Title

Stigma and Inequity for Young Women Accessing Sexual and Reproductive Health Services in a sub-Saharan African Context: A Research in Brief

Authors

Jocelyn E. Finlay, Harvard TH Chan School of Public Health

Chantal Inamahoro, Pathfinder International

Abstract

Young women (15 - 24 years) face an inequity in their access and use of sexual and reproductive health (SRH) products and services compared to adult women (above 24 years) within sub-Saharan African countries. In this research, in brief, we contribute to the understanding of the barriers that prevent young women from seeking and using sexual and reproductive health services by drawing on qualitative research involving key informant interviews and youth participatory workshops in Burundi. We demonstrate how stigma is defined and manifests within the context of young women seeking SRH services, and highlights how it creates inequity in access and use of such services by young women. We provide suggestions on how interventions can be developed to address stigma and empower young women in accessing and using SRH services in Burundi or similar cultures.

Abstract: 135 words

Research in brief: 3364 words

Introduction

Within sub-Saharan African countries, young women face an inequity in their access and use of sexual and reproductive health (SRH) products and services compared to their older (aged 25 years or more) counterparts. SRH of young women (15-24 year old) is a neglected, global, challenge [1,2]. In sub-Saharan Africa (SSA), social norms mean that young women continue to be stigmatize for seeking SRH services [3]. This stigma, in part, creates an avoidable inequality – an inequity – in the access and use of SRH services for young women in SSA.

Stigma is a well-used term, but until recently was variously defined. However, core definitions of stigma are rooted in Goffman's [4] definition which states that "stigma as an attribute that discredits an individual, reducing him or her from a whole and usual person to a tainted, discounted one". Goffman [4] asserts that "there is nothing in the attribute in itself that makes it stigmatizing. Stigma is something that is socially assigned."

Jones [5] also defines stigma as Goffman did, but also introduces that stigma is a "perception of deviance". Crocker, Major, and Steele [6] state that "stigmatized individuals possess (or are believed to possess) some attribute, or characteristic, that conveys a social identity that is devalued" but their important distinction in their definition is that stigma is contextual, and occurs "in some particular social context." Dovidio, Hewstone, Glick, & Esses [7] link stigma to stereotyping and prejudice, where prejudice is an "individual-level attitude . . . toward groups and their members that creates hierarchical status relations between groups." That stigma devalues individuals, puts them into stereotyped categories, sets them apart, and causes prejudice, then leads to inequalities in society[8].

Seminal work by Bruce Link consolidated these definitions, and he summarizes stigma to be defined as the co-occurrence of its components – labeling, stereotyping, separation, status loss, and discrimination[9]. Further, status loss and discrimination lead to inequalities[8].

In the context of young women in SSA, the action of seeking SRH services is stigmatized as the need for services signals that the young woman is sexually active out of wedlock, or seeking to delay a (first) birth if married, both of which are labelled as socially deviant behavior for young women.

Take the young woman who is sexually active out of wedlock, she is labelled as a "bad girl" [10]. This labelling then enables the formation of stereotypes, and the categorization of "us" (the good girls) and "them" (bad girls) and a separation of the (dangerous) young women from socially conformist (safe) young women.

The young women who are "labeled, set apart, and linked to undesirable characteristics leads them to experience status loss and discrimination" [9]. As these young women are set apart and discriminated against, they are "disadvantaged" in their "life chances" [9]. Stigma, as defined by Link and Phelan [9] is a barrier for young women seeking SRH services in Burundi, and this stigma propagates inequity in access to SRH services. Note that Link [8] states that status loss and discrimination lead to inequality, however, as this inequality is avoidable (through sensitization) it is more fitting to say that status loss and discrimination lead to inequity in access to SRH services.

An important addition to Link's clarifying definition of stigma is that for stigmatization to occur, power must be exercised [9]. Referring to feminist literature on empowerment, this kind of "power" is likely to refer to one person or group's "power over" another, rather than the "power to" do something [11]. In the case of young women seeking SRH services, parents, health care providers, and peers are often the ones to exert "power over" young women and "enact stigma" [3,10].

Parents enact stigma as they invest in the education of their daughters, and pre-marital sex and pregnancy – implied by visiting a healthcare clinic – is perceived as a loss of investment for parents as pregnant girls are likely to drop out of school [12]. Parents also aspire for their daughters to marry well, and the perceived loss of virtue associated with pre-marital sex – assumed to be such by the signal of visiting a healthcare clinic – reduces the young women's prospects on the marriage market.

In Kelli Hall's seminal work on stigma and adolescent SRH in Ghana [3,10,13,14], she frames stigma in terms of perceived deviation from community norms, "[s]exual activity, and its consequences, including pregnancy, childbearing, abortion, STIs, and contraception and FP service use", were described by Hall and the study participants as acts of "disobedience" and "disrespect". Pre-marital sex was perceived in "direct conflict with established norms for acceptable, appropriate behavior for adolescents or young women". Hall also frames in terms of enacted stigma, that describes the gossip, marginalization and discrimination that young women who are "sexually active, pregnant, parenting, or had used contraception or had an abortion". The enacted stigma that young women faced in Ghana presented as a barrier for young women in seeking contraception, and seeking SRH services and advice. Internalized stigma is the "negative feelings" of "disgrace, shame, embarrassment, and worry about a tarnished reputation" that Hall's study participants described as "shy". Non-disclosure, and keeping sexual activity, and childbearing, STIs, and abortion secret was one coping mechanism Hall found when adolescents in her study discussed navigating SRH stigma.

For us, rather than framing the study of stigma and SRH of young women in terms of enacted stigma and internalized stigma as Hall did, we use Link's framing of stigma [8,9,15], where stigma is the co-occurrence of labelling, stereotyping, separation, status loss, and discrimination [9]. Status loss and discrimination lead to inequalities[8], and we extend this to say that it leads to inequities.

In this research in brief, we draw on qualitative research that was conducted in Burundi and demonstrate that young women seeking SRH in an SSA context are labelled, stereotyped, separated, experience status loss, and discrimination. Power is exercised over these young women. As a result of this stigma, young women face an inequity in their access to SRH services.

Methods

For this research in brief, we draw on data from two qualitative studies we conducted in Burundi. In Burundi, thanks to the support of the Dutch national science foundation NWO/WOTRO, we conducted a mixed methods project exploring the empowerment of young women in Burundi in their SRH and rights. In the qualitative work, conducted key informant interviews with professionals in the field of adolescent SRH in Burundi [16]. We also conducted youth participatory workshops with young women aged 15-24 from urban and rural areas in Burundi [17].

For the key informant interviews, in October 2016 we interviewed 40 professionals in Burundi who work in the field of adolescent SRH program development and implementation. The interviews were semi-

structured and addressed barriers and solutions to adolescent SRH, with a focus on early childbearing, in Burundi. Key informants ranged from individuals within the Burundian Ministry of Health, to representatives from international non-governmental organizations working in Burundi, such as PSI (Population Services International) and ABUBEF (Association Burundaise poir le Bien-Etre Familial), and working within a rural setting in Kayanaza province in the north of Burundi near the Rwandan border. Interviews were conducted in French by the research team within Burundi, the interviews were recorded and transcribed and translated into English for grounded theory analysis in Atlas.ti to draw out key themes that emerged across the interviews in addressing barriers and solutions to adolescent SRH in Burundi.

For the youth participatory workshops, we worked with 120 15-24 year old females from Bujumbura (urban) and Kayanza (rural) in Burundi using a workshop technique called concept mapping [18]. In groups of 10 females, divided by age (15-17, 18-20, 21-24) and region (Bujumbura, Kayanza), the participants came together to discuss problems and solutions regarding vulnerability to early childbearing in Burundi and adolescent's accessing SRH services in Burundi. The participants worked individually, in small groups, and as a group of 10 to brainstorm ideas regarding problems and solutions and build a concept map that incorporated the ranking of items they consider most to least important. At the end of the workshop, they acted out role-plays that the participants scripted themselves, and then discussed how the role-play reflected every-day life in Burundi regarding vulnerability to early childbearing and access to SRH services. The concept maps were photographed at each stage, transcribed, and translated into English. The workshops were also audio recorded, including the role plays, and the audio recording were transcribed and translated into English. Transcripts were analyzed using a grounded theory approach in Atlas.ti to draw out common themes that the young women thought of as barriers and solutions to their SRH and early childbearing.

Quotes from the key informant interviews and youth participatory workshop were extracted to illustrate the definition of stigma. Where stigma was one of the themes that emerged in both the key informant interviews and youth participatory workshop.

The Harvard TH Chan School of Public Health Institutional Review Board, and the Burundi National Ethics Committee, granted ethical approval for these two studies (key informant interviews and youth participatory workshops).

Results

In both the key informant interviews and the youth participatory workshops, the participants discussed the stigma young women experienced when attempting to access SRH services. Young women were labeled, as one key informant said, as "prostitutes" for going to the health care center,

> *"When they go to the health care center, society teases them about this; society or culture does not recognize that young people can benefit from information relating to family planning. They are accused of being prostitutes." (Key Informant (KI) 33)*

In another example, the young women seeking SRH services were labelled as "impolite girls", which is not as extreme as being labeled a prostitute but still a label that is devalued by society.

“They are afraid to go to these centers, knowing that they are going to find adult people there, whether it’s the neighbors, whether it’s the providers who are used to receive adults, and when they see teenage girls they say: no, she is an impolite girl who is not well raised.” (KI 22)

The stereotype was that clinics were for married couples wanting to space their births, and that young women were not in need of SRH as they should not be sexually active according to social norms. As one key informant describes,

“Burundian culture takes sexual intercourse as a taboo issue. A girl who will go to ask for family planning services is pointed fingers by people around her. Second, family planning sensitization still target couples only, and they forget that girls are exposed to sex.” (KI 30)

Even the term “family planning” reinforces this stereotype of healthcare clinics, and SRH services and products, are for “families”, and not for young unmarried women, as one key informant explained,

“You know national policy talks about family planning. Already when we talk about family planning, it implies “family”, which implies legal couple. Imagine a 16-year-old girl who will ask for “family planning” methods!” (KI35)

The young women in the concept mapping workshops also discussed this same point, that family planning and healthcare clinics are not for them, and were reserved for married couples. As two key informants describes,

“Young women who aren’t married, they don’t go to the family planning clinics. There is the idea that it is only reserved to married persons. This is one of the main reasons they don’t go.” (CM B_2124_6)

“Many [young] people are afraid to go to the family planning clinic because they are still too young; they think if they go there they will no longer have children; that it is reserved for people who already have children.” (CM B_1820_4)

The threat of marginalization of young women who attend the SRH clinics, separating her from the “us” of good girls into the “them” of bad girls, prevents young women from even attempting to access SRH services. As one key informant from Kayanza said,

“A girl thinks, if I go there, people will laugh at me, and begin to gossip about me.” (Kayanza, 18-20 year olds, group 10, K_1820_10)

But the young women face competing demands on their image, with peers pressuring them for pre-marital sex, as another youth participant explains,

“Friends in your group influence you, they ask you how at your age you haven’t had sex yet, and you are ashamed; and in that way you start having sex with your boyfriend. Young women like us are vulnerable [to early childbearing].” (Concept mapping, Bujumbura, 15-17 year olds, group 1, CM B_1517_1)

Yet young women cannot seek support for their SRH, as she foresees she will face a loss of status and discrimination, which she will internalize as shame. As a 15-17 year old youth participant from Bujumbura describes,

“It can happen that a girl feels like adhering to a family planning program but because she is not married, it becomes difficult. She is ashamed, and she abandons the idea.” (B_1517_2)

An 18-20 year old female youth participation from Bujumbura in another session reiterated the power of the threat of status loss,

“Why doesn’t she visit the clinic? She feels shame. This is a reason people don’t go to the clinics. She thinks if so-and-so sees me at this place he will tell the neighbors.” (B_1820_3)

The act of seeking SRH services is stigmatized by her community acts as a warning of how young women will be treated — labeled “impolite” at best, or even a “prostitute”. She will be known as the young woman who does not fit the stereotype of who is invited to the clinic (married couples). She will be marginalized and laughed at. This negative labeling, stereotyping, and separation, would then lead to status loss and discrimination. The threat of this devaluing, and the shame that would be internalized, is sufficient to prevent young women from seeking SRH. The young women are not turning up to the clinics, and stigma propagates an inequity in access and use of SRH products and services in Burundi.

Parents are among the ones to enact this stigma, and exert their power over their daughters for fear of their status loss, for their daughters and for themselves by association. As one key informant recalls a dramatic interaction one day at the healthcare clinic,

“I worked in a clinic, a girl came to ask for these services, and there, there was her mother who was there. When she noticed the presence of her mother, she ran away and her mother ran behind shouting: Come back, come back my daughter! It was a disaster. Everyone was shaken.” (KI 9)

The way that the participants in both the key informant interviews and the youth participatory concept mapping discussed the stigma of accessing SRH services in Burundi, fitted with Link’s definition of the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination. Furthermore, a demonstration of the power that parents exert over their daughters to enact this stigma was also highlighted.

Note that for this research in brief, we drew out one theme that emerged across the two qualitative studies. Other themes were also discussed by the participant, but we isolated this one theme of stigma to highlight that the threat of stigma alone is sufficient to prevent young women in Burundi from seeking SRH services.

Discussion

The inequity that young women face in accessing contraception due to age-based discrimination, gender and marital status remains the major barrier for young women seeking SRH services. In Burundi, we found that young women who seek SRH services were stigmatized, and the threat of stigmatization is sufficient to prevent young women from seeking SRH services.

Following Link’s definitions of stigma as the co-occurrence of its components – labeling, stereotyping, separation, status loss, and discrimination [9], we showed in this paper that the participants discussed stigma within this frame. Young women seeking SRH services are *labelled* prostitutes or “impolite girls”. Visiting the family planning clinic has a negative *stereotype* as it implies that the services are needed only for those who are sexually active, and sex before marriage is a social taboo. This stereotyping

enforces an “us” and “them” labelling, “pointing fingers” as one key informant said. Unmarried girls are expected to abstain from sex, and visiting the family planning clinic is visible evidence of a transgression of social norms [12] and engagement in what is viewed as “socially deviant behavior” [19].

Stigma is enacted in multiple forms ranging from verbal harassment and social exclusion and isolation, to physical punishment [20]. Recalling that one young woman said, “people will laugh at me, and begin to gossip about me.”

Stigma exists, as it has a fundamental purpose to enforce social order [21,22]. However, stigma leads to inequity. Stigma feeds on, strengthens, and reproduced existing inequities of class, race, gender, [21] age and marital status. Those who are then labeled as “them” – those young unmarried women seeking SRH services because they are sexually active – experience status loss and discrimination that lead to unequal outcomes. That is, young unmarried women experience an inequity in access and use of SRH services – as these services are “reserved for married persons”.

For stigmatization to occur, power must be exercised [15]. In our example, social power of older women and men over the young women (consider the mother chasing after her daughter when they met at the family planning clinic), allows the identification of differences and the full exertion of disapproval, rejection, exclusion and discrimination [15].

Stigma devalues relationships rather than being a fixed attribute [19,21], suggesting that stigmatization can be undone, just as much as it were done in the first place. In the early days of the HIV epidemic, when stigma was already recognized as a major barrier for diagnosis and treatment seeking, interventions were aimed at increasing tolerance for people with HIV [21]. In another example, interventions to overcome mental-health-related stigma have focused on knowledge, attitudes, and intended behavior in terms of desire for contact [23].

For young women seeking SRH services, and using contraception, intervention to overcome stigma could be approached at the individual, community, and national level. For example, one would be to reduces the risk factors that increase the likelihood of being stigmatized, however, tautologically, age and receipt of SRH services are major risk factors for stigmatization [3]. Secondly, interventions could be aimed at building stigma resilience so that the stigmatized group (young unmarried women seeking SRH services) can become empowered in their act of seeking SRH services [24] or preserve anonymity [20]. Thirdly, parent and community attitudes can be reversed from stigma to dignity, so that young women can take pride in seeking SRH services. Fourth, laws and policies can be changed that enable young women to seek SRH services without parental or partner consent and bypassing those who would enact stigma.

In this research in brief, we highlighted that the stigma of young women seeking SRH services lead to an inequity for young women in their access to SRH services. Legalizing, dignifying, and empowering young women to seek SRH services will enable young women to overcome this stigma.

References

1. Morris JL, Rushwan H. Adolescent sexual and reproductive health: The global challenges. *International Journal of Gynecology & Obstetrics.* 2015;131:S40-S42.
2. Patton G, Temmerman M. Evidence and Evidence Gaps in Adolescent Health. *Journal of Adolescent Health.* 2016;59(4, Supplement):S1-S3.
3. Hall KS, Morhe E, Manu A, et al. Factors associated with sexual and reproductive health stigma among adolescent girls in Ghana. *Plos One.* 2018;13(4).
4. Goffman E. *Stigma :notes on the management of spoiled identity.* New York1974.
5. Jones EE. *Social stigma : the psychology of marked relationships.* New York1984.
6. Crocker J, Major B, Steele C. Social Stigma. In: Gilbert DT, Fiske ST, Lindzey G, eds. *The handbook of social psychology*. 4th ed. ed. Boston : New York1998.
7. Dovidio JF, Hewstone M, Glick P, Esses VM. Prejudice, stereotyping and discrimination: Theoretical and empirical overview. In: J. F. Dovidio, M. Hewstone, P. Glick, Esses VM, eds. *The Sage handbook of prejudice, stereotyping and discrimination* London, UK: Sage; 2010.
8. Link BG, Phelan JC, Hatzenbuehler ML. Stigma as a Fundamental Cause of Health Inequality. In: Major B, Dovidio JF, Link BG, eds. *The Oxford Handbook of Stigma, Discrimination, and Health*2018.
9. Link BG, Phelan JC. Conceptualizing Stigma. *Annual Review of Sociology.* 2001;27(1):363-385.
10. Hall K, Manu A, Morhe E, et al. Understanding "Bad Girl:" qualitative findings on stigma and adolescent sexual and reproductive health in Ghana. *Contraception.* 2015;92(4):393-394.
11. Rowlands J. Empowerment examined. *Development in Practice.* 1995;5(2):101-107.
12. HP+ Policy Brief. *Held back by fear: How stigma and discrimination keep adolescents from accessing sexual and reproductive health information and services.* 2016.
13. 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. *Journal of sex research.* 2018;55(1):60-72.
14. Hall K, Manu A, Morhe E, et al. Development of a scale to measure adolescent sexual and reproductive health stigma. *Contraception.* 2016;94(4):424.
15. Link BG, Phelan JC. Stigma and its public health implications. *The Lancet.* 2006;367(9509):528-529.
16. Ndoricimpa A, Finlay JE, Inamahoro C, Ngenzebuke RL, Ndikubengenzi J, Niyongabo G. Vulnerability to Poor Adolescent Sexual and Reproductive Health Outcomes: Key informant perspectives of barriers and solutions to the prevention of early childbearing in Burundi *under review at Journal of Adolescent Health.* 2018.
17. Finlay JE, Ndoricimpa A, Inamahoro C, Ndikubengenzi J, Niyongabo G. Inclusive adolescent sexual and reproductive health program creation: Youth participatory workshops in Burundi. Population Association America; 2018; Dever, CO.
18. Bayer AM, Cabrera LZ, Gilman RH, Hindin MJ, Tsui AO. Adolescents Can Know Best: Using concept mapping to identify factors and pathways driving adolescent sexuality in Lima, Peru. *Social science & medicine (1982).* 2010;70(12):2085-2095.
19. Goffman E. *Stigma: Notes on the management of spoiled identity.* Englewood Cliffs, N.J.1963.
20. Nyblade L, Stockton M, Nyato D, Wamoyi J. Perceived, anticipated and experienced stigma: exploring manifestations and implications for young people's sexual and reproductive health and access to care in North-Western Tanzania. *Culture, Health & Sexuality.* 2017;19(10):1092-1107.
21. 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.

22. Foucault M. *Discipline and punish : the birth of the prison.* New York1979.
23. Gronholm PC, Henderson C, Deb T, Thornicroft G. Interventions to reduce discrimination and stigma: the state of the art. *Social Psychiatry and Psychiatric Epidemiology.* 2017;52(3):249-258.
24. Shih M. Positive Stigma: Examining Resilience and Empowerment in Overcoming Stigma. *The ANNALS of the American Academy of Political and Social Science.* 2004;591(1):175-185.