

Eliminating stigma and discrimination in sexual and reproductive health care: a public health imperative

Julia Hussein^a, Laura Ferguson ^b

a Editor-in-Chief, Sexual and Reproductive Health Matters, London, UK. Correspondence: Julia.hussein@srhm.org

b Associate Editor, Sexual and Reproductive Health Matters, London, UK; Assistant Professor and Director, Program on Global Health and Human Rights, Institute on Inequalities in Global Health, University of Southern California, USA

“Because of its pervasiveness, its disruption of multiple life domains (e.g., resources, social relationships, and coping behaviors), and its corrosive impact on the health of populations, stigma should be considered alongside the other major organizing concepts for research on social determinants of population health.”¹

Understanding stigma and discrimination

The occurrence of stigma is closely linked to the context and construct of society and currently understood as a social phenomenon.^{2,3} It is experienced when an individual or group is identified as being different from a perceived norm and subjected to labelling, shame, disapproval and discrimination.¹ Stigma and discrimination are distinct but closely related concepts. At an individual level, the word discrimination is usually loosely used to mean unfair or unequal treatment.³ At a structural level, discrimination occurs when societal conditions constrain wellbeing and access to opportunities and resources,¹ such as health services and good quality care. Discrimination can be a manifestation or expression of stigma. Importantly, sociological analyses of discrimination focus on concepts of power, privilege and dominance,³ placing emphasis on the oppression and loss of power experienced by those who are stigmatised and discriminated against as a human rights violation.

Stigma and discrimination can be real or perceived, with important implications for the health of populations, including the delivery of sexual and reproductive health care, making these obstacles critical public health concerns. Particularly when combined with compelling public health data, the takeaway message is clear: stigma and

discrimination in the context of health care are harmful, and steps should be taken to remedy them in accordance with human rights obligations.⁴ Stigma and discrimination can often be directed towards the marginalised and linked to intersectional factors of age (particularly for adolescents and older people), disability, race, sex, gender, gender expression, sexual orientation and sex characteristics, and marital status. Factors such as poverty, religion, culture, experiences of violence, immigration or refugee status, and occupation can all shape the way that stigma and discrimination are perceived, anticipated or experienced. Further, stigma and discrimination often have a compounded effect, as individuals may face discrimination for multiple reasons, e.g. race, socioeconomic status and health status, each of which can have disproportionate impacts on the same marginalised groups.⁵ Individuals who seek specific kinds of sexual and reproductive health care or services, such as for HIV, sexually transmitted infections, abortion, contraception, sexual dysfunction or transgender health, are particularly affected. As such, stigma and discrimination have been pervasive concerns – whether overt or implicit – within many articles published by SRHM over the years. The discrimination faced by Brazilian men living with HIV who wish to have children,⁶ and stigma and abuses experienced by women who have sex with women in Lesotho⁷ are only two examples of past articles, so this themed journal issue simply serves to call further attention to the inescapable importance of eliminating stigma and discrimination in sexual and reproductive health care.

Recent years have seen increased attention to stigma and discrimination in health care, including sexual and reproductive health, and there are a

range of global commitments and initiatives on these topics, including UNAIDS's *Agenda for Zero Discrimination in Health-Care Settings*,⁸ the World Health Organization's *Global Strategy on Human Resources for Health*,⁹ which prioritises ending discrimination in healthcare settings, and the *Respectful Maternity Care Charter*,¹⁰ which outlines the rights of women and newborns in the context of maternal and newborn care as a way to obviate stigma, discrimination and other rights violations. Each of these covers a different aspect of sexual and reproductive health care; none is comprehensive to all sexual and reproductive health care. These global initiatives are only a starting point: they provide a foundation for action at the local level, which is what is required in order to truly understand and address stigma and discrimination in sexual and reproductive health care. As we have stated in a previous SRHM editorial: "*nuanced evidence that speaks to local contexts and registers is essential if we are to move beyond frameworks and into understanding why services are inadequate and rights unfulfilled and how to address this.*"¹¹

In the call for this themed issue, we sought articles which featured innovative research, analyses on manifestations and drivers, and evidence which could inform pathways towards the ultimate elimination of these barriers. The papers in this compilation are on abortion care, contraceptive use and HIV-related services. They bring attention to perspectives, experiences and attitudes from various settings, including secondary school students in Kenya, formerly trafficked women in Nepal, refugees and displaced youth in Uganda, people using post-exposure prophylaxis for HIV in Brazil and abortion providers across three continents.

Manifestations, drivers and impacts

Rehnström Loi and colleagues measured the attitudes and beliefs of Kenyan secondary school students, finding that over 50% of students had stigmatising attitudes towards abortion and contraceptive use. Younger students (13–15 years) and male students were more likely to exhibit stigmatising views. The authors attribute the views of the young people to community norms and cultural traditions.¹² Cultural and gender norms, many of which were intergenerational, were also identified as drivers of stigma and discrimination in Nepal.¹³ Using a novel combination of participatory methods, involving the making of clay

figurines and photoethnography, the study reveals how women who had previously been trafficked into the sex industry experienced multiple layers of exposure to stigma pertaining to their sexual and reproductive well-being.

In Kenya and India, Makleff et al. explored abortion-related fears and stigma in women who had obtained abortion services. The two countries provided contrasting contexts in relation to laws and policies on abortion, but commonalities nevertheless existed, with women in both countries having little accurate knowledge of safety and side effects, concerns about being judged and low expectations of abortion care. In Kenya, self-stigmatisation and community stigma were pronounced, while in India, women were willing to disclose their abortion to family members. Although reasons for the differences were speculative, legal and policy contexts and social norms were likely key factors.¹⁴ In the article on the underutilisation of emergency hormonal contraception in the UK, the history of its introduction, pricing and marketing was traced, raising considerations of systemic and organisational drivers of stigma and discrimination.¹⁵

Although abortion stigma is commonly discussed from the perspective of the women who experience abortion, health professionals may also be subject to stigma and discrimination. In Argentina, Fernández and Brown follow the evolution of the social, legal and policy environment over a decade, describing how abortion care providers were affected.¹⁶ Elsewhere, narratives of providers of abortion services across three distinct legal and cultural settings illustrate how stigma impacts on the management and outcome of abortion complications.¹⁷

Articles on HIV and associated services included Logie et al.'s work on stigma-related barriers to HIV testing uptake in a Ugandan urban refugee and displaced youth population. What was striking about their findings was that young women had lower awareness of testing services than their male counterparts but were more likely than young men to have had a recent HIV test. Furthermore, in young women, stigmatisation related to sexual and reproductive health – not HIV-related stigma – was linked with lower HIV testing services awareness and uptake.¹⁸ For the measurement enthusiasts among our readers, this paper also examines the reliability and factor structure of the Adolescent Sexual and Reproductive Health Stigma Scale.¹⁹ In Brazil, Ferraz and colleagues explore how stigma impacts the use of post-

exposure prophylaxis for HIV after sexual contact. Secrecy dominated the experiences of the participants, driven by the fear of being discriminated against and mistaken for a person living with HIV, and a desire to hide aspects of their sexual identity.²⁰

Challenging, disrupting, resolving

Many of the papers included in this issue underscore something we already know: that stigma and discrimination, particularly in sexual and reproductive health care, are social constructs rooted in the desire to control the sexuality and related behaviours of women and sexual and gender minorities to conform to norms that are acceptable to a majority. Understanding the localised nuance of this is key to informing the range of actions that might be needed to address stigma and discrimination. Working directly with vulnerable groups in the design and delivery of services is believed to have potentially powerful impact. Community-based approaches to address adolescent sexual and reproductive health stigma in families, communities, and various healthcare settings can identify contextually relevant strategies for transforming inequitable gender norms to improve uptake of HIV-related services.¹⁸ Low expectations among women seeking abortion care have implications for effective practice, and Makleff et al. emphasised the need for locally relevant interventions, delivered by health services, to address women's fears and help them cope with stigma.¹⁴

As the papers demonstrate, multiple avenues can be used to challenge stigma and discrimination and disrupt the pathways that serve to propagate these obstacles. Amongst healthcare providers, stigma impacts decisions on referral, disclosure and treatment, so, alongside reducing legal restrictions, broader de-stigmatisation and culture change at the individual, community and institutional levels was recommended.¹⁷ The means to do so included supportive interventions such as workshops and identifying mentors and advisers amongst senior medical staff. Health system changes that appropriately shift abortion care to lower level, accessible and cost-effective health facilities may reduce delays and improve the experience of women.¹⁷ From a policy and regulation perspective, Murphy and Pooke suggest that removing restrictions and changing practices in the sale of emergency hormonal contraception

may be a way to resolve stigmatisation related to post-coital contraception.¹⁵ Although conducted in the UK, their commentary provides useful reflections for other countries at different stages of introducing, licensing or classifying products for sexual and reproductive health care. Using a comprehensive analysis of drivers, intersections, manifestations and outcomes of stigma for HIV prophylaxis, Ferraz and colleagues propose multi-level interventions ranging from societal (publicity and public debate) and systems approaches (monitoring, identifying good practices), to individual (training, counselling) responses.²⁰

Cullen and Korolczuk look at the role of public discourse and mass culture in disrupting stigmatisation. They provide a fascinating analysis of how the abortion campaigns in Poland and Ireland framed their arguments, combating stigmatisation of abortion through mainstreaming and empathetic or emotive means. Despite the gains achieved through these approaches, the authors encourage us to resist “monolithic and reductive” framing of abortion and argue that intersectionality, and the opening up of spaces for diverse experiences to be represented, will allow longer term changes, durable foundations for solidarity and strengthened coalitions across activists, especially when these represent a diversity of views.²¹ In her book review, Olivia Engle signposts us to Elizabeth Kissling's book, *From a Whisper to a Shout: Abortion Activism and Social Media*, which provides added analysis on the way social movements play a part in contesting stigma.²²

The missing pieces

While acknowledging that this themed issue is by no means intended to be a comprehensive volume on stigma and discrimination in sexual and reproductive health care, and that much work on the subject is available elsewhere, a number of the questions originally posed in our call for papers were less clearly answered.

Stigma featured strongly as the main subject of most of the articles, more so than paradigms or expressions of discrimination. Going back to the definitions laid out at the beginning of this editorial, it may be that the reason for this was because discrimination is assumed or subsumed within what is seen as the broader concept of stigma.¹ It may also be that the complexity of measuring discrimination, which in addition to accounting for cultural specificity, needs to be

situated within local, legal and policy contexts, has impeded the development of measures that are locally relevant and still internationally comparable. Stigma and discrimination, although strongly inter-related, provide different, complementary entry points for work that might address both areas. Using the framework of legal obligations that is linked to the human rights principle of non-discrimination can draw attention to the types of actions that constitute discrimination, highlight that such actions constitute human rights violations, and help health workers and other duty bearers to fulfil their legal obligations with regard to non-discrimination. It can also identify where legal and policy environments provide useful protections against discrimination as well as where they might need to be strengthened to ensure that adequate protection can be provided.

We heard little of specific interventions – programmatic or policy oriented – being put into place and tested for effectiveness, although there was promise of future evidence from a randomised controlled trial of sexuality education in schools.¹² Accountability, and the means by which mechanisms could be set up to monitor and eliminate stigma and discrimination, for example, through access to justice systems, and remedies for violations of human rights was not prominently

featured in this compilation. Societal, cultural and gender norms came out strongly as drivers of stigmatisation, but analysis of specific roles played by organisations and individuals, such as community-based or faith-based organisations or politicians, in perpetuating or combatting stigma was less dominant. Moving forward, funding should be allocated to ensuring that rigorous evaluation can be carried out to ascertain which approaches to this work are most effective.

Do we know enough about good practices to eliminate stigma and discrimination in sexual and reproductive health care? Are the complex pathways to stigmatisation and discrimination, their role in the maintenance of inequalities and the interaction of stigma with other determinants of health understood well enough?¹ If the elimination of stigma and discrimination is to become a public health imperative, then we have some way to go before we can comprehensively answer these crucial questions. Nevertheless, one thing is clear: identifying, addressing and eliminating stigma and discrimination is central to the realisation of sexual and reproductive rights for all.

ORCID

Laura Ferguson  <http://orcid.org/0000-0002-1340-793X>

References

1. Hatzenbuehler M, Phelan J, Link B. Stigma as a fundamental cause of population health inequalities. *Am J Pub Health*. 2013;103(5):813–821.
2. Hanschmidt F, Linde K, Hilbert A, et al. Abortion stigma: a systematic review. *Perspect Sex Reprod Health*. 2016;48(4):169–177. DOI:10.1363/48e8516.
3. Parker R, Aggleton P. HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action. *Soc Sci Med*. 2003;57(1):13–24.
4. Maluwa M, Aggleton P, Parker R. HIV and AIDS-related stigma, discrimination and human rights: a critical overview. *Health Hum Rights*. 2002;6(1):1–18.
5. OHCHR and WHO. The right to health. Factsheet No. 31. Geneva. [cited 2019 Nov 11]. Available from: <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf>
6. Paiva V, Ventura Filipe E, Santos N, et al. The right to love: the desire for parenthood among men living with HIV. *Reprod Health Matters*. 2003;11(22):91–100. DOI:10.1016/S0968-8080(03)02293-6.
7. Poteat TC, Logie CH, Adams D, et al. Stigma, sexual health, and human rights among women who have sex with women in Lesotho. *Reprod Health Matters*. 2015;23(46):107–116. DOI:10.1016/j.rhm.2015.11.020.
8. UNAIDS. Agenda for zero-discrimination in healthcare settings. 2017. [cited 2019 Nov 9]. Available from: https://www.unaids.org/sites/default/files/media_asset/2017ZeroDiscriminationHealthCare.pdf
9. World Health Organization. Global strategy on human resources for health: workforce 2030. 2015; Geneva. [cited 2019 Nov 9]. Available from: <https://apps.who.int/iris/bitstream/handle/10665/250368/9789241511131-eng.pdf;jsessionid=3D152380E16DC547B7C85EE821556D65?sequence=1>
10. The respectful maternity care charter: universal rights of women and newborns. 2019 Oct 2. [cited 2019 Nov 11]. Available from: <https://www.healthynewbornnetwork.org/hnn-content/uploads/Respectful-Maternity-Care-Charter-2019.pdf>

11. Ferguson F, Desai S. Sexual and reproductive health and rights for all: translating the Guttmacher-Lancet commission's global report to local action. *Reprod Health Matters*. 2018;26(52):6–7. DOI:10.1080/09688080.2018.1487621.
12. Rehnström Loi U, Otieno B, Oguttu M, et al. Abortion and contraceptive use stigma: a cross-sectional study of attitudes and beliefs in secondary school students in western Kenya. *Sex Reprod Health Matters*. 2019;27(3). DOI:10.1080/26410397.2019.1652028.
13. Ong TM, Mellor D, Chettri S. Multiplicity of stigma: the experiences, fears and knowledge of young trafficked women in Nepal. *Sex Reprod Health Matters*. 2019;27(3).
14. Makleff S, Wilkins R, Wachsmann H, et al. Exploring stigma and social norms in women's abortion experiences and their expectations of care. *Sex Reprod Health Matters*. 2019;27(3). DOI:10.1080/26410397.2019.1661753.
15. Murphy C, Pooke V. Emergency contraception in the UK: stigma as a key ingredient of a fundamental women's healthcare product. *Sex Reprod Health Matters*. 2019;27:3. DOI:10.1080/26410397.2019.1647399.
16. Fernández S, Brown J. From stigma to pride: health professionals and abortion policies in the metropolitan area of Buenos Aires. *Sex Reprod Health Matters*. 2019;27(3).
17. Seewald ME, Martin LA, Echeverri L, et al. Stigma and abortion complications: stories from three continents. *Sex Reprod Health Matters*. 2019;27(3).
18. Logie C, Okumu M, Mwima S, et al. Exploring associations between adolescent sexual and reproductive health stigma and HIV testing awareness and uptake among urban refugee and displaced youth in Kampala, Uganda. *Sex Reprod Health Matters*. 2019;27(3).
19. Hall KS, Manu A, Morhe E, et al. Development and validation of a scale to measure adolescent sexual and reproductive health stigma: results from young women in Ghana. *J Sex Res*. 2018;55(1):60–72. DOI:10.1080/00224499.2017.1292493.
20. Ferraz D, Couto MT, Zucchi EM, et al. AIDS- and sexuality-related stigmas underlying the use of post-exposure prophylaxis for HIV in Brazil: findings from a multicentric study. *Sex Reprod Health Matters*. 2019;27(3). DOI:10.1080/26410397.2019.1650587.
21. Cullen P, Korolczuk E. Challenging abortion stigma: framing abortion in Ireland and Poland. *Sex Reprod Health Matters*. 2019;27(3).
22. Engle O. From a whisper to a shout: abortion activism and social media. *Sex Reprod Health Matters*. 2019;27:3. DOI:10.1080/26410397.2019.1652029.