown that vaginal thrush may cause great misery and embarrassment. The symptoms of thrush cause pain and itching, and the constant need to scratch may disrupt normal daytime activities, sexual activity, sleep and even spiritual activities such as daily prayer. The study suggests that it is important to look at the meanings women attribute to their experience of vaginal thrush, not only in the everyday sense but also in the theological or metaphysical sense. As Conrad (Conrad, 1990) notes, ‘even in our scientific age dominated by biomedicine, these issues of meaning still may affect how people experience their illness and what they do about it’.

While the findings reported in this paper confirm the results of studies conducted with white women (Irving, 1998; Chapple et al., 2000), they also suggest that some women of South Asian descent have additional anxieties and difficulties. Some of these South Asian women felt a greater sense of
stigma, perhaps because of the way in which white vaginal discharge has previously been conceptualized in Indian culture.

Kelly and Field (Kelly and Field, 1998) suggest that in Britain modern communications may have changed, and expanded our range of explanations and understandings of chronic illness. They suggest that communication systems, such as the Internet, may perform important informational and support functions. A few of the white women interviewed by Chapple et al. (Chapple et al., 2000) volunteered that they thought that the stigma associated with thrush was disappearing to some extent, because having seen television advertisements for antifungal drugs they knew that many other women suffered from thrush. However, the women of South Asian descent seemed less aware of television and magazine advertising for these products, and the advertisements did not appear to have had as much impact on the Asian women as they seem to have had on the white women.

Some women treated themselves successfully without seeking medical advice, with products such as natural yoghurt. It should be noted that a few GPs now accept the idea that yoghurt is a useful remedy for thrush (Chapple et al., 2000). Thus as Bury (Bury, 1997) points out, ‘it is important not to overplay the existence of a separate set of consistent lay ‘health beliefs’ (or a range of beliefs) in sharp contrast with medical knowledge’.

Some of the South Asian women felt too embarrassed to consult their GPs. It appears that this was partly because they were taught to cover their legs at all times, and partly because white discharge is sometimes associated with witchcraft and promiscuity. However, those who wanted to consult their doctors faced additional problems associated with social class and gender. Thus structural factors as well as culture need to be considered when trying to understand the experiences of women from ethnic minority groups (Smaje, 1996).

It is vital to remember that ‘ethnic identity cannot be considered as fixed, because culture is not an autonomous and static feature in an individual’s life’ (Nazroo, 1998). Although most of the women in this study originated from Gujarat, they reported a wide range of experiences and they reacted to their symptoms in many different ways. As this paper has shown, some of the women who had lived all their lives in Britain, appeared to be less influenced by Gujarati cultural traditions than the older women who had closer ties with Gujarat. Since individuals experience illness in many different ways, it is important to avoid stereotyping (Pill and Stott, 1987).

The study has its limitations. Firstly, this was a small study of a group of Muslim women whose parents were almost all born in Gujarat. Further research should include more elderly women who may have serious language difficulties and who may have additional problems, and also women from other ethnic minority groups. Secondly, although most of the women had, at one time or another, been given a diagnosis of thrush by their doctors, only some had the condition confirmed by a laboratory. Although women described their symptoms in detail and certainly appeared to have suffered from thrush, it is possible that some of them were suffering from another gynaecological problem. Thirdly, although some of the women were suffering from thrush at the time of the study, other women had to recall previous experiences and some women may have forgotten exactly what happened when they consulted their doctors (Sensky and Catalan, 1992).

Although most of the respondents spoke English and although most transcripts were returned to respondents for verification, there may have been misunderstanding due to language difficulties (Temple, 1997). Some concepts are difficult to translate and as May (1997) points out, ‘even if the interviewees’ command of English is good, there may be terms in their own language for which they do not know the English equivalent and this can [also] lead to ambiguity’.

**Practical implications**

In spite of its limitations, the results of this study have implications for clinical practice.

- Attention to women’s discourse may make it easier for doctors and nurses to make a diagnosis of vaginal thrush. Some women of South Asian descent may be too embarrassed to discuss their
symptoms and they may refer instead to aching bones, tiredness or weakness (Bang and Bang, 1994).

- It is important to listen carefully to each individual concerned, because women report a wide range of experiences and have a wide range of ideas about thrush.
- Women need reassurance that thrush is a common problem; one that is not normally regarded as sexually transmitted. This may reduce the stigma associated with the condition and may encourage women to seek advice.
- Many women would benefit from information about the causes of thrush. Women should be reassured that thrush is not due to poor personal hygiene and that long hot baths may make the condition worse.
- Advice on how to prevent subsequent attacks would be useful (e.g. avoid hot, tight trousers).
- When prescribing antibiotics GPs could warn women that thrush might develop. The subject could also be discussed during anti-natal classes, because pregnant women frequently develop thrush. Thus women would not be distressed by unexpected symptoms.
- Health care professionals could also discuss thrush with groups of women in the community (as part of general health promotion), in order to reach those women who are too embarrassed to consult for this condition.
- Women suffering from thrush should have access to female health care professionals.
- Health care professionals may benefit from additional training to help them deal with problems that they may find embarrassing themselves (Moss, 1999).
- Doctors’ training should include discussion about alternative therapies used by women to cure thrush, such as the use of natural live yoghurt, even though such treatments may be hard to test via large-scale randomized controlled trials.
- Some health care professionals should make more use interpreting services.
- In some areas of the country, where there are ethnic minority groups, doctors should display leaflets about thrush in other languages such as Urdu and Punjabi. The information leaflets inside the boxes containing anti-fungal products are only available in English.

Note

Before starting the research the author contacted the local ethics committee. She was advised that permission to conduct the research was not needed because she did not intend to obtain respondents via the National Health Service, nor did she intend to use National Health Service premises to conduct the research.

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References

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