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A Systematic Review on the Moral and Faith-Based Values Surrounding Reproductive Health Stigma in the United States

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A Systematic Review on the Moral and Faith-Based Values Surrounding Reproductive Health Stigma in the United States

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2018

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An abstract of
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Abstract

A Systematic Review on the Moral and Faith-Based Values Surrounding Reproductive Health Stigma in the United States

By Busola Akingbade

Introduction: Religious and moral values can produce social expectations and attitudes towards reproductive health. As a result, individuals who seek reproductive health methods are perceived as defying social norms and are stigmatized due to their health choices. Outcomes of reproductive health stigma are increased morbidity and mortality, as well as discrimination and social isolation. Therefore, there is a need to examine and synthesize the aspects of morality and religion influencing reproductive health stigma.

Methodology: Electronic searches to identify moral and religious determinants of reproductive health stigma were conducted using the three online databases: PubMed, Scopus, and ATLA. All databases were searched from their inception date until December 31, 2019. The initial articles from the search underwent a title and abstract screening. A full-text review was then conducted on the remaining articles, and 18 articles were selected for the review based on inclusion and exclusion criteria. Data extracted from the selected reviews include study aims, data collection methods, sample population, and study limitations.

Results: Religious doctrines (n=11) as a well as cultural norms and moral values (n=8) were identified as religious and moral determinants of reproductive health stigma. Abortion stigma was the most prevalent type of reproductive health stigma discussed in the reviewed studies (n=10). Religiosity was a contributing factor in stigma, as individuals who follow their religious doctrines were more likely to have stigmatizing attitudes towards reproductive health. When it comes to morality, many studies found that women perceived motherhood as a moral obligation and this expectation leads to stigmatized attitudes towards family-planning methods, such as contraceptives and abortion, within one's community. Additionally, one article discussed how women use the flexibility of their religious doctrines to combat abortion-related stigma.

Conclusion: The results suggest that religious beliefs influence perceptions of morality and can contribute to reproductive health stigma. Although many studies found that religious values contribute to reproductive stigma, individuals can use their religious values to also manage stigma related to reproductive health. The findings from this review can aid in stigma reduction interventions, thus increasing access to more stigmatized family-planning methods.

Keywords: *religion, morality, reproductive health, abortion, pregnancy, contraceptives, stigma*

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CHAPTER ONE – INTRODUCTION

Introduction and Rationale

Stigma is a social process enforced by societal expectations and contributes and discriminatory attitudes and practices towards those most marginalized in society (Millar, 2020). According to Link and Phelan (2001), stigma exists when stereotyping, separation, status loss, and discrimination occur together in a situation where power allows them to occur. More specifically, stigma occurs when there is an unequal power dynamic, thus leading to status loss and discrimination. An individual can experience stigmatization for social differences, such as race/ethnicity, sexual orientation, or health status. Similar to other social determinants, such as socioeconomic status (SES) and public policies, stigma can significantly affect health outcomes (Hatzenbuehler, Phelan, & Link, 2013). Implications of health-related stigma are an increase in morbidity and mortality; however, according to Hatzenbuehler et al. (2013), there has been much public health research on several stigmatized health conditions and health experiences such as HIV stigma, mental health stigma, and reproductive health stigma. As there has been much debate around reproductive health and policies, particularly around the access and legality of abortion, it is critical to identify the factors contributing to attitudes regarding reproductive health.

Within the past 30 years, the U.S. has seen notable improvements in the access to reproductive health services. For example, the U.S. has seen higher early detection of cervical cancer in young women ages 21 to 25 due to the implementation of a provision in the Affordable Care Act (ACA) that offers health insurance coverage to dependent children until they are 26 (Robbins et al., 2015). There was also a significant decrease in the out-of-pocket costs for reversible contraceptives under the ACA contraceptive mandate (Snyder, Weisman, Liu, Leslie,

& Chuang, 2018). Furthermore, many states have expanded their insurance requirements, with 25 states expanding Medicaid eligibility specifically for family planning services (Keller & Sonfield, 2019).

Perhaps in part due to these insurance coverage expansions, the U.S. has seen a 20% decrease in the number of abortions from 2011 to 2017 (R. K. Jones, Witwer, & Jerman, 2019). Also, as of 2017, approximately 65% of women aged 15-49 are using some form of contraceptive (Daniels & Abma, 2018). This is an increase from 1982, where 56% of women in this age range used some form of contraceptive (Daniels, Mosher, & Jones, 2013). Yet, since 2016, there have been attempts by Congress at repealing and reforming provisions under the ACA (Brindis & Freund, 2018). It is also important to note that although women may have more access to reproductive health services due to policies and affordability, many women may not access these services to avoid social isolation and judgment for their health care decisions. It may also be due to healthcare providers choosing not to provide services that are more stigmatized. This is especially observed among women who seek abortions, as abortion stigma occurs in multiple levels of society (Cockrill, Herold, et al., 2013).

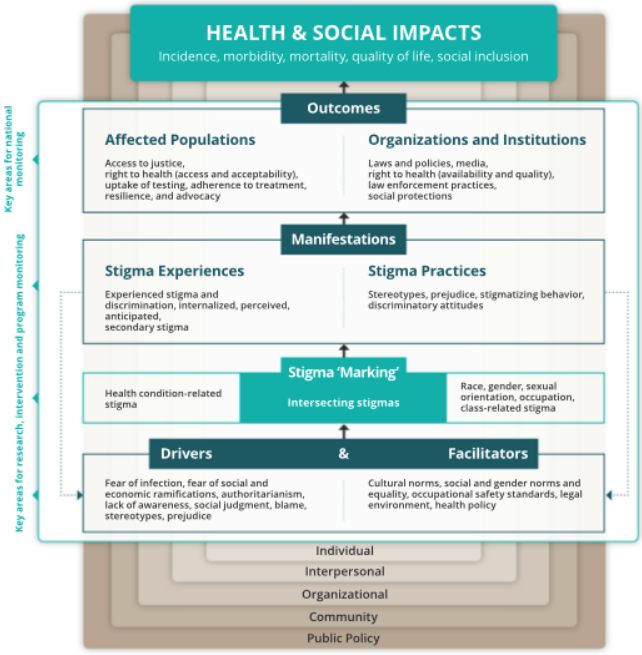
Theoretical Framework

This thesis is guided by the Health Stigma and Discrimination Framework (See Figure 1), developed by Stangl et al. (2019). According to the framework, stigma is better understood as a process that begins with drivers and facilitators, with drivers leading to stereotypes, judgment, and discriminatory attitudes, that result in negative health and social outcomes. For example, the drivers and facilitators of abortion stigma include cultural norms and beliefs about abortion, which then lead to the manifestation of social judgment and discrimination around abortion in the form of enacted stigma (Cockrill, Herold, et al., 2013). Examples of enacted stigma are

verbal threats from protestors outside an abortion clinic or judgment from healthcare providers due to an individual's reproductive health decisions. On a social-structural level, such enacted stigma could support laws that criminalize or hinder access to obtaining an abortion. Consequently, this outcome can lead to inadequate access to reproductive health care and social isolation (Cockrill, Herold, et al., 2013).

The framework champions interventions at the driver and facilitator level in order to interrupt the process prior to the point when stigma occurs. To do this, we must examine and shift social and cultural norms. The social and cultural norms explored in this thesis are religious and moral values; therefore, per the framework, this review will be examining one type of cultural norm—religious and moral values—and their role in reproductive health stigma.

Figure 1. Health Stigma and Discrimination Framework



Note. Health Stigma and Discrimination Framework by Stangl et al., (2019). Retrieved from https://bmcmedicine.biomedcentral.com/track/pdf/10.1186/s12916-019-1271-3

Problem statement

Stigma can act as a barrier to seeking and accessing health care services. Investigating the root causes of health-related stigma can mitigate the effects of stigma on health felt by individuals and communities who experience prejudice, discrimination, or judgment due to their health conditions. Unfortunately, there has not been much research on the intersection of religious and moral values and reproductive stigma. To address this gap in knowledge, we need a better understanding of how beliefs and values influence the stigmatization of others. There is also a need to understand what specific aspects of these beliefs and values lead to reproductive health stigma.

Purpose statement

The purpose of this literature review is to identify moral and religious determinants of reproductive health stigma and to explore the effects this stigma has on reproductive health status, history, and services. This paper will review studies examining the relationship between stigma as it relates to reproductive health and faith-based or moral values.

Research Question

In this research, I seek to answer:

1. What are the moral, faith-based, or religious determinants influencing stigma surrounding reproductive health status, services, and experiences in the United States?
2. How do moral, faith-based, or religious determinants affect stigma surrounding reproductive health status, services, and experiences in the United States?

Significance Statement

Without changing the stigma around reproductive health, those who seek services, such as family planning methods, may be less likely to consider these options due to the fear of social repercussions and can prevent individuals from accessing necessary medication, testing for health conditions, and seeking support from those in their community (Mohammadi, Kohan, Mostafavi, & Gholami, 2016). The additional stress of guilt, judgment, or discrimination, along with the lack of social support, can lead to an increased risk of experiencing depressive and anxiety symptoms (Steinberg, Tschann, Furgerson, & Harper, 2016). Therefore, a better understanding of the moral factors driving reproductive health stigma can contribute to future SRH research in the U.S. by addressing the barriers preventing individuals from accessing reproductive health services. This research can also help prevent negative health outcomes by informing interventions that seek to mitigate the effects of stigma.

Definition of Terms

***Faith-based values*:** values based on religious beliefs, traditions, and norms

***Morality*:** a set of personal standards set by societal norms and expectations used to decide right and wrong behavior

***Religiosity*:** the degree to which one is devoted to their religious beliefs

***Reproductive health*:** contraceptive use, pregnancy, abortion, sexually transmitted infections (STIs), and other family planning related methods, services, and experiences

***Stigma*:** the social devaluing of an identity, condition, or behavior, which results in associated feelings of shame or guilt, resulting in stereotyping, separation, loss of status, prejudice, and/or discrimination

CHAPTER 2 – REVIEW OF THE LITERATURE

Introduction

According to the literature, understanding the moral values of society is crucial in combatting stigma (Kleinman & Hall-Clifford, 2009). Kleinman and Hall-Clifford (2009) state, **"**The moral standing of an individual or group is determined by their local social world, and maintaining moral status is dependent on meeting social obligations and norms," and note that society perceives stigmatized individuals as being unable to fulfill these obligations and norms because of their moral status. Much research has been conducted on Religious values and practices, such as prayer, being an impactful tool in stigma-reduction interventions (Reyes-Estrada, Varas-Díaz, & Martínez-Sarson, 2015). Findings indicate that individuals use their religious beliefs as coping strategies and aid in their psychological well-being. The following studies discuss the implications of stigma for reproductive health, connections between religion and morality, and the potential role of religious and moral values in reproductive health stigma. The review and contextualization of this literature will provide a rationale for the need to understand and engage with the systemic influence that faith-based and moral values have on reproductive health stigma.

Reproductive Health Stigma

Hatzenbuehler et al. (2013) define stigma as the social devaluing of an identity, condition, or behavior, which may result in associated feelings of shame and guilt, and in stereotyping, separation, loss of status, prejudice, and discrimination. Many who face stigmatization experience stress, fear, and isolation due to possible discrimination and judgment from family and peers (Hatzenbuehler et al., 2013). Sociologist Erving Goffman was one of the

first people to study the effects of stigma and developed the theory of social stigma. In his 1963 book, "Stigma: Notes on the Management of Spoiled Identities," Goffman discussed the many consequences of stigma as well as how stigmatized individuals try to conform to the norms of society. Since then, much research has been conducted on the role that stigma plays in society and the effects it has on most stigmatized identities (Hatzenbuehler et al., 2013).

When examining stigma through a public health perspective, we see that stigma can prevent people from obtaining health services such as contraceptives (Håkansson, Oguttu, Gemzell-Danielsson, & Makenzius, 2018). Håkansson et al. used a mixed-methods approach to investigate stigmatizing attitudes related to adolescent pregnancy, abortion and contraceptive use among healthcare providers in Kisumu, Kenya. In this study, Håkansson et al. (2018) found that the key barrier for young women accessing contraceptives is perceived stigma with some young women being viewed as “promiscuous” for seeking contraceptives and the perception that only married women should have access to contraceptives. Similarly, another study conducted in Baltimore City, Maryland explored the health impacts that STI-related stigma has on individuals. In this study, researchers identified STI-related stigma as a barrier to STI screening in young adults (Cunningham, Kerrigan, Jennings, & Ellen, 2009). Mitigating stigmatized attitudes around contraceptive use, STIs and related sexual and reproductive health experiences and conditions may increase access to health care needs critical to long term health and well-being (Håkansson et al., 2018).

The repercussions of abortion stigma include tendencies for women to seek more discreet abortion services even if the medical facility was less reputable (Håkansson et al., 2018). Moreover, another study by Mohammadi et al. (2016) used a qualitative approach to explore the stigma regarding reproductive health service among unmarried women in Isfahan, Iran.

According to the findings, unmarried women were not expected to have gynecological diseases as it is believed that infections and gynecological diseases occur after marriage and are caused only by sexual intercourse. Because of these stigmatizing attitudes, unmarried women feared discrimination and felt ashamed of receiving reproductive health services (Mohammadi et al., 2016).

Morality and Religion

With more than half of Americans believing that it is impossible to have morals without believing in God, some would argue that religion and morality go hand-in-hand (Kohut, 2007). Morality is the ability to know right from wrong. Similarly, those who are religious use their faith to decipher what is moral and immoral. Though what is moral and immoral differ by culture, many still derive their morality and decipher what is moral or immoral from their religion (McKay & Whitehouse, 2015). For example, many individuals' views on the morality of abortion derive from their religious beliefs and interpretation of religious texts (Hess & Rueb, 2005).

In recent years, research on religious involvement in behavioral and social sciences has increased (Chatters, 2000). This increase in research has shown social influences of religion on various disciplines, including sexual and reproductive health. A literature review of research into religion and sexual health reveals a burgeoning interest in religion's influences, although no consensus has emerged as to what those influences are (Gaydos, Smith, Hogue, & Blevins, 2010). Qualitative research demonstrates that religion's influences are varied and complex. For example, a case study of a support program for men who have sex with men in Mtwapa, Kenya shows that religion is both a driver of bias and stigma against LGBT people in general as well as a source of support and social cohesion for the participants in the program (Blevins & Irungu,

2015). Religion is important topic for reproductive health research because individuals often employ religion to inform their understanding of reproductive health and their reproductive health decisions.

Moral and Religious Attitudes and Their Influence on Reproductive Health Rights, Policies, and Experiences

The literature suggests many positive impacts of religious and moral values on reproductive health. For example, a study conducted in Nigeria assessed the impact of religious leaders' involvement in exposing individuals to family-planning methods. The findings showed significantly higher uptake of contraceptive among women who were exposed to family-planning messages via religious leaders (OR, 1.70; 95% CI: 1.54-1.87; $p<.001$) (Adedini et al., 2018). Furthermore, in a study examining barriers of family-planning uptake in Tanzanian women, researchers found that although some women believe their religion disapproved of family-planning methods, some women believe their religion encouraged it (Sundararajan et al., 2019). Women in this study stated that their religious texts say to live within one's means. By using family-planning methods, these women felt that they could take care of their children and live within their economic capacity.

As the previous studies have shown, the morality of reproductive health experiences and family planning methods, such as contraception and abortion, has been a complex topic as the history and interpretation of religious doctrines on reproductive health can differ by and within denomination (R. P. Jones, Jackson, Bola, & Greenberg, 2019). According to the UNFPA (2015), in the early history of many cultures, a woman's purpose was childbearing. This belief was supported by religious texts, hence the reason for laws and patriarchal traditions that reinforced these beliefs and values (UNFPA, 2015). These traditional beliefs can be found in

many religious doctrines. An influential teaching from Roman Catholic mortal theology in the area of human sexuality is that the primary purpose of marriage is procreation; therefore, contraceptives violate this belief as many Catholics believe contraceptives destroy the potential to produce new life (Schenker, 2000). In 1995, Pope John Paul II referred to abortions as the "rise of a culture of death" in his letter to Catholics (Schenker, 2000). Although these beliefs may be salient in some religions, certain religious affiliations have become more liberal with their views on reproductive health. For example, the Episcopal Church issued a report in 1979 declaring the purpose of human sexuality as not only for procreation but also for pleasure and more abundant quality of life (Schenker, 2000). This position reflects the official doctrinal statements of many Christian Protestant traditions.

The beliefs previously mentioned are important to note as these beliefs can have an influence on U.S. policies and laws. The realignment of evangelical Protestants in the Republican party and their traditionalist stance on social issues have led to ongoing conflicts and opposition to reproductive health rights in the U.S. (Guth, Kellstedt, Smidt, & Jelen, 2010). For example, the opposition to legalizing abortion is widely popular amongst Protestants and smaller Christian groups and has become more popular since the Supreme Court case that legalized abortion across the U.S. known as *Roe v. Wade* (R. P. Jones et al., 2019). When it comes to party affiliation, Democrats are twice as likely as Republicans to favor the legality of abortion (R. P. Jones et al., 2019). It is notable, however, only 22% of individuals who affiliate with the Republican party say abortion should be illegal in all cases (R. P. Jones et al., 2019).

All aspects of reproductive health are subject to stigmatization; however, abortion stigma seems to be the most prevalent in reproductive health stigma research. Interestingly, Norris et al. (2011) described abortion stigma as a "concealable" stigma as there is much secrecy not only by

women who seek abortions but also by healthcare providers who perform them. Norris et al. (2011) continue by saying that abortion stigma may stem from the idea that it violates feminine ideals of womanhood, since womanhood is often defined as motherhood and sexual purity. Additionally, religious beliefs contribute to the idea that all human life is sacred and life should remain undisturbed according to God's rules; therefore, individuals who are religious view abortion as devaluing human life (Hess & Rueb, 2005). Another study found that an individual's society, community, significant others, and medical institutions can be a source of abortion-related stigma (Hanschmidt, Linde, Hilbert, Riedel- Heller, & Kersting, 2016). This study also linked the perception of abortion stigma to many factors, one being exposure to antiabortion beliefs and attitudes.

Religiously influenced antiabortion attitudes could have consequences for health and well-being. For example, a study investigating the impact of religion and politics on women's reproductive health outcomes found health disparities in access between different states within the U.S (Kimball & Wissner, 2015). This study used secondary datasets between 2007 and 2008 and included data from each U.S. state. Results from the research showed that states with a higher religiosity score were associated with higher infant mortality rates (Kimball & Wissner, 2015). Specifically, 50% of evangelical churches are in the South, where the infant mortality rates are high. Kimball and Wissner (2015) suggest the potential reasons for this disparity in health outcomes is due to the lack of available abortion services as well as cost, local laws, and harassment due to stigma.

Gaps in the Literature and Future Health Implications

All in all, multiple studies found that many women face various potential consequences of reproductive health stigma, such as higher infant mortality rates and restricted access to

reproductive health care. Researchers suggest that morality and faith-based values play a role in reproductive health stigma; however, the most significant limitation of the existing literature is that it has not synthesized the aspects of religious and moral values influencing reproductive stigma. Therefore, to bridge this gap in knowledge, this systematic review seeks to understand the question: what are the moral and religious factors that drive stereotypical, prejudicial, and discriminatory reproductive health attitudes? The review will contribute to current research on the intersection of moral/religious values and reproductive health stigma.

CHAPTER 3 - METHODS

Search Strategy

Electronic searches were conducted using the MEDLINE database (PubMed), an online database consisting of a vast amount of peer-reviewed research literature (Scopus), and a religion and theology focused database (ATLA). All databases were searched from their inception date until December 31, 2019. The search for the review was conducted in February of 2020.

Key search terms included “religion”, “morality”, “faith”, “abortion”, “pregnancy”, “contraceptives”, and “stigma”. Table 1 displays the full list of search terms used by database.

Table 1. Search Terms by Database

Search Terms	Database
(U.S.[tiab] OR united states[tiab] OR USA[tiab] OR american[tiab] OR united states[mesh]) AND ("Religion and Medicine"[Mesh] OR "Religion"[Mesh] OR religious OR religion OR spirituality OR faith OR faith-based OR "faith based" OR "Morals"[Mesh] OR morals OR morality OR christian OR Christianity OR Catholic* OR Evangelis*) AND ("Reproductive Health"[Mesh] OR "Reproductive Rights"[Mesh] OR reproductive OR reproduction OR "Contraception"[Mesh] OR birth control[tw] AND contraceptive OR "Pregnancy"[Mesh] OR pregnancy OR pregnant OR "Prenatal Care"[Mesh] OR prenatal OR "Postnatal Care"[Mesh] OR perinatal OR abortion OR "Abortion, Induced"[Mesh] OR abortive) AND (social stigma[mesh] OR stigma OR discrimination OR social discrimination OR stereotyp* OR prejudice)	PubMed
(religious OR religion OR spirituality OR faith* OR moral* OR christian* OR Catholic* OR Evangelis*) AND (reproduct* OR "birth control" AND contracept* OR pregnan* OR prenatal OR postnatal OR perinatal OR abort*) AND (stigma* OR discrimination OR stereotyp* OR prejudice)	Scopus
(reproduct* OR abort* OR contracept* OR birth control OR pregnan*) AND (religious aspects OR Christian*) AND (social OR stigma OR discrimination OR prejudice) AND (U.S. OR United States)	ATLA

Inclusion Criteria & Study Selection

Titles and abstracts were screened by two reviewers (BA, WSR) based on the below inclusion and exclusion criteria set for the review. Articles selected for inclusion met the following criteria: 1) contained human subjects, 2) consisted of original quantitative or

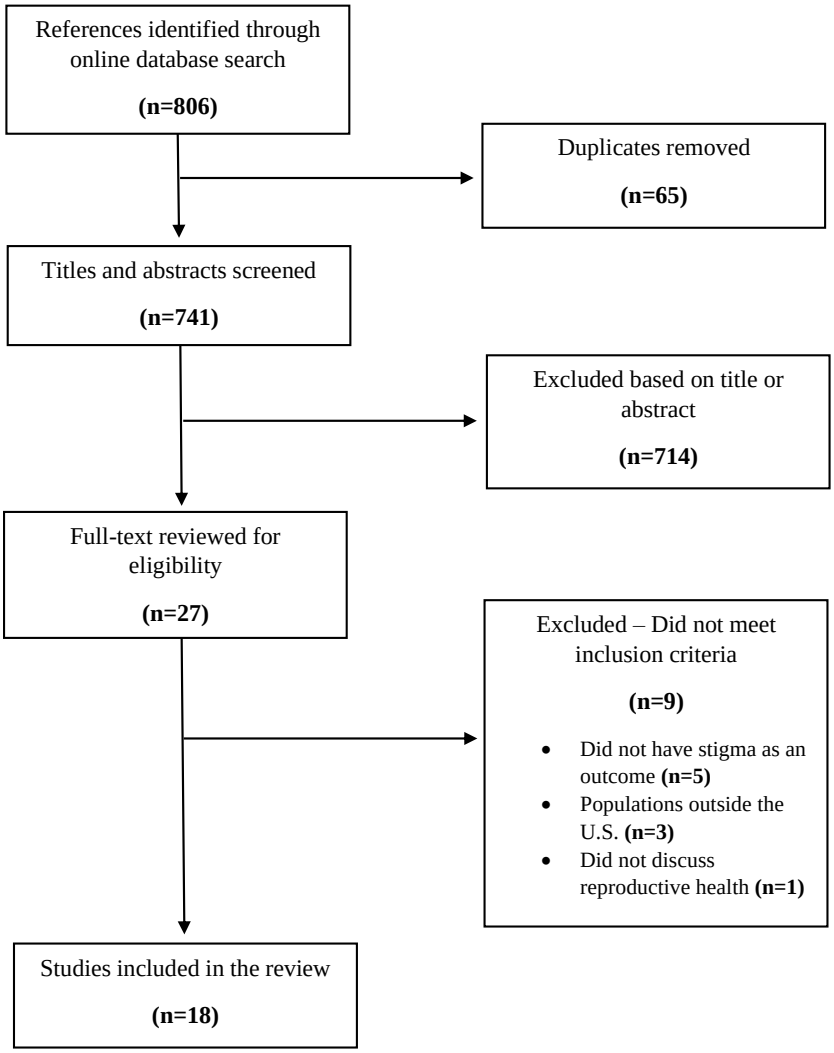
qualitative research studies, 3) published in peer-reviewed journals, 4) contained a full-text review of the research article, 5) included populations within the United States, 6) written in English, and 7) discussed stigma surrounding reproductive health due to religious beliefs, faith-based values or morality as defined by the primary reviewer. Papers that were not original research, that included populations outside the U.S., and that did not discuss stigma surrounding reproductive health due to religious beliefs, faith-based values or morality were excluded.

After selecting studies from the abstract review, two reviewers (BA, WSR) conducted a full-text review on identified articles for eligibility criteria. Figure 2 summarizes the entire process by which articles were excluded and selected as well as the number of articles excluded, and the final number of articles selected for the review. Reviewers resolved conflicts regarding the inclusion or exclusion of articles by re-screening full-texts and making a unanimous decision on the final selection of articles.

Data Extraction

One author (BA) extracted data to an electronic spreadsheet. The following are information extracted from the selected studies: author name(s), publication year, study location, research type, data collection methods, study aim, results, and study strengths and limitations.

Figure 2. PRISMA flow diagram of systematic review and selection process



CHAPTER 4 – RESULTS

Study Characteristics

Characteristics of the 18 selected articles are shown in Table 2. Of the articles selected, 8 were quantitative studies, 6 were qualitative studies, and 4 were mixed methods. In-depth interviews (n=8), focus groups (n=3), and surveys (n=11) were the primary data collection methods for the studies selected in the review. The study publication years ranged from 1979 to 2019 with 2007 being the median year. The year 2017 had the most publications represented in the selection. The sample size ranged from 19 participants to 18,004 participants, with an average of 1535 participants in the selected studies. A wide range of ages were represented in the studies (15-72 years old). The review sample also included several religious denominations with Catholicism (n=9) and Protestantism (n=8) being the most predominant. The review sample was heavily weighted toward Christianity (n=17), with nine studies of Catholicism and eight studies of Protestantism. Nine articles included other religions, one being Judaism.

Studies in the review were conducted in various regions and states across the U.S. Most studies were conducted in the western region (n=6) of the U.S., with California having the most representation among states (n=5). Five studies included participants from multiple U.S. locations and did not specify those locations. Other studies took place in the southern, southeastern, northern, and northeastern parts of the U.S. Additionally, the majority of studies sampled women of reproductive age (n=9) and healthcare providers (n=5).

Analysis of Findings & Main Themes

The study findings are categorized below into findings specific to religion and religious doctrine and moral values, with the majority of the studies discussing religion and religious

doctrines (n=11). The combination of religious doctrines and moral values were also discussed in three studies. The main type of reproductive health stigma identified in the included studies was abortion stigma (n=10). Stigma towards contraceptive use was the second most prevalent type of stigma (n=4). Studies also included stigma around potential pregnancy decisions (n=3), unintended pregnancy (n=2), parenthood (n=2), and assisted reproductive technology (n=1). Multiple studies discussed more than one type of reproductive health stigma. When examining stigma outcomes, fourteen studies discussed the outcome as stigmatizing attitudes, such as judgment and condemnation of specific reproductive health methods. Four of the studies, however, included discriminatory practices as an outcome of reproductive health stigma, such as the refusal and restriction of services.

Religion and Religious Doctrines

Numerous studies discussed relationships between a person's religiosity and stigmatization. Studies also explored the implications of religious teachings for reproductive health stigma. Some studies also identified religious affiliation or denomination as a contributing factor. Finally, a few studies examined religious versus non-religious individuals' beliefs on reproductive health, and how differences in beliefs can result in differences in degree of stigmatizing attitudes.

Five studies found that being religious or religious affiliation are factors contributing to reproductive health stigma. For example, a study conducted by De Kanter et al. (2019) assessing practices and perceptions of reproductive health services among military family physicians across the U.S. found that 22.8% of physicians did not feel comfortable administering emergency contraceptives and would require service women to see another provider due to religious, ethical, or training issues. In comparison, 4.5% of physicians stated they would never prescribe this

method for the same reasons. Another study examining pharmacists' beliefs on abortion found that 29% of pharmacists within their western Pennsylvania-based study sample would refuse to dispense an abortifacient on moral or ethical grounds (Giannetti, 1996). Notably, 57% of the sample of pharmacists rated the significance of religious beliefs in their lives as very significant.

Furthermore, one study used an anonymous online survey instrument to identify barriers to fatherhood and family planning access among gay men across the U.S. Of the 63.5% men who reported stigma regarding becoming a father, 34.8% of gay men reported stigma occurring in religious environments (Perrin, Hurley, Mattern, Flavin, & Pinderhughes, 2019). The researchers found that the likelihood of experiencing stigma in a religious environment inversely correlated with "tolerance" (religious group-specific beliefs regarding homosexuality). Higher tolerance was correlated with a lower probability of having experienced "active" stigma, with active stigma defined as the feeling of discomfort, exclusion, shame, or hurt in specific social contexts (Perrin et al., 2019). This finding is consistent with another reviewed study that pilot tested an intervention introducing abortion patients in New York to a support system. Researchers found that 60% of participants listed "certain religious groups" as a source of abortion stigma (Littman, Zarcadoolas, & Jacobs, 2009). In this same study, pro-life participants rated their religious beliefs as extremely important, while pro-choice participants rated their religious beliefs as somewhat important (Littman et al., 2009).

Similarly, other studies examined whether the degree to which one identifies with their religion is associated with stigmatized attitudes towards reproductive health. For example, one study conducted on Mexican American women in Los Angeles, California investigated the extent to which variation in women's reproductive attitudes and behavior is related to acculturation and religiosity. According to Amaro (1988), attitudes towards contraceptives were

correlated with religiosity. Women who did not affiliate strongly with their religion or who did not engage in religious activity had more favorable attitudes towards contraception. However, religion was rarely cited for a reason not to use contraception, and there was no correlation between religiosity and experience with having an abortion (Amaro, 1988). A study looking at "anti-legal attitudes" towards abortion in women across the U.S. found that participants who identified as fundamentalist had higher odds of having anti-legal attitudes than other religious affiliations (aOR, 1.9; 95% CI:1.2–3.2), while those who identified as non-fundamentalist Catholic were more likely not to hold anti-legal attitudes (Thomas, Norris, & Gallo, 2017). It is worth noting term "fundamentalist" is tied to a specific religious tradition demonstrated by a strict reading of doctrine and sacred text.

Furthermore, several articles found that the frequency of church attendance is a factor contributing to stigmatizing attitudes towards reproductive health. For example, researchers saw a negative correlation between the frequency of church attendance and the support of a woman's abortion decision amongst student nurses in Connecticut (Fischer, 1979). This religious observance was more pronounced for Catholic than for non-Catholic participants, with Catholics being more likely to disagree with abortion even when the pregnancy posed a serious threat to a woman's health (Fischer, 1979). Another study also found a significant interaction between the attendance at religious services and abortion attitudes in freshman college students as those who frequently attended religious services were more likely to oppose the legalization of abortion (Rhodes, 1985). It is also important to note that the same study found that opposition to abortion was linked to denominational preferences as views on legalization were widely different within the Protestant denomination, especially among smaller denominations.

Three studies in the review made comparisons of the level of stigma between those who are religious and those who are not. Specifically, Cockrill et al. developed an abortion stigma scale to measure individual-level abortion stigma for women across the U.S. who have had an abortion. Through this scale, researchers found that women who were religious (Catholic and Protestant) scored highly on the worries about judgment subscale as many of these women feared judgment, isolation, and community condemnation due to their religion (Cockrill, Upadhyay, Turan, & Green-Foster, 2013). In contrast, women who were not religious or spiritual scored lower on the worries about judgment subscale. Additionally, a study conducted by Rice et al. developed three distinct scales to measure stigma around potential pregnancy decisions among young adult women in Birmingham, Alabama. Researchers found that women who were very religious/spiritual scored higher on the abortion norms and stigma scale than women who are not at all or somewhat religious/spiritual (Rice et al., 2017).

Additionally, one study sampled women from nine abortion clinics across multiple U.S. states. This study explored religious influences on women's abortion decision making and experiences, and found that for non-religious women, religion informed, rather than dictated, the experience of internalized abortion stigma (Frohwirth, Coleman, & Moore, 2018). However, non-religious women still felt the need to reference religion when discussing abortion stigma due to fearing judgment and condemnation from their family and their community.

Cultural Norms and Moral Values

Seven studies also identified moral values as a contributor to reproductive health stigma. There were multiple studies where participants viewed themselves as immoral or sinful due to their health decisions not aligning with the norms or values in their community. Six of the studies also discussed how religion could serve as a guide for moral values.

The study conducted by Frohwirth et al. (2018) found that for many participants, religious doctrines and communities deem abortion to be wrong; therefore, violating the norms of those groups may result in subjection to tribal stigma. Tribal stigma, defined in this study, is stigma enacted by a group or community of people. In a study exploring contraceptive care in health care systems of different religious affiliations, healthcare providers cited Catholic teachings as reasons for restrictions on the provision of contraceptives with one physician stating, “Things that are medically feasible are not always morally appropriate within a Catholic health care setting.” (Liu, Hebert, Hasselbacher, & Stulberg, 2019). Catholic hospitals restricted staff from providing long-acting reversible contraception (LARC) to patients, and short-acting contraceptive methods were only prescribed for medical needs that did not pertain to pregnancy prevention. The church also prohibited clinics on their land from performing abortions and prescribing LARCs. Additionally, a study on the sexual knowledge, attitudes, and behaviors in Mexican-American students found that students whose value system were more in favor of traditional standards were more likely to hold more conservative attitudes towards masturbation, abortion, and pre- and extramarital relations than their white counterparts (Padilla & O'Grady, 1987).

Several qualitative studies described that women struggle with the idea of having an abortion and still being considered a “good person.” One explanation for this pattern was the belief that women have a biological responsibility to give birth as well as anti-abortion views shared in an individual’s communities (Altshuler, Ojanen-Goldsmith, Blumenthal, & Freedman, 2017). Other studies explored religion’s role in participants’ attitudes towards reproductive health experiences. Three articles described how women and other individuals in their community view these experiences as “sinful.” In a study conducted by Ellison (2003), single

mothers in southern California viewed their pregnancy decisions as moral an obligation to themselves and their children. Many of the participants expressed not wanting to be seen as "loose" or "easy" women in fear of not fitting the ideal image of female sexual purity and honor (Ellison, 2003).

Likewise, a study in western Pennsylvania examining the range of attitudes around abortion stigma in low-income women found that abortion was commonly viewed by participants as an immoral act and frequently depicted as murder (Gelman et al., 2017). One participant's mother described having an abortion as a sin while another participant was encouraged by her Catholic family to not get an abortion even though the fetus had fetal abnormalities (Gelman et al., 2017). Moreover, women often discussed not wanting to partake in sinful behavior and expressed guilt due to their sexual activity not conforming to their religious beliefs (Chandler, Anstey, Ross, & Morrison-Beedy, 2016).

In one study, clinical directors across the U.S. were given a survey with several scenarios in which they were asked if they would fulfill the patients' needs. The purpose of this study was to explore physicians' ethics and beliefs on assisted reproductive technology. One scenario was about a couple who did not want a multiple pregnancy and decided to abort both fetuses. Clinicians were asked if they would perform the abortion. The percentage of 'yes' responses, in this case, was 46.5%, while the percentage of 'no' responses was 53.5% (Stern, Cramer, Green, Garrod, & DeVries, 2003). Clinicians showed concerns about the morality demonstrated by the couple. Many participants judged the couple by calling them "callous" and questioning the couple's parenting ability (Stern et al., 2003).

Table 2. Study Characteristics of Studies

Reference & Year	Region/Country	Research Type & Data Collection Methods	Population/Sample Size	Aim	Strengths/Limitations
Altshuler et al., (2017)	Northern California/USA	Qualitative; *Semi-structured intensive interviews*	20 women 58% religious or spiritual Ages: 18-49	To examine ways in which women's needs and preferences in abortion care differ from intrapartum care	**Strengths:** Racial and ethnic diversity in sample. Participants were recruited for community in a non-medical environment **Limitation:** The study was conducted in a geographical region with better comprehensive care than other parts of the country
Amaro (1988)	Los Angeles, California/USA	Mixed Methods; *self-administered questionnaire and personal interview*	137 women 81.6% Catholic 7.4% Fundamentalist Protestants 1.5% Other Ages: 18-65	(1) To investigate the attitudes and experiences of Mexican-American women with respect to motherhood and pregnancy, sexuality, and unwanted pregnancy and abortion and (2) to study the extent to which possible variations among women's reproductive attitudes and behaviors are related to socioeconomic status, acculturation, and religiosity.	**Limitation:** Reliance on self-reported attitudes and practices

Chandler et al., (2016)	Unspecified state, Southeastern/ USA	Qualitative; *Focus groups*	32 women Religion not specified Ages: not specified	(a) To evaluate culturally specific HIV prevention information, motivation, and behavioral skill needs of Black college-age women, (b) identify potential determinants of HIV prevention behavior in this population, and (c) identify potential cultural differences between women enrolled in HBCU colleges and those enrolled in traditional public universities	**Limitations:** Researchers did not collect family background, religiosity, and geography; thus, findings cannot be generalizable to all Black women
Cockrill et al., (2013)	Interviews: Northern California/USA Survey: California, Colorado, Florida, Michigan, New Jersey, Tennessee/USA	Mixed-Methods; *surveys and interviews*	2214 women 19.1% Protestant 25.6% Catholic 13.6% Other Christian 5.8% Other 35.8% Not religious/don't know Ages: 15+	To introduce a multidimensional measure of individual-level abortion stigma for women who have had an abortion	**Strength:** Researchers developed a recruitment protocol that did not require women to report past abortion experiences **Limitations:** Experiences can be subjected to recall bias. Abortion experiences is also vulnerable to selective underreporting
de Kanter et al., (2019)	Unspecified locations in the USA	Quantitative; *Survey*	207 physicians Female: 85 Male:119 Religion not specified Ages not specified	To assess practices and perceptions about reproductive health services among military family physicians, with focus on those currently conducting readiness visits.	**Limitation:** Technological issue rendered over 15% of responses unusable. Recall bias/ Strength: sampling frame

Ellison (2003)	Southern California/USA	Mixed-Methods; *Focus groups, surveys, and interviews*	92 women Religion not specified Ages: 22-72	To examine how white middle-class women negotiate, resist, and reproduce the scientific and biomedical authority that informs normative models of sexuality, fertility, and maternity.	**Limitations:** The study contained a small and self-selected sample which can introduce selection bias which and limit the generalizability. The study is also retrospective.
Fischer (1979)	Connecticut/USA	Quantitative; *Questionnaires*	198 student nurses Female: 191 Male: 7 62% Roman Catholic Ages not specified	To examine the role of abortion as a potential stigma in a woman's medical history as well as examine attitudinal and context variables	**Limitations:** The student nurses in the study had little experience. Findings may be different with more experienced nurses
Frohwirth et al., (2018)	Connecticut, Michigan, New Mexico, Texas, Washington/USA	Qualitative; *Semi-structured in-depth interviews*	78 women 17% Protestant 32% Catholic 18% Nondenominational Christian 8% Other 26% None Ages: 18+	To explore how religion influences religiously affiliated, and non–religiously affiliated women's abortion decision making and experience.	**Limitations:** Participants were more religiously affiliated and specifically more Catholic than abortion patients nationally which limits generalizability.
Gelman et al., (2017)	Western Pennsylvania/USA	Qualitative; *Semi-structured interviews*	19 low-income women 63.2% None 15.8% Baptist 10.5% Catholic 10.6% Other Ages: 18-45	To examine sources and range of attitudes that could reflect or contribute to abortion stigma among low-income women and their social networks	**Limitations:** The study did not ask women to list all sources of stigma in their community.

Giannetti (1996)	Western Pennsylvania/USA	Quantitative; *Survey*	120 Pharmacists Female: 75 Male: 45 66% Catholic 22% Protestant 3% Agnostic 9% Other Ages: Median age 36	to survey pharmacists' beliefs about abortion, the dispensing of abortifacients, and the refusal to provide pharmaceutical care on the basis of a conscientious objection to abortion.	**Limitations:** The study used a small, geographically restricted, nonrepresentative sample of religiously oriented pharmacists,
Littman et al., (2009)	New York/USA	Qualitative; *In-depth interviews*	22 women Religion not specified Ages: 18-42	To pilot test an intervention that introduces abortion patients to a "culture of support" by providing validating messages and information about groups and services that support women in their reproductive decisions, addressing stigma, and providing information to help women identify and avoid sources of abortion misinformation.	**Strengths:** The use of the in-depth interview to obtain qualitative information, the focus on women who have recently had abortions **Limitations:** A small sample size and no control group
Liu et al., (2019)	Illinois/USA	Qualitative; *In-depth interviews*	28 healthcare providers Female: 19 Male: 9 Religion not specified Ages not specified	To provide in-depth understanding of contraceptive care in health care systems of different affiliations	**Strengths:** A diverse group of clinical and nonclinical key informants. **Limitations:** Recall bias, providers were not drawn from a nationally representative sample, so researchers cannot generalize findings
Padilla & O'Grady, (1987)	Southern California/USA	Quantitative; *Questionnaires*	264 students Female: 131 Male: 133 Religion not specified	To establishing an empirical base for the comprehensive study	**Limitations:** The study only consisted of college students which makes findings less

			Ages not specified	of sexual knowledge, attitudes, and behavior among Mexican Americans.	generalizable to the general public.
Perrin et al., (2019)	Unspecified locations in the USA	Quantitative; *Survey*	732 men 14.9% Catholic 18.7% Protestant 23.5% Agnostic 25.1% Other 17.8% Unaffiliated Ages not specified	To discover whether gay men continue to encounter barriers in becoming fathers and stigma in various contexts and to examine associations between these experiences and legal and social structures that surround these families.	**Strength:** The study sample size consists of >700 fathers from 47 states **Limitation:** There is a lack of ethnic and racial diversity
Rhodes (1985)	Unspecified locations in the USA	Quantitative; *Survey*	18004 freshmen college students Sex not specified 8.3% Catholic 64.2% Protestant 4.9% Other 5.8% Unaffiliated Ages: 17-20	To see if there is any relationship between religion and attitude toward abortion	**Limitation:** The sample contains a young demographic making findings difficult to generalize to the those in older age groups
Rice et al., (2017)	Birmingham, Alabama/USA	Mixed Methods; *Focus groups, Survey*	642 women 34.6% Very Religious/Spiritual 65.4% Not or Somewhat Religious/Spiritual Ages: 18-24	To develop three distinct scales to measure norms and stigma around each potential pregnancy decision, and to identify predicting factors for each scale.	**Limitation:** Possibility of selection bias as women with more socially liberal views may have been more likely to participate. Possibility of social desirability bias as people are less likely to report more stigmatizing views

Stern et al, (2003)	Unspecified locations in the USA	Quantitative; *Survey*	324 clinical directors Female: 68 Male: 256 45% Protestant 24% Roman Catholic 29% Other Ages not specified	To increase understanding of how patient selection is handled by assisted reproductive technology (ART) clinicians	**Strength:** Large sample size from experienced professionals
Thomas et al., (2017)	Unspecified locations in the USA	Quantitative; *Survey*	4492 women Religion not specified Ages: 17+	To measure the prevalence of believing that abortion should be illegal in all or most cases among women obtaining an abortion in the United States and to identify correlates of holding this belief	**Strength:** The large number of observations from a nationally-representative study of abortion patients. **Limitation:** Social desirability bias could have prevented women from answering more sensitive questions

CHAPTER 5 – DISCUSSION

This systematic review aims to identify the religious and moral determinants contributing to reproductive health stigma. Although published research on religion and reproductive health has increased, there is a need for more research on the aspects of moral values and their influence on reproductive health stigma. A better understanding of the religious and moral drivers influencing reproductive health stigma will help prevent adverse health outcomes by informing interventions that seek to reduce stigma outcomes.

Findings from this review indicate that moral and faith-based determinants contributing to reproductive health stigma can be categorized into religious doctrines, cultural norms, and moral values. There were twelve studies that suggest that the more one follows the teachings of their religious doctrines, the more likely they are to express stigmatized attitudes towards reproductive health. In a study conducted by Håkansson et al. (2018), researchers explored religious and cultural attitudes towards reproductive health. In this review, we found that stigmatizing attitudes towards women included them being viewed as promiscuous, sinful, and shameful for seeking family-planning methods, such as contraceptives or abortion (Ellison, 2003).

Abortion stigma was the most common type of stigma found in this review. According to existing literature, women seeking abortions often question their morality (Norris et al., 2011) with the findings from the review suggesting that this moral dilemma is a product of internalized stigma (Chandler et al., 2016). Women in these situations struggled with the idea of seeking an abortion and being a good person (Chandler et al., 2016). Similar to the findings from existing studies on reproductive health stigma, the review also found the cultural belief that motherhood

is a moral obligation contributed to the perception of stigma among many women (Altshuler et al., 2017).

Much of the stigma outcomes found in the reviewed studies were stigmatized attitudes towards the individual seeking care. Women often felt judged or condemned for their reproductive health choices. There were a few cases where the outcome of stigma was discriminatory practices. In studies that discussed discriminatory practices, it was found that healthcare facilities restricted or refused services to women based on stigma (Liu et al., 2019).

The studies in the review also suggest that the religious and moral values of healthcare providers' play a role in reproductive health stigma. Much of the existing literature on the stigmatization of reproductive health often characterize healthcare providers as a stigmatized group or as a contributor to reproductive health stigma (Norris et al., 2011). The findings from this review align with previous articles which saw that health care providers experience stigma as well as contribute to the judgment and discrimination of those seeking reproductive healthcare (Stern et al., 2003).

Nevertheless, some individuals use their religious values and interpret their religious doctrines as a way to manage and combat stigmatizing attitudes reproductive health as opposed to contribute to these attitudes. In one of the reviewed studies, participants often found flexibility in their religious doctrines as it pertains to stigmatized attitudes towards reproductive health as a way to manage abortion stigma (Frohwirth et al., 2018). This flexibility is seen in other literature on sexual and reproductive health. One study on implementing church-based adolescent sexual health programs in Baltimore City, Maryland, found that although the topic sex can often be taboo in religious environments, many adolescents and their parents were in support of a sexual health program that also includes biblical scripture and is more palatable for the congregation

(Powell et al., 2017). This acceptance of a sexual health program in a religious environment is important to note as faith-based values can be used to positively acknowledge sexual and reproductive health conditions. For example, many faith-based organizations (FBOs) provide health services to poor and undeveloped communities as well as mobilize public health initiatives around HIV/AIDS and maternal and child health (O'Brien, 2017).

Limitations

This review has limitations. First, this review only included populations within the U.S. Second, this review focused almost exclusively on variations within the Christian tradition, with only one article reviewed examining this topic in the context not only in the context of Christianity but also of other religious traditions. Both limitations hinder the generalizability of result findings to the general population but highlight the influence of the predominant religion in the United States—Christianity—on attitudes and stigma related to reproductive health. Third, due to the limitation of the search terms used, this review may not have captured all of the forms of stigma and discrimination, such as discrimination in reproductive health policy. Finally, this review followed a public health framework and was limited to the social sciences and the health sciences; therefore, there is an absence of religious and theological texts. It is important to note that several religious traditions argue for a variety of positions on sexual and reproductive health topics, and this is particularly true for American Christianity.

Conclusion

The results from the studies show that the degree to which an individual is religious can influence what they see as moral and immoral, thus influencing how they perceive stigmatized behavior in themselves and others. Furthermore, the results in the study align with the findings of

existing literature on the perception of motherhood and how it can be perceived as a moral responsibility for women. This places pressure on women to feel as if it is their obligation to birth and raise children; therefore, the perception of not conforming to society's norms and expectations only contributes to judgment and social condemnation.

It is important to acknowledge that not all outcomes of moral and religious beliefs are harmful, and religious and moral values can lead to positive public health outcomes. The purpose of this review is to indicate areas where there are opportunities to grow.

Public Health Implications

The findings from this systematic review can inform interventions that aim to combat stigma around reproductive health services, status, and experiences. As a result, more individuals will seek and have access to quality, patient-centered reproductive health care if effective interventions of this type were developed and implemented. Furthermore, addressing the role that moral values play in the decisions of healthcare providers and how those values contribute to reproductive stigma can also inform future stigma reduction programs and help patients feel more comfortable with their reproductive health care decisions. Finally, this research addresses the religious, cultural, and moral norms that drive and facilitate stigmatized attitudes towards reproductive health. As suggested by the Health Stigma and Discrimination Framework (Stangl et al., 2019), challenging stigma on the driver and facilitator level can prevent manifestations of stigma on the institutional level, such as preventing policies and laws restricting and criminalizing access to reproductive health services.

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