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ETHICAL AND LEGAL ISSUES IN REPRODUCTIVE HEALTH

Reducing stigma in reproductive health

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ABSTRACT

Stigmatization marks individuals for disgrace, shame, and even disgust—spoiling or tarnishing their social identities. It can be imposed accidentally by thoughtlessness or insensitivity; incidentally to another purpose; or deliberately to deter or punish conduct considered harmful to actors themselves, others, society, or moral values. Stigma has permeated attitudes toward recipients of sexual and reproductive health services, and at times to service providers. Resort to contraceptive products, to voluntary sterilization and abortion, and now to medically assisted reproductive care to overcome infertility has attracted stigma. Unmarried motherhood has a long history of shame, projected onto the “illegitimate” (bastard) child. The stigma of contracting sexually transmitted infections has been reinvigorated with HIV infection. Gynecologists and their professional associations, ethically committed to uphold human dignity and equality, especially for vulnerable women for whom they care, should be active to guard against, counteract, and relieve stigmatization of their patients and of related service providers.

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1. Introduction

Stigma, understood as a mark of disgrace or discredit, has permeated attitudes often taken toward recipients of sexual and reproductive health services, and at times to providers of such services. The stigma of a failure of moral self-restraint once was attached both to resort to artificial contraception [1] and to non-resort. The disgrace of the unwed mother, the “fallen woman,” has a long history, which persists in some cultures, as does the bastard status of “the illegitimate child.” Contracting a sexually transmitted infection, whether or not evidenced by blemished skin, disclosed a blemished character, and in more modern times homosexuality—whether or not resulting in HIV infection—was a stigmatizing disposition, still characterized in the Roman Catholic Church as an “abomination” justifying disgust. Although without moral taint, infertility is sometimes considered shameful or discrediting, not least by married couples anxious to conceal resort to medically assisted reproduction. Women’s contraceptive sterilization was once considered their dishonorable denial of the duty and virtue of motherhood, and a man’s vasectomy without just cause, such as preventing transmission of hereditary disease, was considered “degrading to the man himself [and] injurious to his wife...to say nothing of the way it opens to licentiousness” [2]. However, perhaps the clearest instance of stigmatizing reproductive health treatment, by those who seek it and those who provide it, concerns abortion.

Stigma is a social, cultural, or psychological attitude that often overlaps with but is distinguishable from stereotypical thinking in

reproductive healthcare [3]. Stereotyping can be negative or positive [4], whereas stigma is invariably negative. The influential sociologist Erving Goffman explained that stigma spoils or tarnishes stigmatized individuals’ social identities, with the effect of cutting them off from reputable society so that they stand discredited and face an unaccepting world [5]. In a seminal study, he showed how a spoiled identity could rarely be redeemed because it denies stigmatized individuals an opportunity to present themselves to others and to society as they might justly be entitled to appear [6]. Individuals’ means to present themselves as they wish are denied when they have already been identified by a stigmatizing characteristic: for instance, as being unmarried mothers, patients of venereal disease clinics, or abortionists. When the characteristic attributed to them includes engaging in conduct that is punishable as in violation of the law, they may be outcast as criminals [7], and therefore as unacceptable in, and possibly dangerous to, decent society.

Stigma can take different forms. *Perceived* stigma refers to how individuals perceive others to feel about them in light of what the individuals have done or propose to do, such as having or performing abortion. Others’ perceived negative reactions may cause individuals to delay or avoid having or performing the procedure. *Experienced* stigma refers to suffering disadvantage or discrimination because of others’ negative reactions to one’s conduct or disposition, such as denial of health services for having or seeking to have an abortion. *Internalized* stigma refers to a stigmatized individual incorporating others’ negative perceptions, beliefs, or attitudes into the individual’s self-assessment, resulting in reduced self-esteem or feelings of guilt or shame. Forms of stigma may arise from what an individual has done or proposed to do, but also from what the person has innocently suffered, such as the lost social status sometimes experienced by victims of rape. It has been observed that “the risk of stigma and other negative

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implications of rape are major concerns for those seeking to respond to sexual violence" [8].

Rendering individuals stigmatized as outcasts or social pariahs may be deliberate, by for instance presenting women requesting abortions and doctors performing them as "murderers," or employing holocaust descriptions. It may also be incidental to other activities such as asking children of unmarried mothers to provide their mothers' maiden names as a security safeguard in communications. Stigma may be imposed accidentally, or by negligence, such as when a venereal disease or infertility clinic is named as such on its envelopes mailed to patients' home addresses.

Medical conditions and care outside the field of sexual and reproductive healthcare may also attract stigma, particularly in mental illness and healthcare and the associated area of suicide, which in the Roman Catholic tradition may—like abortion—be a mortal sin, perhaps more grave since it cannot be redeemed by repentance. In societies conditioned to view the indulgence of human sexuality through the lens of sin, however, resort to and provision of sexual and reproductive health services are a major source of stigma.

2. Stigmatizing language

The deliberate, incidental, or accidental use of language can have a stigmatizing effect. The effect is magnified through the language of authority figures such as political leaders, judges, and medical professionals. For instance, when the US Supreme Court addressed late-term abortion governed by what politicians had named the Partial-Birth Abortion Ban Act, the majority judgment referred to "abortion doctors" [9] but advocates and public commentators opposed to the procedure spoke of "abortionists," applying the word as a derogatory epithet. The Court's judgment, vigorously contested by the 4 dissenting judges, considered the legislation only as written, without regard to how it may be applied. The Act exempted from its ban only a procedure to save a woman's life, but not to preserve her health. The Court rejected a background claim adopted in the US Congress that the procedure was never necessary to preserve women's health, but upheld the Act as constitutional pending any subsequent case presenting evidence that the Act as applied would impose an undue burden on a particular woman preservation of whose health required the procedure. The hostile environment in which such a case would have to be presented, however, and the repetition of stigmatizing descriptions of medical personnel liable to be involved might deter proceedings to challenge the Act as applied taken through a lower state trial and appeal court to reach the federal Supreme Court. As a US physician noted in 2012, "Though abortion providers now work within the law, they still have much to lose, facing stigma, marginalization within medicine, harassment, and threat of physical harm" [10].

Celebrated, or notorious, judicial stigmatization linking alleged mental deficiency to irresponsible childbirth occurred in the US Supreme Court 8 decades earlier, in its 1927 judgment in *Buck v. Bell* [11]. This concerned the legality of Virginia's state legislation permitting the non-consensual sterilization of an allegedly "feeble-minded" teenaged daughter of a similarly affected mother, who had herself given birth to a child found to have inherited her mother's and grandmother's intellectual impairment. Reflecting the popular negative eugenic disposition of the times, the judge, Justice Holmes, upheld the legislation, observing that "[t]hree generations of imbeciles are enough" [11] (p. 207). Subsequent scholarship has cast considerable doubt on the factual claims of imbecility on which the judgment was based, including that Carrie Buck, who was sterilized under the legislation, was of normal intelligence and became pregnant not because of her sexual irresponsibility but by rape, probably committed by a member of the family that employed her [12].

The stigma of undergoing and of performing abortion is frequently reduced when the pregnancy was caused by rape. Laws that criminalize abortion often have explicit exemptions for victims of rape, and those

that allow abortion only on grounds of danger to life or health are often understood to treat rape as implicitly satisfying the mental health indications. Nevertheless, in some cultures in which young women are valued for their virginity, it is stigmatizing for them and their families should they be victimized by rape. Rape becomes a means of degrading their families.

In the leading case defining the historical crime of abortion in England, and in many countries that inherited English criminal law, the judge informed the jury of the contrast between the distinguished doctor charged with performing the procedure and "the professional abortionist" [13] (p. 618), and between the 14-year-old rape victim in the case, "brought up in an ordinary decent way," and one described as of "the prostitute class" [13] (p. 620). The jury acquitted the doctor, who had explained that the respectable young rape victim was different from a member of the latter class, whose pregnancy he claimed he would not have terminated because her mental health would not have been comparably affected by pregnancy. This reflected the view that a young girl stigmatized by her low social class would not be further stigmatized or psychologically harmed by teenage unmarried motherhood. This stereotype may be contested in terms of the impact of internalized stigma on affected persons' self-esteem, particularly when their deprived circumstances leave them and their dependents no means of sustenance other than through the persons' sex work.

3. Effects of stigmatization

Documentation of the social, psychological, and health-related harms of stigmatization establishes an ethical basis for initiatives to achieve its elimination or reduction but also exposes the challenge of securing legal remedies [14]. The law of defamation addresses what are described as "injurious falsehoods," whether in the written or enduring form of libel, or the spoken or transient form of slander. Defamation causes a person unjustifiably to be brought into hatred, ridicule, or contempt, or to be shunned and avoided or lowered in the estimation of reputable members of society. Stigma results, however, from injurious truths such as that women had or practitioners performed abortions or that a person is HIV positive. Laws protecting privacy, where they exist, tend to be undeveloped. In the healthcare sector, requirements of medical confidentiality may be more clear and enforceable but they are inapplicable outside the scope of professional discipline.

There is evidence that people who perceive themselves demeaned by stigma often undergo a chronic physiological stress response, affecting for instance their cardiovascular health [15]. Regarding resort to healthcare services, people who experience or fear stigmatization in this setting may avoid seeking care from which they would benefit. Stigmatization and disadvantage due to HIV-positive status have deterred those aware that their sexual practices and/or needle sharing in drug injection exposed them to infection from seeking testing, and treatment to which a positive test result might lead, although those exposed to risk of HIV infection from blood transfusion appear not to be comparably deterred [16]. Aggravating avoidance of HIV testing may be minority racial status believed to cause healthcare providers to attribute personal irresponsibility to infected patients [17].

Stigmatization may not only cause individuals to avoid HIV testing, for fear of exposing their homosexual behavior or illicit drug use, but also cause women legally entitled to abortion services to resort instead to unsafe providers who share the interests of the women they treat in concealment. Similarly, providers of lawful abortion services may be deterred from publicly advertising themselves as such, but may prefer to be known by euphemisms that refer, for instance, to women's health. In some countries, however, this has opened the way to deceptive practices of so-called crisis pregnancy centers, whose staff lack gynecologic training and are motivated only to prevent women's access to abortion services, even in cases of health- or life-endangering pregnancy [18]. Stigmatization such as of unmarried pregnancy, abortion, and HIV positivity may drive resort to indicated medical care underground, into the

hands of unqualified caregivers, and so exacerbate risks to the health of affected individuals and to the wellbeing of their dependents.

4. The role of law

Law is often employed for the purpose of deterring behavior considered socially undesirable by invoking the stigma of criminality. Some conduct is criminalized simply on the utilitarian ground of being inconvenient or obstructive of good government, such as tax evasion or illegal immigration. However, in the field of sexual behavior and reproduction, criminal law has often been employed to reinforce moral prohibitions attached to concepts of sin by application of retributive punishment, which is imposed in order to restore tribute of obedience due to divine authority [19]. Criminal law employs retributive stigma by naming offenders according to the offences of which they are convicted. One convicted of murder is “a murderer,” and theft is committed by “a thief,” robbery by “a robber,” burglary by “a burglar,” and abortion by “an abortionist.”

Non-criminal law may also reflect stigma, such as of illegitimate birth or bastardy, but the stigma of being an “illegitimate child” condemns the victim and is misplaced. A child deemed illegitimate may forfeit claims to family status and inheritance, but is more properly considered the child of illegitimate parents: that is, people who should not have become parents together because they were not legally married to each other. Laws may allow the child's legitimation when, following its birth, the mother and father marry each other but many modern family laws have abolished the status of children's illegitimacy, except perhaps for inheritance of titles of nobility, which may remain barred on historical grounds of illegitimacy or gender [20].

Induction of abortion has been stigmatized on moral grounds for many years and there are conservative agencies, particularly inspired by religious convictions, that are committed to keep it so [7]. Many of these agencies have been similarly censorious of birth outside marriage, their hostility being directed not to childbirth itself but to the indulgence of human sexuality outside the confines of legal marriage, and in some traditions within such confines with resort to artificial means of contraception. A rising number of jurisdictions have decriminalized induced abortion on the basis of court decisions or legislation but the criminal prohibition of abortion in Ireland was left in place in 2010 when it was challenged before the European Court of Human Rights, out of deference to the sensitivities of Irish society represented by its elected government [21]. The Court noted that Irish law accommodates nationals obtaining abortions under the laws of other countries, and accepted that the country is not prepared to change the generally prohibitive direction of existing legislation.

Restrictive abortion laws are, nevertheless, open to legal challenge on grounds of human rights [22]. Innumerable instances over centuries show how criminalization and stigmatization of abortion, particularly when continuation of pregnancy endangers women's lives and/or health, have violated women's human rights to life, to protection of health, to dignity, and to freedom from inhuman and degrading treatment. On several occasions, the European Court of Human Rights has condemned the application of restrictive abortion laws on such grounds [23]. Evolving human rights principles show how laws prohibiting or restrictively conditioning medical treatment that only women may require violate human rights provisions against sex discrimination and that mandate equal rights of the sexes to access to health services without discrimination [24]. Laws to overcome such violations help to reduce stigma in abortion and to promote exercise of reproductive choice as a facet of individuals' equal rights to self-determination, dignity, and citizenship.

Homosexual behavior, particularly among males, remains stigmatized under laws that criminalize it in at least 70 countries. In India, for instance, the Supreme Court reinstated in December 2013 legislation of 1860 that the Delhi High Court had ruled unconstitutional in 2009. The Supreme Court explained that any change in the punitive provisions of

the legislation should come from the legislative branch of government rather than from the judicial branch, but commentators consider it unlikely that the government will take a stand on the issue in light of a pending general election [25]. Homosexuality is illegal in Uganda under legislation introduced under colonization but the legislature is proposing harsher punishments under the Anti-Homosexuality Bill 2009, which the country's President has still to sign into law [26]. A survey of workplace stigma reported that “[r]esults from an HIV Stigma Index Report show that 62% of individuals with HIV/AIDS in Uganda have encountered stigma through gossip. 11% of responders were forced to undergo sterilisation and 20% had been physically assaulted” [27].

5. New expressions of stigma

The potential for stigma to attach to health conditions or behaviors newly perceived to be dysfunctional for individuals, and for public health policies to address them is always present. Stigma and preventive policies may be counterproductive, however, when they drive people disadvantaged by their stigmatized conditions or practices underground, rendering their conditions or behavior more difficult to prevent or redress. It has been observed that [28]:

Historical examples abound of stigma interfering with effective collective response to diseases ranging from cholera to syphilis. In all of these cases, the social construction of illness incorporated moral judgments about the circumstances in which it was contracted as well as pre-existing hostility toward the groups perceived to be most affected by it. Such constructions can contribute substantially to the social risk and felt stigma associated with a disease and, consequently, influence the behavior of individuals at risk for contracting it.

An interesting debate concerns whether tobacco use, particularly cigarette smoking, can and should be stigmatized to promote deterrence, as a matter of both individual and public health, and whether there can be “good” stigma [29]. Smokers have been denied some healthcare services, such as IVF treatment [30], raising the question of whether tobacco addiction is regarded as a moral or personal failing or a physiological or psychological condition or disability. Alternative strategies to reduce tobacco use may also employ forms of stigma, including raising taxes on potentially harmful products such as alcohol and tobacco (“sin taxes”) and fines to punish smoking that endangers others, such as children exposed to “second-hand” or passive smoking [31].

A similar debate concerns stigmatization of obesity—for instance, by denial of fertility treatment [32]. An explanation that medically assisted reproduction is a health risk or ineffective, or less effective, for overweight women may appear as a shield for discrimination and raises questions under the UN Convention on the Rights of Persons with Disabilities. Article 23(1) of the Convention provides that “States Parties shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family [and] parenthood...so as to ensure that...b) The rights...to decide freely and responsibly on the number and spacing of their children and to have access to...the means necessary to enable them to exercise these rights are provided” [33].

An emerging area of potential stigma and discrimination concerns genetic status and diagnosis. Couples liable to transmit deleterious genes to their children may be counseled against natural reproduction or be denied medically assisted reproduction. Furthermore, with developments in cell-free fetal DNA testing and the prospect of a safe, reliable, inexpensive test being available early in pregnancy [34], women will have to decide whether to continue pregnancies of fetuses affected by a range of possibly stigmatizing chromosomal or other genetic abnormalities, where termination would be lawful. The concern is not simply that anomalous children at birth might face stigma but that parents who favor the births of fetuses they knew in advance to be affected, for

instance by Down Syndrome, might be stigmatized in their families and communities.

This development might expand the scope of stigma affecting reproductive choice to range from decisions to terminate pregnancies to decisions to continue them. It also projects stigma beyond birth to death into prenatal life and decisions regarding children yet unborn, and unconceived. That is, stigma can attach to the full spectrum of reproductive choice, concerning whether to conceive; selection of reproductive partners or third-party gamete or embryo donors; acceptance or rejection of in vitro embryos for transfer; continuation of pregnancy; and neonatal care of seriously impaired newborn children.

6. Professional responses

Creation of stigma can be accidental, such as by thoughtless, insensitive, or unreflective acts; incidental to another purpose such as presenting a prenatal diagnosis; or deliberate, such as to deter or punish conduct seen as harmful to the actors themselves, others, society, or moral values. However generated, stigma triggers disgust toward those it taints, and sometimes—as self-loathing—in victims themselves. The personal shame, guilt, and humiliation that stigmatized persons may experience and internalize may compromise their health, understood in WHO terms as a state of “physical, mental and social well-being” [35]. For healthcare professionals to induce patients’ ill health, even inadvertently, violates the basic ethic of healthcare: to do no harm. It has been observed that, at both the clinical and the public health level, “[o]nce stereotypes and stigma are established, they can result in individuals being feared, avoided, regarded as deviant, and even blamed for engaging in the immoral behaviors that must have elicited the ‘punishment’ of their affliction... This type of social climate can be devastating to members of vulnerable populations who suffer from stigmatized medical conditions since it can result in the internalization of self-blame and destruction of self-esteem” [36].

Accordingly, as caring practitioners, healthcare professionals ethically should be alert to how their conduct may stigmatize their patients, their colleagues, and members of the wider community. This is a particular responsibility of gynecologists and obstetricians because gender discrimination may cause the women for whom they care to be vulnerable in their families and communities. As the FIGO ethics statement on the role of such specialized providers as advocates for women’s health notes, “[t]his obligation is increased by the unique vulnerability of women because of their reproductive function and role. Social discrimination and abuse based on gendered undervaluing of women may further compromise women’s health” [37].

Beyond the duty of clinicians in their individual capacities to guard against, counteract, and relieve stigma are the responsibilities of their health professional associations and societies to prevent harms done to patients and populations due to promotion or perpetuation of stigma. It may be claimed that “[t]here is surely something indecent about the idea that a ... society, one built upon ideas of human dignity and equality, and respect for the individual” would allow or fail to discipline members’ denigration of patients through the power of stigma and shame [38]. Similarly, providers of controversial services should not be allowed to be stigmatized. Gynecologists who undertake lawful abortions, for instance, should be afforded the same respect as others, not denigrated as “abortionists,” even when providing services in the private sector that public sector facilities decline to undertake [39]. The role of creating stigma as a governmental public health strategy, for instance to reduce cigarette smoking, may remain politically contentious [29] but, regarding patients and providers of reproductive healthcare, the judgment remains that “[s]tigma can without exaggeration be considered a barbarous and unacceptable form of regulation that a humane society must reject” [40].

Conflict of interest

The authors have no conflicts of interest.

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