Sexual Health Environments and Privacy

Good health is critical to personal peace, and sexual health (SH) is key to physical and mental health. Unfortunately, the UK has a high rate of late diagnosis of HIV (NHS England, 2022) . Stigma or fear prohibits people from being tested, and they are concerned about lack of personal privacy and the impact of the results on others.

Fear, humiliation and disempowerment, even brought on by doctors, can be significant barriers to accessing healthcare (Malterud, 2005) and a disruption to personal peace. The stigma associated with SH amplifies this barrier, which is further exacerbated by medical buildings that reproduce mechanisms of power and control (Markus, 1993). Eliminating privacy, implemented in asylums incarcerating people with syphilis such as Panopticon (see Godbey, 2000), has been one of those. Today, privacy is fundamental for SH provision (Heath et al., 2023; Warr & Hillier, 2008), although not always practiced. Understanding how it can be designed and implemented is essential for patients' journey to recovery and personal peace (see Figure E8.1).

Figure E8.1 Counter design that enables patients in a sexual health clinic to enter their medical information privately.

Once I visited a sexual health ward in London, being in the process for in vitro fertilization (IVF). Upon arrival, I completed a form requiring an exhaustive account of my health and sexual life. I had to grab a chair from those forming a sociofugal link around the walls. I covered my replies to protect my territoriality. I longed for some positive distraction. I ended up observing people, invading their personal space bubble. People's forms were in my visual field. I fixed my gaze at my lap. To hear each other, an employee and a visitor, separated by clear plastic screens, spoke loudly:

(employee): Do you know why you are here?

(girl): No.

(employee): X tested positive for HIV. He said you had sex with him . . .

HIV sounds like death sentence. Being told in public is devastating (Malterud & Hollnagel, 2007). We became unwilling participants in the scene. I too explained why I was there and moved to another waiting area. The female area was full. I was sent to the male. It was bare, artificially lit, without windows. Later, I was escorted to a tiny examination room, with charts and photos of infected body parts. A droplet's distance from the examination bed, a urinal self-flushed every 15 minutes. Droplets invaded my space.

Alternatively, a woman might seek maternity wards for SH testing. Some women attempt IVF after having a miscarriage but are reluctant to pursue this option due to the co-location with women experiencing successful pregnancies. Women from one culture might not feel comfortable in certain health services architecturally designed to encourage another culture (Chiotti & Joseph, 1995). Contemporary aesthetics may encourage some people and discourage others. SH facilities need to accommodate victims of trauma, such as those who have experienced sexual abuse or the impacts of violence. War immigrants and refugees are disproportionately affected by STGs (McGinn, 2000). A sense of privacy and control is indispensable. We all need a place to connect with our inner self to achieve wellbeing and inner peace and allow those who care for us in, on our terms.

As SH is one of the most stigmatized areas of health, the associated facilities must incorporate psychosocially supportive features inside generic services that convey neutrality. This specialized design prototype constitutes an area in which design could aid health equity and justice. Space and society are deeply interlinked. Supporting people's sexual health, we foster inner peace.

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