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Commentary

The role of sexually transmitted infections (STI) prevention and control programs in reducing gender, sexual and STI-related stigma

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Stigma refers to socially undesirable attributes of individuals or groups, associated with isolation, rejection, and discrimination. Stigma is an essential contributor in the causal web of sexually transmitted infections (STIs) that flourish within the global context of inequities associated with STIs: social class, race/ethnicity, immigration status, gender, gender expression, and sexual orientation [1]. Public health capacity to address the diverse pathogens associated with STIs – including HIV – has been astoundingly transformed by the basic, clinical, and translational sciences advances of the past half-century. Paradoxically, despite great strides in capacity to understand, detect, and treat, STIs remain key indicators of global health inequity that have worsened in recent years [2].

Our great knowledge of STIs fails its worldwide potential largely because of deeply engrained sexual, and STI-related stigma [3]. Stigma is often amplified by public health policies and clinical procedures that reproduce cultural, social, and structural production of stigma, separating people into sexual and behavioral categories (enforced by social power, often through threat of violence) associated with disapproval, rejection, and exclusion that reflect the global epidemiology of STIs [4]. Stigma causes many people to avoid seeking STI-related services because of experiences such as discrimination, indifference, and overt hostility in health care setting. World-wide barriers to a full range of reproductive health services (for example, restricted access to STI testing for new immigrants), criminalization of sexual behaviors associated with STI transmission (for example, commercial sex work or same-sex sexual relationships), and restriction of access to evidence-based information and services (for example, abstinence-only-until-marriage sexuality education for young people) illustrate ways stigma is created and maintained in health care settings. Global STI prevention and control efforts require – in addition to effective public health infrastructures and the technologies needed for diagnosis and treatment – renewed commitment to systematic programmatic approaches to prevent or reduce STI-related stigma [4].

This programmatic and facilities-based approach to stigma mitigation directly addresses stigma by an emphasis on routine implementation of four key practices: person-center approaches; sex positivity; trauma-informed care; and, community-engagement. Here, "person-centered" refers to systematic practices that emphasize communication, individuality, autonomy, and dignity of people receiving STI services, with respectful and non-coercive services led by staff training in cultural competence, safety, and humility. A person-centered approach addresses commonplace experiences of feeling judged negatively or even harshly by providers during the course of STI-related care. Person-centered STI services are part of the World Health Organization (WHO) strategy for STI, [5] as well as other national health organizations [6,7].

Sex positivity refers to clinical policies and approaches that acknowledging sexual diversity as a healthy norm, recognizing sexuality as an asset that contributes to individual and relational wellbeing. This means, for example, shifting away from judgmental professional language (for example, commonly used assessments such as "risky" or "unsafe" sex) to refocus on the importance of each person's sexuality for health and wellbeing [8]. Sex positive approaches supports engagement in sexual decision-making that is autonomous and safer from an STI-prevention perspective.

Trauma-informed STI-related services respond to the complex consequences of systemic and interpersonal violence and

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discrimination suffered by people in the greatest need of STIs-related services. Registration, sexual history taking, genital examinations, sample collection, prevention and treatment discussion are all points where trauma triggering can occur [9]. This requires proactive policies and training to understand the role of trauma in STI, and respond by implementing trauma informed practices as routine. Careful review of procedures, training of all staff, integration of screening items into interviews, and linkage to appropriate services are all critical to trauma-informed STI-related care [10].

Community-engaged refers to meaningful involvement of people most affected by STI, and also is part of the WHO strategy for STI control [5]. Community-engaged STI programs allows for effective voice for marginalized people, providing a means for exercise of sexual and reproductive rights. Inclusion of community perspectives responds to the sources of structural and institutionalized stigma that are often directly associated with STI control and prevention. Community engagement also allows for the redress of sources of institutional mistrust (e.g., past discrimination, loss of confidentiality, arrest) than many hold for STI prevention and control programs, and for tailoring programs to reflect each community's needs.

Stigma has many sources outside of the direct influence of STI prevention and control programs, but this call to action is consistent with WHO and (as well as other national STI control organizations) guidance for equitable access to sexual health and STI-related services [5,6]. We now have extensive understanding of the origins of stigma within existing STI prevention and control infrastructures, and we have evidence-based approaches for reducing and preventing stigma experiences in STI-related clinical encounters. Systematic implementation of these evidence-based approaches to stigma is an intervention tool for world-wide STI as essential as ongoing prioritized issues such as antimicrobial resistance, additional highly effective STI vaccines, and prevention of STI-related reproductive health outcomes. Now is the time to systematically implement tools to confront and ameliorate STI-related stigma.

Contributors

DF wrote the first draft, all authors (PG, AM, SG, ME, DF) contributed reviewing and editing the text.

Declaration of Competing Interest

PG, AEM, SG,ME, DF declare no conflicts of interests. SG reports grants and personal fees from Merck, outside the submitted work.

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