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REVIEW ARTICLE

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Experiences of Gender-Based Stigma in Health Care in North America: A Mixed-Methods Scoping Review and Synthesis of the Literature

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Abstract

Background: Gender-based stigma (GBS) is widely recognized as a barrier to health care-related outcomes globally, including in North America. Although GBS permeates health care institutions, little research has examined the individual-level experiences of GBS in health care, how these may intersect with other marginalized social positions, or how GBS shapes health care outcomes.

Materials and Methods: Following Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews guidelines, this scoping review synthesized the peer-reviewed English scientific literature, through April 2023, on GBS related to health care for cisgender persons. Articles were included if they were from North America and quantitatively or qualitatively investigated either (1) experiences of GBS in health care settings or (2) the relationship between GBS and health care outcomes (e.g., health care access, health care engagement, and treatment adherence).

Results: Of the 25 studies included, the quantitative articles ($n = 13$) demonstrated mixed findings regarding both the prevalence of experiences of GBS in health care (8–53%) and the impact of GBS on health care outcomes. However, all ($n = 14$) of the qualitative articles demonstrated that GBS negatively shapes health care experiences, particularly for those occupying intersectional social positions, and is influenced by societal gender norms. Furthermore, gendered experiences of violence and abuse negatively shape care outcomes, both inside and outside of health care contexts.

Conclusions: The quantitative literature lacks consensus regarding the influence of GBS in health care, but the qualitative literature more clearly demonstrates GBS's deleterious effect on health care, especially for

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women. The use of validated GBS measures and intersectional approaches is needed to fully understand the role of GBS in health care.

Keywords: sexism; gender-based discrimination; cisgender women; women's health; health care engagement; intersectionality; North America

Introduction

Sexism in health care

Gender-based stigma (GBS) has fundamentally shaped the conceptualization of the diagnosis and treatment of illnesses in Western medicine since its inception, profoundly shaping health along gender lines.¹ GBS (also termed sexism, gender-based discrimination, and gender bias), broadly, has been conceptualized as a multilevel social process whereby individuals are labeled, devalued, and rejected based on one's gender.² Although GBS can be perpetuated at multiple levels (*i.e.*, structural, interpersonal, and individual levels), much of the existing literature has focused on the structural (*i.e.*, how members of specific gender groups are disadvantaged by policies, laws, and institutions) and interpersonal levels (*i.e.*, the perspectives of individuals perpetuating GBS).^{3–7} At the structural level, GBS permeates North American health care institutions, with research on women-specific diseases being underfunded and with women being underrepresented in the medical literature.^{4,8} Additionally, structural-level GBS is linked to greater barriers to accessing care and poorer health outcomes for women.⁵ At the interpersonal level, sexism among health care professionals may result in the underdiagnosis of certain disorders and the bullying, coercion, and nonconsensual treatment (*e.g.*, obstetric violence) of women.^{7,9,10}

Despite the emerging field of structural sexism research¹¹ and what is known about interpersonal-level GBS, little is known about women's experiences with individual-level GBS (*i.e.*, the perspective of persons experiencing GBS)³ in health care and how those experiences may impact health care outcomes. This limited knowledge on individual-level GBS necessitates a synthesis of the literature to better understand the state of the research, both in terms of the quantity and focus of research on this topic. This review focuses on GBS in health care in North America, where rapidly changing laws, policies, and social norms related to reproductive and other health care-related rights are profoundly impacting women's health care experiences and outcomes. Concomitantly, there

is growing investment in advancing women's health research,¹² and a greater understanding of the state of the literature can guide future work on GBS in health care in North America at this historically significant timepoint.

Intersectional stigma

Intersectional stigma is a framework combining intersectionality (*i.e.*, an acknowledgment of interlocking systems of oppression) and stigma.^{13–16} One's experiences of gender are inextricably linked with one's experiences occupying other social positions (*e.g.*, race, HIV status) and necessitate an acknowledgment that individual-level stigma occurs within larger power structures (*e.g.*, health care policies and institutions). Given other reviews demonstrating that GBS intertwines with other forms of stigma,¹⁷ and that leading intersectionality scholars argue that examining stigmatized social positions in isolation can conceal complex experiences of stigma and their impacts on health disparities,^{14,18} we employed an intersectional lens in the design and conduct of the current review.

The current study

Considering the existence of sexism within health care, the limited research employing intersectional, individual-level approaches to investigations of GBS, and the potential negative ramifications of GBS on women's health care, this scoping review synthesized the North American scientific literature on (1) individual-level experiences of GBS within health care from the perspective of cisgender persons and (2) how experiences of GBS impact health care-related outcomes.

Methods

Search strategy

All review procedures adhered to the *Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews* guidelines,¹⁹ and a review protocol may be accessed through the corresponding author. Search terms were developed and piloted to capture published articles that examined (1) gender



(*i.e.*, gender-based, sex-based, sexist, sexism, or misogyny), (2) stigma (*i.e.*, social stigma, discrimination, bias, mistreatment, shame, perceived stigma, anticipated stigma, internalized stigma, or enacted stigma), and (3) health care (*i.e.*, healthcare, health care, health services, health care access, or health care engagement) in PubMed and PsycINFO (Supplemental Document 1). Given that initial piloting of the search terms across multiple databases revealed considerable overlap in search results and that research indicates searching as few as two databases can achieve sufficient coverage,²⁰ the PubMed and PsycINFO databases were used for the current review. The initial search was conducted on August 18th, 2021, yielding an initial sample of 983 articles, and was updated on April 20th, 2023, yielding a final sample of 1157 articles.

Title and abstract screening and full-text review

After excluding 87 duplicate entries, the titles and abstracts of 1070 unique articles were screened to identify articles that potentially contained topics related to stigma, gender, and health care and warranted a full-text review. A total of 125 articles were excluded that lacked one or more of the requisite topics in the title or abstract.

Next, trained coders (S.A.M.P., J.M., and I.Y.) reviewed the text of the remaining 945 articles. Articles were excluded if they (1) were not in English ($n = 26$), (2) were not an original, peer-reviewed research article ($n = 377$), (3) did not measure GBS for cisgender individuals ($n = 250$), (4) did not measure stigma from the individual perspective ($n = 93$), (5) did not measure a health care-related outcome ($n = 123$), or (6) if the research was conducted outside of North America ($n = 51$). This review focused on research within North America, given that both stigma and health care are fundamentally shaped by structural and sociocultural environments that vary across geographical contexts. We chose to synthesize the literature from Canada, the United States, and Mexico together given the economic, political, and historic linking of (*e.g.*, the North American Free Trade Agreement), and frequent border crossings and coordination of health care research and services across, these countries.^{21–26} We also focused on the experiences of cisgender persons as the experiences of transgender and gender diverse persons with transphobia and gender identity stigma may differ markedly from the experiences of cisgender persons who

experience GBS.^{27,28} Following the full-text review, 920 articles were excluded for not meeting inclusion criteria, resulting in the retention of 25 articles for this review. All articles were double-coded by two independent raters, and coding decisions were reviewed at weekly team meetings. Code-by-code comparisons were reviewed, and any coding discrepancies were discussed by coders until they came to consensus and determined a final code category. Article screening and coding were conducted in Covidence.²⁹

Study quality ratings

We employed the 14-item Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies to evaluate the quality of the included quantitative studies.³⁰ Quality scores ranged from 0 to 14, and items assessed whether the measures were clearly defined, valid, reliable, and implemented consistently across all study participants and whether key potential confounding variables were measured and adjusted for statistically.

The quality of qualitative studies was evaluated using the 10-item *Critical Appraisal Skills Program* checklist, with scores ranging from 0 to 10.^{17,31,32} Sample criteria included whether the research design was appropriate to address the research aims and whether data analyses were sufficiently rigorous. For both checklists, higher scores represent higher study quality. Quality ratings were conducted individually (S.A.M.P. and J.M.), and any scoring discrepancies were resolved in weekly consensus meetings.

Analysis of data

The primary quantitative outcomes of interest were health care-related variables (*e.g.*, health care engagement and treatment adherence), and the secondary quantitative outcomes were GBS/discrimination-related variables. Data related to the study characteristics (*i.e.*, sample size, population, location, and design),³² GBS measure used, the health care outcome(s) measured, and the main findings related to GBS (including intersectional stigma) and health care were extracted and organized into tables for synthesis.

Qualitative data were analyzed via thematic synthesis,³³ which involves the development of descriptive and analytical themes through the coding of original studies.^{17,32,33} After reviewing the qualitative articles, two coders (S.A.M.P. and J.M.) iteratively developed a coding framework to guide the synthesis of study



themes related to GBS, the intersection of GBS and other stigmas, and health care. Our approach emphasized the constructs identified by study authors to prevent potential biases that may result from the reinterpretation of primary data, given our limited understanding of the original study context and the potential for misinterpreting isolated data fragments.^{17,32,33} The coding framework and process facilitated the “reciprocal translation” of findings,^{17,32,33} which allowed the synthesis of concepts across studies. The study team discussed and achieved consensus on the coding and analysis process, the translation of concepts from different studies, the comparison of codes within code categories, and the grouping of codes into categories.

Results

Study selection and characteristics

Twenty-five articles met inclusion criteria and were retained for analysis (Fig. 1), of which 11 (44%) were quantitative, 10 (40%) were qualitative, and 4 (16%) were mixed methods. Mixed-methods articles were analyzed as quantitative ($n = 2$) and/or qualitative ($n = 4$) based on which portion(s) of the studies pertained to the current review. Most studies were conducted in the United States ($n = 16$; 64%), with 20% ($n = 5$) in Canada, 8% in Mexico ($n = 2$), and 8% being continent-wide ($n = 2$).

Methodological quality assessment. Of the 13 quantitative articles included, all were observational. Most investigated GBS related to health care cross-sectionally ($n = 10$; 76.9%). The mean quality score was 8.5 (range: 6–12; interquartile range [IQR]: 8–9), with nearly all adjusting for confounding variables ($n = 11$; 84.6%) and providing sample size justifications, power, or variance and effect estimates ($n = 11$; 84.6%). Given that most studies were cross sectional, only one (7.7%) measured the exposure of interest prior to the outcome(s), and none measured their exposure variable more than once over time.

Of the 14 included qualitative articles, the mean quality score was 9.1 (range: 8–10; IQR: 9–9.8), with all articles providing sufficient details on participant recruitment and most providing adequate details of the analysis process ($n = 13$; 92.9%). Ten (71.4%) of the articles, however, did not adequately describe whether the relationship between the research team and participants had been considered.

Quantitative synthesis

For the 13 quantitative articles, 4 (30.8%) investigated individuals' experiences of GBS within health care settings, 7 (53.8%) investigated GBS and a health care-related outcome, and 2 (15.4%) investigated both (Table 1).

Quantitative synthesis of GBS in health care. The five quantitative articles that assessed GBS within health care contexts investigated this phenomenon among general samples of women,^{34,35} women receiving mammography services,³⁶ women veterans,³⁷ and women living with HIV (WLHIV).³⁸ The percentage of participants reporting experiencing GBS within a health care setting included 7.8% from women receiving mammography services [1; see Table 1 for article numbers referenced in brackets], 18%–24% from women [8, 12], 33.7% from women veterans [10], and 53% from WLHIV [3].

Quantitative synthesis of GBS and health care outcomes.

Within the nine quantitative articles that assessed the relationship between GBS and health care outcomes, this phenomenon was investigated among WLHIV,^{39–45} women veterans,³⁷ and women receiving mammography services.³⁶ Three articles (33.3%; [4, 6, 11]) measured both GBS and health care outcomes but did not test the association between them. Three articles, however, found that greater levels of GBS were associated with poorer health care outcomes (*i.e.*, barriers to HIV care, lower HIV medication adherence, and missed HIV care appointments; [5, 7, 9]). For example, study findings from longitudinal multivariable analyses found that WLHIV ($n = 1578$) who reported GBS had a greater prevalence of missing an HIV care appointment in the past 6 months (United States; [9]). In contrast, three articles did not find a significant, direct association between GBS and health care outcomes (*i.e.*, mammography screening, HIV viral load, and HIV medication adherence; [1, 2, 13]).

GBS is intersectional and complex. The quantitative articles also indicate that GBS is intersectional and warrants complex analytical approaches. For example, three studies either employed an intersectional measure of stigma (*i.e.*, gendered racial microaggressions scale; [5, 13]) or created a latent class of stigma [7] to explore the co-formation of gender-, race-, and/or HIV-related discrimination and how that intersection



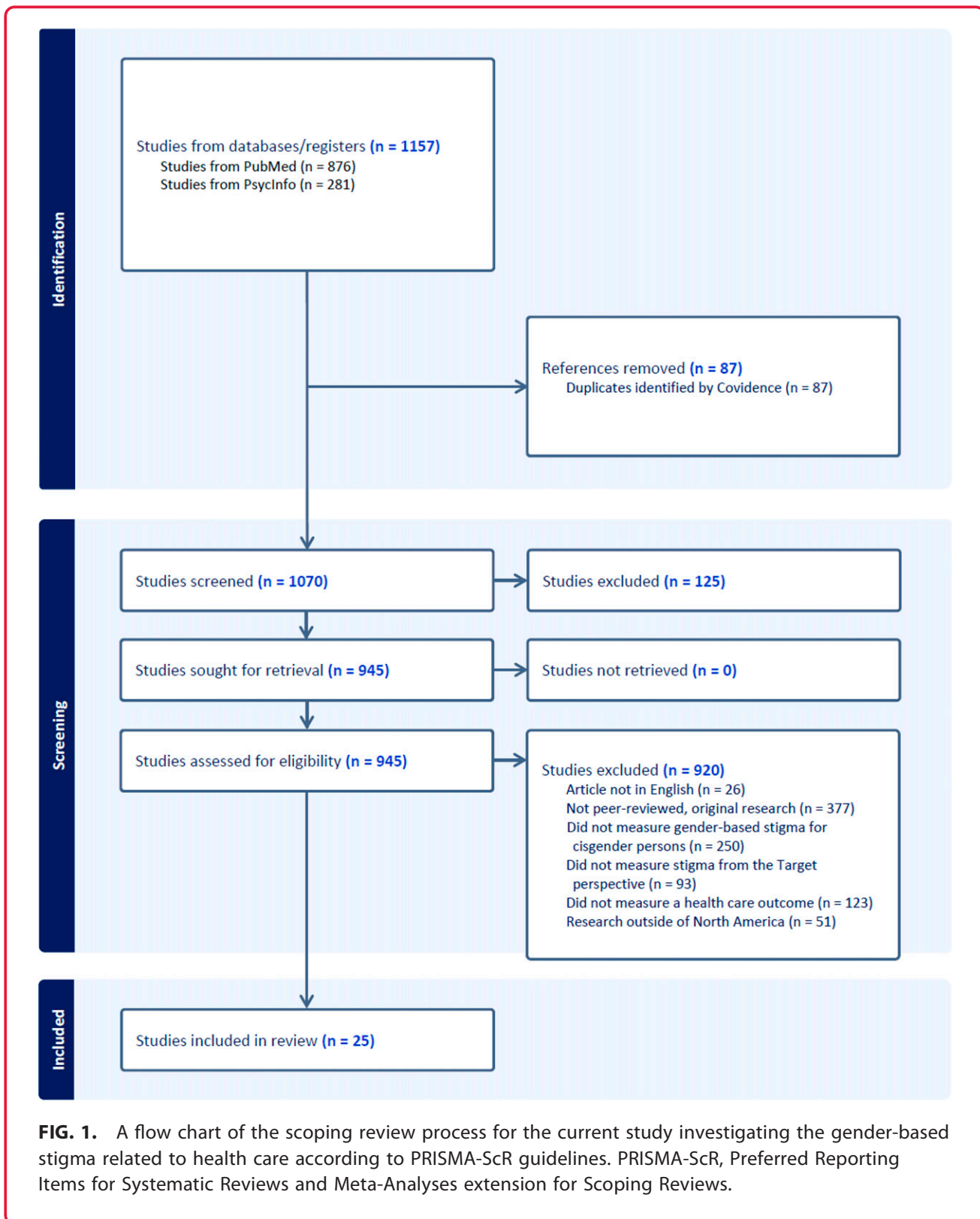


Table 1. A Scoping Review of Studies Investigating Gender-Based Stigma Related to Health Care Within North American Settings (n = 25)

#	Author (year)	N	Study characteristics				Stigma measure	Health care outcome	Findings	Quality score
			Population	Location	Study design	Quantitative studies (n = 13)				
1	Dailey (2008) ³⁶	1229	Women who received mammography services Age: 40–49 = 36.1%; 50+ = 63.9% Race: White = 60%; Black = 40%	Connecticut, USA	Prospective survey design	Adapted Krieger and Sydney's discrimination measure to assess lifetime experiences gender-based discrimination across a variety of settings, including when getting medical care. In addition, the measure assessed whether participants ever decided not to do something (e.g., get medical care) because of anticipated or assumed gender-based discrimination	Nonadherence to mammography screening guidelines	Nearly 38% of participants reported experiencing gender-based discrimination in at least one situation in their lifetime; 7.8% of participants reported experiencing gender-based stigma in a health care setting. Gender-discrimination was associated with nonadherence to mammography screening guidelines among participants who made at least \$50,000 a year in multi-variable analyses	10	
2	Kelso (2014) ³⁹	67	African-American women living with HIV Age: Mean = 45.96; SD = 8.93. Race: Black = 100%	Chicago, Illinois, USA	Cross-sectional survey design	A modified Detroit Area Study—Discrimination Scale assessed perceived gender discrimination	HIV disease markers (CD4 cell count and HIV viral load)	Eighty-five percent of participants reported at least some perceptions of discrimination "a few times a year"; 87.3% attributed at least some of the perceived discrimination to gender. At higher levels of perceived gender discrimination, women endorsing high critical consciousness had a larger positive difference between nadir CD4 ⁺ (lowest pre-HAART) and current CD4 ⁺ count when compared with women endorsing low critical consciousness	9	
3	Orza* (2015) ³⁸	832	Women living with HIV around the world Age: Range = 15–72 years (32% in 30s; 32% in 40s). Race: Did not report	North America	Mixed methods: cross-sectional survey design	Items asking participants to report experiences of gender-based violence (GBV) across various settings, including within health settings, and whether their experiences of GBV were before, since, and/or because of their HIV diagnosis	N/A	53% of participants reported experiencing GBV in a health setting. 11% of those who reported GBV in a health setting said they experienced GBV prior to their HIV diagnosis, 53% experienced GBV after their diagnosis, and 65% experienced GBV because of their diagnosis	6	
4	Logie (2018) ⁴⁰	1420	Women living with HIV. Sexual minority women Age: Median = 38; Race: White = 46.1%; Indigenous = 35.6%; ACB Black = 11.7%; Other = 6.7%; <i>Heterosexual women</i> Age: Median = 43; Race: White = 40.4%; Indigenous = 20.3%; ACB = 31.9%; Other = 7.4%	Canada	Cross-sectional survey design	Everyday Discrimination Scale—Sexism	HIV medical care barriers (whether participants had received HIV medical care in the past year) and barriers to HIV support services (whether participants had tried to access HIV support services but been unable to)	Relationship between gender-based discrimination and HIV medical barriers not tested	8	

(continued)



Table 1. (Continued)

#	Author (year)	Study characteristics			Stigma measure	Health care outcome	Findings	Quality score	
		N	Population	Location					Study design
5	Dale (2019) ⁴¹	100	Black women living with HIV Age: Range = 22–67; mean = 49.25; SD = 10.89; Race: Black: 100%	Southeast USA	Cross-sectional survey design	Gendered Racial Microaggressions Scale—Black Women	Barriers to HIV care (comprised of four subscales: geography/distance, medical and psychological, community stigma, and personal resources)	In multivariable analysis, higher gendered racial microaggressions significantly predicted higher total barriers to care scores and higher medical and psychological, community stigma, and personal resources barriers to care subscale scores. When all predictors were entered together with covariates, gender-based discrimination contributed uniquely to total barriers to care and both the community stigma and personal resources subscales	8
6	Logie (2019) ⁴²	1367	Women living with HIV. Age: Median = 42.5; Race: White = 41.62%; Black = 28.82%; Indigenous = 22.46%; Other = 7.10%	Ontario, Quebec, and British Columbia, Canada	Cross-sectional survey design	Everyday Discrimination Scale—Sexism	HIV Care Engagement (Antiretroviral adherence), HIV-related health outcomes (CD4 cell count, HIV viral load), and whether participants have received women-centered HIV care	In path analysis, gender discrimination had a significant direct effect on depressive symptoms and women-centered HIV care mediated this relationship. There was also a significant direct effect of depressive symptoms on CD4 cell count	9
7	Shokoohi (2019) ⁴³	1422	Women living with HIV in Canada Age: Mean = 42.8; SD = 10.6; Race: White = 41.1%; ACB = 29.4%; Indigenous = 22.3%; Other = 7.2%	Canada	Longitudinal survey design	Everyday Discrimination Scale—Discrimination due to Gender	Difficulties in Access to Care (Barriers to Access to Care Scale); Combined Antiretroviral Adherence	57.1% of the sample reported gender-based discrimination. Results of an LCA found four classes, one of which was a “Discrimination/ Stigma Class” (Gender-, Race-, and HIV-related stigma, and barriers to care) and another that was the “Most Adversities” group (Gender-, race-, and HIV-related stigma, low social support, barriers to care, food insecurity, low income, and unemployment). Class membership was bivariately associated with cART adherence with greater proportions of suboptimal cART adherence in the discrimination/stigma and most adversities classes	12
8	SteelFisher	1596	Women Age: 18–29 years = 17%; 30–49 years = 31%; 50–64 years = 29%; 65+ years = 22%; Race: White = 65%; Hispanic/Latina = 15%; Black = 13%; Asian = 6%; Native American = 1%	USA	Cross-sectional telephone survey	Items asking participants to report experiences of differential or unfair treatment based on their self-identification as a woman/female. Assessed both institutional discrimination (e.g., health care) and interpersonal discrimination (i.e., gender-based slurs, microaggressions, harassment, and violence)	N/A	18% reported gender-based stigma when going to a doctor or health clinic. Those that identified as Black or Native American were more likely to report experiencing gender-based discrimination in health care settings. Further, those that identified as Hispanic/Latina or Native American were more likely to report avoiding going to the doctor due to concerns about gender-based discrimination. Additionally,	9

(continued)



Table 1. (Continued)

#	Author (year)	Study characteristics			Quantitative studies (n = 13)			Findings	Quality score
		N	Population	Location	Study design	Stigma measure	Health care outcome		
9	Cressman (2020) ⁴⁴	1578	Women living with HIV Age: Median year of birth was 1965 (~48 to 51 years); Race: Black/ African American = 74%; Hispanic/ Latina = 15%; White = 11%	USA	Longitudinal survey design	Major Experiences of Discrimination Scale (Abbreviated Version) with follow-up questions asking the type(s) of discrimination experienced (e.g., gender)	Missed HIV care appointment(s) in the past 6 months	those that were uninsured or had a college education were more likely to report experiencing gender-based discrimination in a health care setting and avoiding going to the doctor because of gender-based discrimination concerns 15% reported major experiences of discrimination related to gender. Women who reported discrimination related to gender had a significantly greater prevalence of missing an HIV care appointment in the past 6 months. Additionally, African American women who reported discrimination related to gender had a significantly greater prevalence of missing an HIV care appointment in the past 6 months	9
10	MacDonald (2021)	2294	Women veterans Age: Median = 35; Range = 21–45; Race: White = 51.6%; Black/ African American = 29%; Hispanic/ Latina = 12.3%; Other = 7.1%	USA	Cross-sectional survey design	An adaptation of the Everyday Discrimination Scale to assess perceived gender-based discrimination while accessing VA health care	Whether the participant received most of their health care from the same provider and whether there was a women's health clinic at the site of VA care	33.7% of participants reported experiencing gender-based discrimination while accessing VA health care. Those that had a history of medical illness, mental illness, or military sexual trauma were more likely to report gender-based discrimination in health care. Hispanic/Latina or Black/ African American women were significantly less likely to report gender-based discrimination when compared with those who were White. Those who reported receiving most of their care from the same provider and having a women's health clinic at their VA health care site were also significantly less likely to report gender-based discrimination	9
11	Saint Arnault (2022)	309	Women GBV survivors Age: Mean = 34; SD = 13.4; Race: White = 80.6%; Black = 5.1%; Asian = 6.8%; Hispanic/ Latina = 4.6%; Native American = 2.1%	Midwestern USA	Cross-sectional scale development survey design	Adapted Barriers to Care Seeking Scale (Barriers to Help Seeking-Trauma version [BHS-TR]) to assess experiences, feelings, and attitudes (e.g., shame) related to GBV influenced the decision to not seek care	N/A	In the psychometric analysis, the average score on the Shame factor of the BHS-TR was a 1.53 (SD = 1.03; range = 0–3). This was the factor with the second highest average score	8

(continued)



Table 1. (Continued)

Quantitative studies (n = 13)								
#	Author (year)	Study characteristics			Health care outcome	Findings	Quality score	
		N	Population	Location				Study design
12	Alspaugh (2023) ³⁵	628	Women. Age: Mean = 33.7; SD = 6.6; Race: White = 89.8%; Not white = 10.2%.	Appalachia, USA	Mixed methods: Cross-sectional survey design	Items asking if participants had negative experiences with a health care provider that made them not want to return for care due to their gender and/or multiple intersecting identities Gendered Racial Microaggressions Scale—Black Women	N/A 24% of participants reported a negative experience with a health care provider due to their gender	6
13	Sharma (2023) ⁴³	119	Black women living with HIV Age: M = 49.27; SD = 10.81; Race: 100% Black	USA	Cross-sectional survey design	Past 2-week medication adherence (measured via Wisepill) and HIV viral load	Gendered racial microaggressions were not significantly associated with medication adherence or HIV viral load	8
Qualitative studies (n = 14)								
#	Author (Year)	Study Characteristics			Location	Study Design	Themes	Quality score
		N	Population	Location				
14	Teram (2006) ⁵⁴	95	Adult male (52%) and female (48%) survivors of childhood sexual abuse. Age: Not reported; Race: Not reported Women living with HIV Age: Range = 20–57; Mean = 38.3; SD = 9.1; Ethnicity: African = 31.6%; European = 18.0%; Aboriginal = 16.5%; Canadian = 14.6%; Latina = 3.6%; Asian = 2.6%; South Asian = 2.6%	British Columbia, Alberta, Saskatchewan, Ontario, New Brunswick, and Nova Scotia, Canada	In-depth and focus group interviews	Themes: Differential treatment due to societal gender norms; gendered loss of autonomy and human rights violations. Codes: Manhood and masculinity; patronization and dismissal	Differential treatment due to societal gender norms; gendered loss of autonomy and human rights violations; violence as a barrier to care	9
15	Logie (2011) ⁵⁰	104	Women living with HIV Age: Range = 20–57; Mean = 38.3; SD = 9.1; Ethnicity: African = 31.6%; European = 18.0%; Aboriginal = 16.5%; Canadian = 14.6%; Latina = 3.6%; Asian = 2.6%; South Asian = 2.6%	Ontario, Canada	Focus group interviews	Themes: Gender-based stigma is intersectional; differential treatment due to societal gender norms; gender-based violence. Codes: HIV; sex work; womanhood and motherhood; lack of women-specific care; violence as a barrier to care	Gender-based stigma is intersectional; gendered loss of autonomy and human rights violations; violence as a barrier to care	10
3	Orza (2015) ⁵¹	832	Women living with HIV Age: Range = 15–72 years (32% in 30s; 32% in 40s); Race: Not reported	North America	Mixed methods: Cross-sectional survey design with free text responses	Themes: Gender-based stigma is intersectional; gendered loss of autonomy and human rights violations; gender-based violence Codes: HIV; uninformed and misinformed; forced/coerced health care; violence as a barrier to care	Gender-based stigma is intersectional; gendered loss of autonomy and human rights violations; violence as a barrier to care	8
16	Orza (2015) ⁵¹	766	Women living with HIV Age: Mean = 32.98; SD = 6.91 Race: Not reported	North America	Mixed methods: Cross-sectional survey design with free text responses	Themes: Gender-based stigma is intersectional; differential treatment due to societal gender norms; gendered loss of autonomy and human rights violations Codes: HIV; mental health; womanhood and motherhood; uninformed and misinformed; forced/coerced health care	Gender-based stigma is intersectional; differential treatment due to societal gender norms; gendered loss of autonomy and human rights violations	9

(continued)



Table 1. (Continued)

#	Author (Year)	N	Study Characteristics			Themes	Quality score
			Population	Location	Study Design		
17	Santiago (2018) ⁴⁶	20	Women who received health care for childbirth Age: 13–18 years = 39%; 20–24 = 39%; 25–29 = 11%; 30–34 = 6%; 35–39 = 5%; Race: Not reported	Mexico	Mixed methods: semi-structured interviews	Themes: Gender-based stigma is intersectional; differential treatment due to societal gender norms; gender-based violence. Codes: Socioeconomic status; womanhood and motherhood; verbal abuse/neglect in health care; violence in health care	9
18	Callegari (2019) ⁵²	32	Women veterans who had a primary care visit at a VA health care system in the past 2 years. Age: Range = 18–44; Mean = 35; SD = 7; Race: White = 47%; Black = 34%; Latina = 13%; Asian = 6%	Puget Sound, Washington and Pittsburgh, Pennsylvania, USA	In-depth, semi-structured, telephone interviews	Themes: Gender-based stigma is intersectional; differential treatment due to societal gender norms; gendered loss of autonomy and human rights violations Codes: Mental health; womanhood and motherhood; patronization and dismissal	9
19	Higgins (2019) ⁴⁷	22	Queer/non-heterosexual women Age: Mean = 23.8; SD = 2.77; Race: White = 78.8%; Hispanic/Latina = 6.1%; Filipina and White = 3%; Indian = 3%; Japanese American = 3%; Arab American and White = 3% White = 3%; Mixed = 3%	Chicago, Illinois, Salt Lake City, Utah, and Madison, Wisconsin, USA	Focus group interviews	Themes: Gender-based stigma is intersectional; gendered loss of autonomy and human rights violations; gender-based violence Codes: Sexual orientation; disempowerment; patronization and dismissal; violence as a barrier to care	9
20	Mattocks (2020) ⁵³	80	Women veterans who received VA specialty care. Age: Range = 30–71; Mean = 44; Race: White = 50%; Black = 21%; Hispanic ethnicity = 18%; Other = 11%	USA	Semi-structured telephone interviews	Themes: Gendered loss of autonomy and human rights violations Codes: Patronization and dismissal	9
21	Firmin (2021) ⁵⁵	53	Adult women (50.9%) and men (49.1%) with a diagnosis of schizophrenia or schizoaffective disorder Age: Range = 26–59; Mean = 43; SD = 8.8; Race: Black/ African American = 62.3%; White = 35.9%; Hispanic/Latino = 1.2%	USA	Face-to-face interviews	Themes: Gender-based stigma is intersectional; differential treatment due to societal gender norms; gendered loss of autonomy Codes: Mental health; womanhood and motherhood; manhood and masculinity; patronization and dismissal	10

(continued)



Table 1. (Continued)

Qualitative studies (n = 14)							
#	Author (Year)	N	Study Characteristics				Quality score
			Population	Location	Study Design	Themes	
22	Adkins-Jackson (2022) ⁵⁶	12	Black women who provide self-care services to others and who engage in self-care Age: Range = 20–64; Race: Black = 100% African American women Age: 70% were 55 or older; Race: 100% African American	USA	In-person or Zoom semi-structured interviews	Themes: Gender-based stigma is intersectional; differential treatment due to societal gender norms Codes: Race; womanhood and motherhood	9
23	Garza (2022) ⁵⁷	30	African American women breast cancer survivors Age: 70% were 55 or older; Race: 100% African American	Midwest, USA	Focus group interviews	Themes: Gender-based stigma is intersectional; differential treatment due to societal gender norms; gendered loss of autonomy and human rights violations Codes: Race; socioeconomic status; womanhood and motherhood; patronization and dismissal Themes: Gender-based stigma is intersectional; differential treatment due to societal gender norms; gendered loss of autonomy and human rights violations Codes: Race; immigration; womanhood and motherhood; disempowerment; patronization and dismissal; forced/coerced health care; violence in health care	10
24	Vazquez Corona	133 posts; 80 articles; 6350 comments	Social media posts about cesarean sections	Mexico	Mixed-methods content analysis	Themes: Gender-based stigma is intersectional; differential treatment due to societal gender norms; gendered loss of autonomy and human rights violations Codes: Race; immigration; womanhood and motherhood; disempowerment; patronization and dismissal; forced/coerced health care; violence in health care	9
25	Willie (2022) ⁴⁹	37	Black cisgender women who are PrEP eligible Age: Mean = 32; Race: 100% Black/African American	Jackson, Mississippi, USA	Focus group interviews	Themes: Gender-based stigma is intersectional; differential treatment due to societal gender norms Codes: Race; lack of women-specific care	10
12	Alspaugh (2023) ³⁵	628	Women Age: Mean = 33.7; SD = 6.6; Race: White = 89.8%; Not white = 10.2%	Appalachia, USA	Mixed methods: Cross-sectional survey design with free text responses	Themes: Gender-based stigma is intersectional; differential treatment due to societal gender norms; gendered loss of autonomy in health care; gender-based violence Codes: Drug use; womanhood and motherhood; disempowerment; patronization and dismissal; uninformed and misinformed; verbal abuse and neglect in health care; violence in health care	9



relates to HIV care outcomes, although these studies produced disparate results (see section “*Quantitative synthesis of GBS and health care outcomes*”). Other studies found marginalized social positions significantly impacted experiences of GBS in health care settings [3, 8, 10] or that GBS was a significant factor within moderation or path analyses [1, 2, 6, 9]. Specifically, these studies indicated that income [1], HIV serostatus [3], race/ethnicity [8, 9], and a history of medical or mental illness and/or military sexual trauma [10] either exacerbated experiences of GBS in health care settings or impacted the relationship between GBS and health care outcome(s). Additionally, complex mediation and path analyses identified that critical consciousness (*i.e.*, an awareness of social oppression that promotes uniting with others to advance social change) [2], depression [6], and women-centered care [6] were important factors in understanding the relationship between GBS and health care outcomes.

Quantitative stigma measurement. There was large variability in the measures employed to assess GBS; six (46.2%) studies used three different pre-existing measures of GBS [4, 5, 6, 7, 9, 13], three (23.1%)

studies developed GBS items [3, 8, 12], and four studies (30.8%) adapted an existing stigma measure to assess GBS [1, 2, 10, 11]. Nearly half (46.2%) reported or provided a reference for the reliability and validity of the measure employed, a quarter of the studies (23.1%) provided information regarding just the reliability, and nearly a third of the studies (30.8%) did not provide any information on the reliability or validity of the GBS measure(s) used.

Qualitative thematic synthesis

The 14 included qualitative articles examined GBS in health care among women who were eligible for and/or received sexual and reproductive health care,^{35,46–49} WLHIV,^{38,50,51} women veterans,^{52,53} child sexual abuse survivors,⁵⁴ persons with schizophrenia,⁵⁵ Black women self-care experts,⁵⁶ and Black breast cancer survivors.⁵⁷ The overarching analytical theme for this synthesis explored how GBS negatively impacts health care for women and men and four descriptive themes were identified: (1) GBS is intersectional, (2) differential treatment due to societal gender norms, (3) gendered loss of autonomy and human rights violations, and (4) gender-based violence (GBV; Fig. 2). While these themes capture unique facets of GBS in health

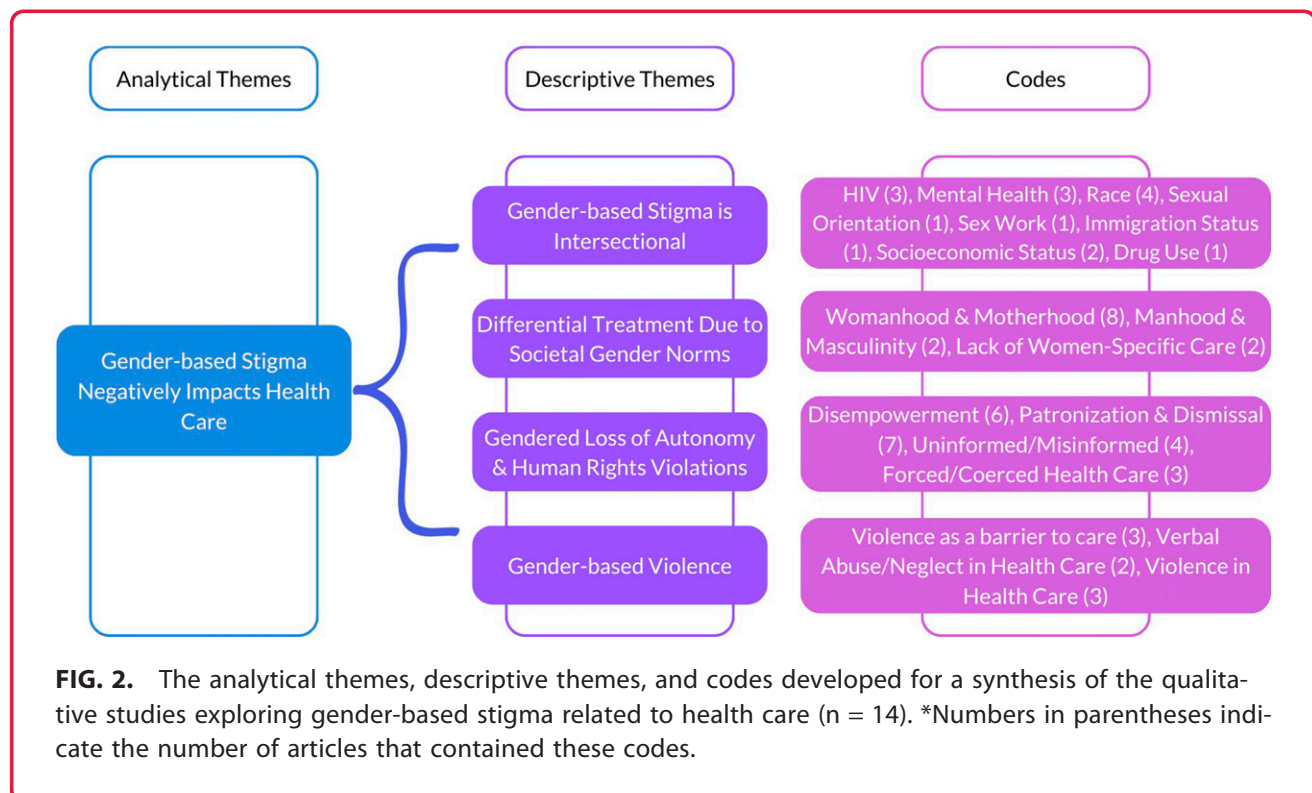


Table 2. Examples of the Qualitative Excerpts Featuring Gender-Based Stigma Related to Health Care, with the Corresponding Descriptive Themes and Code Categories Derived from the Thematic Synthesis

First author (year)	Excerpts	Theme(s)	Code categories
Teram (2006) ⁵⁴	The literature suggests that male survivors who were sexually abused by women may interpret the experience as a “coming of age” experience, as an educational experience, or in other positive terms (Banyard et al., 2004; Holmes & Slap, 1998; Romano & De Luca, 2001). Our participants did not share this view. As one man described the attitudes of health professionals, “Well no, they’re [providers] not saying, “I don’t believe you.” Some of them will say to you, “Well you know—sexual experimenting.” And I told them, “Well look, I was sexually abused by someone who was 18 years old approximately, and I was about 11. There’s no sexual experimentation there, not on my part. I was abused. I wasn’t experimenting. I didn’t even know what the hell sex was.” I think for a lot of doctors it is discounting the importance of what happened or blaming the victim, blaming myself. To me that’s very damaging when you’re told that. (p. 7)	Differential treatment due to gendered social norms; gendered loss of autonomy and human rights violations	Manhood and masculinity; patronization and dismissal
Logie (2011) ⁵⁰	Sexism and gender discrimination were highlighted in relationships and societal attitudes and participants highlighted a dearth of women-specific HIV services... “Women with HIV often end up in abusive relationships, suffer from violence” (African Caribbean participant, Toronto); “It’s more acceptable for a man to have HIV than a woman. Women, they’re looked at like they’re dirty” (sex worker participant); “Sometimes a woman cannot get out of the relationship. If the husband has papers [immigration] but not the woman, when it comes to violence you cannot leave him” (African Caribbean participant, Ottawa) (pp. 6–7)	Gender-based stigma is intersectional; differential treatment due to gendered social norms; gender-based violence	HIV; womanhood and motherhood; lack of women-specific care; violence as a barrier to care
Orza (2015) ⁵¹	In the one mandatory survey section, violence emerged as a key theme in free text responses to the question “What’s the most important issue that you would like to see the WHO Guidelines address in order to make it the most useful tool for you?” Answers varied from one word, “violence” (multiple responses), to longer statements concerning ways GBV intersects with HIV: The impact of violence and the trauma associated with being a girl/woman in many parts of the world affect every aspect of our fight against HIV — from risk to diagnosis to accessing care to managing treatment to survival. (USA) (p. 3) Respondents also reported mixed experiences regarding contraceptive choice. Service providers reportedly told many only to use condoms. Others have been coerced or forced into using long-acting or permanent birth-control methods, including intra-uterine devices (IUD, coils), injectable hormonal contraceptives, or tubal ligation (sterilization). Once diagnosed, women also reported treatment refusal (especially fertility treatment) or being forced or coerced into services they did not freely choose, including abortion: Make sure that there is a law that can heavily penalize doctors who perform forced sterilization and more; in many cases like mine we only realize many years later and [then] you cannot do anything. (Mexico) (p. 4)	Gender-based stigma is intersectional; gender-based violence Gender-based stigma is intersectional; gendered loss of autonomy and human rights violations	HIV; violence as a barrier to care HIV; disempowerment; uninformed and misinformed; forced/coerced health care
Orza (2015) ⁵¹	Respondents discussed many reproductive health barriers and HR violations, including being dissuaded from having children, mistreatment while pregnant and forced or coerced sterilization. Women who wanted to have children were often constructed as wanting to transmit the virus. . . This construction of women living with HIV as wanting to transmit the virus through childbirth resulted in some respondents unwillingly choosing not to have children: When I found out I was HIV positive, my doctor at Planned Parenthood told me I could never have children. That I might infect them and I would be [a] “horrible woman” to	Gender-based stigma is intersectional; differential treatment due to gendered social norms; gendered loss of autonomy and human rights violations	HIV; womanhood and motherhood; uninformed and misinformed; forced/coerced health care

(continued)



Table 2. (Continued)

First author (year)	Excerpts	Theme(s)	Code categories
Santiago (2018) ⁴⁶	do so. I didn't have children but I have regretted that decision every day of my life since. I did refuse sterilization when it was "encouraged" but still wish I had considered having children as a possibility. (USA) (p. 6)		
	Some women also reported coerced and forced sterilization, which can have a profound and devastating impact on a woman's mental health: Find a law that strongly punishes doctors performing forced sterilization and that does not expire, and [allows] time to make a lawsuit if necessary because many times we realize that we were sterilized many years later and we can do nothing. (Puerto Rico) (p. 6)	Gendered loss of autonomy and human rights violations	Forced/coerced health care
	Testimonies reflected the self-perception of the women regarding poverty and explained their behavior: in identifying themselves as poor, they did not believe they could protect themselves from the insults of attending personnel. The majority of women interviewed did not see themselves as citizens with rights. Because they had no money to pay for other services, most were affiliated with the Seguro Popular. They felt, therefore, that they had no choice but to tolerate the treatment they were given; this, in addition to experiencing a constant fear that something would happen to their babies. Whether from shame or fear of being treated even worse, they did not respond to reprimands from the staff for not being knowledgeable about the physiological processes of infant care, or to their comments concerning their economic situation. (p. 6)	Gender-based stigma is intersectional; gendered loss of autonomy and human rights violations	Socioeconomic status; disempowerment
The physical abuse reported by the women was characterized by the following actions: having their legs manipulated roughly, being slapped, pinched and strapped to the bed. Physical abuse also translated into poorly practiced routine clinical procedures, for example, sticking women numerous times in the attempt to administer anesthesia or intravenous (IV) serum, performing medical procedures, such as an episiotomy, without anesthesia, and repeating pelvic examinations carelessly and without providing an explanation. Painful in themselves, these are aggravated when conducted without the proper technique. The following testimony details how these procedures were carried out: The interviewer asked one of the women in the study sample, "Did you know what they were injecting you with?" "Well, no," replied the woman, "it was like...when I asked [they said], 'it was to speed it up [the delivery],' but I felt something burning on my back. They had to bend me over and they kept touching my back. The nurse kept on doing it wrong. It would have been better if the doctor did it, right? And again she did it wrong and kept on asking. I mean, they gave me the injection [epidural] three times." (15-year-old first-time mother). (p. 6)	Gender-based violence	Violence in health care	
This form of abuse [psychological abuse] was characterized by screaming, verbal humiliation, offensive jokes, reprimands for expressing pain or requesting service, scowling gestures and disapproving faces. Screaming and humiliation were described as a routine form of communication: "You're not at home;" "You're not alone, so be quiet!" Ill-treatment extended to the newborns as well: "Do you do this by kilos?" [referring to a large baby], and "This product is for men" [referring to a female baby]. These are vivid examples of the objectification of the female body-even that of female babies. (pp. 6-7)	Differential treatment due to gendered social norms; Gender-based violence	Womanhood and motherhood; verbal abuse/neglect in health care	

(continued)

Table 2. (Continued)

First author (year)	Excerpts	Theme(s)	Code categories
Callegari (2019) ⁵²	Many participants discussed receiving patronizing or dismissive treatment related to their gender in their interactions with military and/or VA reproductive health care providers. For example, one woman described frustration with discussing her family planning needs with military providers, whom she felt spoke differently to her because she was a woman: "Just how they word stuff, like you're a kid. I can't really explain it. Like they'll try to shy away from the topic [of pregnancy and birth control], especially the military ones when I was active duty" (age 32, White). (p. 3)	Gendered loss of autonomy and human rights violations	Patronization and dismissal
	Women veterans with PTSD seemed to be particularly vulnerable to perceiving dismissal and devaluation from providers, causing an additive negative effect related to gender and mental health on their reproductive health and family planning interactions. One veteran explained of her experience with counseling at VA, "they kind of blow me off with, 'you have PTSD and you're a woman, so it must be in your head, it's not something real'" (age 44, Black). (p. 3)	Gender-based stigma is intersectional; gendered loss of autonomy and human rights violations	Mental health; patronization and dismissal
	Black women veteran participants in particular reported fearing that providers would judge them as promiscuous for requesting contraception or as irresponsible for desiring childbearing in family planning encounters. One woman needing contraception in the military explained: "I was like, 'Oh my God, my doctor is going to think that I'm a whore.' I knew that was unrealistic and she probably didn't think anything of it, but it was just those racing thoughts talking to her about birth control" (age 26, Black). (p. 3)	Differential treatment due to gendered social norms	Womanhood and motherhood
Higgins (2019) ⁴⁷	Participants said that, in keeping with other exclusionary practices, the larger heteronormative world fails to perceive queer women as contraceptive users. Some women had internalized this idea, not thinking of themselves as contraceptive users even when in sexual situations that could result in pregnancy. Buffy (21 years old, pansexual, focus-group participant) suggested that contraception is culturally controversial, and queer people's contraceptive needs can be even more marginalized: "People make it pretty clear that they don't really care about women's rights to birth control. When we talk about queer women in particular, it's even less so. No one even talks about us, really. . . . All the media and conversations that happen around contraception have to do with heterosexual sex, so you don't think about yourself as a part it." (p. 2)	Gender-based stigma is intersectional; gendered loss of autonomy and human rights violations	Sexual orientation; uninformed and misinformed
	Qualitative data collection on sexual and reproductive health with all women can be closely linked to narratives of gender-based power and sexual violence. However, we were still struck by the airtime given to power, violence, and trauma in our focus groups and interviews. This preponderance is not surprising given well-established connections between sexual minority identities and increased risk of violence. Unique to the current analysis is how participants connected this phenomenon to contraceptive use. (p. 4)	Gender-based stigma is intersectional; gender-based violence	Sexual orientation; violence as a barrier to care
Mattocks (2020) ⁵³	Many women interviewed for this study had been told by doctors that their health concerns or conditions were directly attributable to their hormonal states, or that they were overreacting to their subjective experiences of pain and discomfort. One female combat veteran described her experiences as following: I was told by my VA doctor that though I was a woman in combat, I should be over it by now. That, you know, my female hormones are in overdrive and that's my problem. (p. 116)	Gendered loss of autonomy and human rights violations	Patronization and dismissal

(continued)

Table 2. (Continued)

First author (year)	Excerpts	Theme(s)	Code categories
Firmin (2021) ⁵⁵	A final notable difference between men and women emerged in discussions of experiences with stigma. Both men and women discussed encounters with stigma (e.g., being called 'crazy', experiencing discrimination) and ways these experiences posed challenges to their sense of self. Only male participants, however, discussed being perceived by others as "dangerous" because of their mental illness, and this experience appeared to pose unique challenges for males as they struggled against internalizing these messages they received from others. For instance, one male explained that he became isolated after experiencing psychosis because his family members were "scared" of him. (p. 9)	Gender-based stigma is intersectional; differential treatment due to gendered social norms	Mental health; manhood and masculinity
	By contrast, more female participants discussed experiencing stigma in the form of paternalism in relationships. Many females believed people treated them like children, dismissed their opinions, minimized their experiences, or "used my illness to try to manipulate me." (p. 9)	Gender-based stigma is intersectional; gendered loss of autonomy and human rights violations	Mental health; patronization and dismissal
Adkins-Jackson (2022) ⁵⁶	Participants frequently referred to illness, trauma, fatigue, and invulnerability when describing the effect of social forces on themselves and the women they worked with but did not reference specific diseases or conditions. According to several participants, these forces make it difficult for Black women to be "vulnerable." One participant stated, "You have to not only stuff and stifle for a world that essentially hates us, but we also have to stuff and stifle when it comes to our own men. A lot of times, also with our own women as well who have drunk the Kool-Aid" (SME 3, Astrologist). Another participant discussed the pressure to put themselves last, explaining, "Even from childhood, I was taught to never make your plate until everybody else's plate is made. . . I am always last. Everybody's physical exams and well-baby exams are all scheduled, but who has not had a physical in three years? Me" (SME 2, Acupuncturist). (p. 10)	Differential treatment due to gendered social norms	Womanhood and motherhood
Garza (2022) ⁵⁷	The third theme is how intersectionality impacts survivorship. It is closely related to the fourth concept of BFT—that African American women live at the intersection of race, social class/socioeconomic status, and gender oppression. The oppression that comes from intersecting and marginalized identities can make survivorship for African American women more challenging. Survivors shared concerns related to finances, unsafe neighborhoods, health insurance, and access to healthy food. (p. 6)	Gender-based stigma is intersectional	Race; socioeconomic status
	Exacerbating these challenges, a few participants shared experiences of racial discrimination as an additional barrier to receiving services. As one participant shared: "I don't mind exposing his name because he deserved exposing, Dr. XX at the time, was at the XYZ hospital but wouldn't come and see me. And um, so I got out of the hospital and I went to his office and I asked why didn't you come and see me. He said "Well, there's nothing we can do for you." And my husband was like "Man, you her doctor, why wouldn't you come and at least check in on your patient, and we actually saw you walking around the hall and you totally ignored her. (p. 6)	Gender-based stigma is intersectional; gendered loss of autonomy and human rights violations	Race; patronization and dismissal
Vazquez-Corona (2022) ⁴⁸	"They (in the public health system) treat you like an ill woman, that knows nothing about her body, and it seems like you are not allowed to ask. . ." (article 10) There were reports of Mexican women being discriminated and abused during cesarean sections due to their Indigenous status, immigration status, and their gender. Two articles reported on the case of an Indigenous woman and her family who received inadequate care during and after cesarean section (article 2 and 67). An article reported on a Mexican woman handcuffed during a cesarean section in the United States of America (article 49). (p. 9)	Gender-based stigma is intersectional; gendered loss of autonomy and human rights violations; gender-based violence	Race; immigration status; patronization and dismissal; disempowerment; violence in health care

(continued)



Table 2. (Continued)

First author (year)	Excerpts	Theme(s)	Code categories
	There were two main cases reported on the media in Mexico where women's worth was implied to be diminished after having a cesarean section. The governor of a state in northern Mexico who was aiming to promote vaginal births made a statement saying that a woman who avoids cesarean section is more of a mother (article 36), which led to a congresswoman reporting the governor to the National Human Rights Commission for sexism (article 66). The other case involved a woman who was kidnapped outside a metro station in Mexico City (most likely for sexual trafficking) and released when the captors noted her cesarean section scar claiming she was "useless" now (articles 8 and 34). (p. 9)	Differential treatment due to gendered social norms	Womanhood and motherhood
Willie (2022) ⁴⁹	Equally important, some women discussed the socio-historical underpinnings of medical research and practices with Black Americans. For example, these prior socio-historical practices may cause additional concerns and red flags for Black women considering PrEP: "Just culturally, when you think about studies and medication, the African American community. The thinking for African Americans, they're like, "Well, they're probably tryin' to kill us all. They're tryin' to harm us all. Why are y'all takin' that medication?" (p. 6)	Gender-based stigma is intersectional	Race
	Likewise, women described their experiences of racial- and gender-related discrimination with healthcare providers as a significant barrier to preventative healthcare, including PrEP access. "A lot of these health care providers are very critical and judgmental, and they don't treat all patients fairly, you know...They judge automatically on appearance, look, race, and sexuality...And often, at times, they don't get the best health care because of the health care provider (p. 6)	Gender-based stigma is intersectional	Race; sexual orientation
Alspaugh (2023) ³⁵	Patriarchal views were experienced at a community level and through individual interactions. Participants described how 'women's health', especially reproductive health, was marginalised in their community because of commonly held attitudes regarding sexuality and anti-abortion or anti-contraception sentiments. Participants also described patriarchal interactions with health care providers in which the providers talked about how many children women should have or required that they seek spousal consent for birth control. (p. 9)	Differential treatment due to gendered social norms; gendered loss of autonomy and human rights violations	Womanhood and motherhood; disempowerment
	When health care mistreatment was rooted in bias against women and pregnancy capable people, it was categorised as health care misogyny... Several other participants noted mistreatment during pelvic examinations or while giving birth that went ignored by health care providers. In other cases, participants wrote about conversations in which a provider "slut-shamed" them or blamed their experience of rape on their looks. One participant reported experiencing a sexual assault perpetrated by a health care provider. (pp. 10-11)	Gendered loss of autonomy and human rights violations; gender-based violence	Disempowerment; verbal abuse/neglect in health care; violence in health care

care, they were not mutually exclusive, and there were instances in which they overlapped (Table 2; Supplementary Table S2).

GBS is intersectional. Similar to the quantitative literature, most articles (n = 12; 85.7%) contained themes related to individuals' experiences with GBS as it intersected with other marginalized social positions, namely HIV status [3, 15, 16], mental

health [16, 18, 21], race [22, 23, 24, 25], sexual orientation [19], sex work [15], immigration status [24], socioeconomic status [17, 23], and substance use [12]. These studies described how stigma within health care can be amplified for those who occupy intersecting marginalized social positions, leading to negative health ramifications:

Women veterans with PTSD seemed to be particularly vulnerable to perceiving dismissal and devaluation from providers,



causing an additive negative effect related to gender and mental health on their reproductive health and family planning interactions. One veteran explained of her experience with counseling at VA, “they kind of blow me off with, ‘you have PTSD and you’re a woman, so it must be in your head, it’s not something real.’” (Callegari, 2019, United States, p. 3, [18])

Differential treatment due to gendered social norms.

Several articles explored how societal expectations surrounding womanhood and motherhood perpetuated and shaped experiences of GBS [12, 14, 15, 17, 18, 21, 22, 23, 24, 25]. These studies described how GBS within health care can result from societal standards surrounding cleanliness and purity for women, as well as the moral-based ideals for what makes a “good” mother. Study themes demonstrated that women experienced GBS from health care providers when they were viewed as violating any of these expectations, which, in turn, negatively impacted the care they received. The following excerpt depicts how HIV serostatus can be viewed as a violation of the societal norms surrounding womanhood and motherhood within health care:

Women who wanted to have children were often constructed as wanting to transmit the virus... This construction of women living with HIV as wanting to transmit the virus through childbirth resulted in some respondents unwillingly choosing not to have children: “When I found out I was HIV positive, my doctor at Planned Parenthood told me I could never have children. That I might infect them and I would be [a] ‘horrible woman’ to do so. I didn’t have children but I have regretted that decision every day of my life since.” (Orza, 2015, North America, p. 6, [16])

Limited accounts also suggest that societal expectations surrounding masculinity and manhood may also diminish men’s ability to ask for, and receive good quality, health care [14, 21]. Further, other studies demonstrated how these gender norms have resulted in a distinct lack of gender-responsive health care options, particularly for women [15, 25].

Gendered loss of autonomy and human rights violations.

Several articles detailed a gendered loss of autonomy and the commission of human rights violations in health care contexts, ranging from feelings of disempowerment, patronization, and dismissal, to being uninformed or misinformed about available treatment options, to being forced or coerced into procedures. Specifically, study themes highlighted gendered disempowerment within health care settings, where women recounted feeling powerless and unable to advocate for themselves in health care

settings [12, 19, 24], as well as instances where health care workers neglected to share, or provided inaccurate/incomplete health-related information [3, 12, 16]. Further, over half of the articles highlighted themes related to the patronization and/or dismissal of women in health care contexts [12, 14, 18, 19, 20, 21, 23, 24]. These studies, exemplified below, illustrate how women are often perceived as not being the experts of their own bodies and that the stereotypes of the hysterical and hormonal woman persist:

Many women interviewed for this study had been told by doctors that their health concerns or conditions were directly attributable to their hormonal states, or that they were overreacting to their subjective experiences of pain and discomfort. One female combat veteran described her experiences as following: “I was told by my VA doctor that though I was a woman in combat, I should be over it by now. That, you know, my female hormones are in overdrive and that’s my problem.” (Mattocks, United States, 2020, p. 116, [20])

In extreme examples of lost autonomy, studies discussed gendered human rights violations, most often in the form of coercion into long-acting birth control methods or forced tubal ligation (sterilization) [3, 16, 24].

GBV and health care. Many articles demonstrated that extreme forms of GBS (*i.e.*, gender-based abuse) limited women’s engagement with health care and exists within health care environments [3, 12, 15, 17, 19, 24]. Study findings highlighted how past experiences of GBV outside of health care contexts adversely impacted women’s access to, and engagement with, health care services [3, 15, 19]. Furthermore, article themes underscored accounts in which women depicted experiences of verbal abuse and/or neglect [12, 17] and physical violence [12, 17, and 24] within health care contexts. Importantly, all instances of abuse were within the context of women accessing reproductive health services (*i.e.*, pelvic examinations/pap-smears, childbirth, and/or postpartum care), illuminating a potentially precarious point of care for women. The following excerpt demonstrates the vulnerability that can accompany these services:

The physical abuse reported by the women was characterized by the following actions: having their legs manipulated roughly, being slapped, pinched and strapped to the bed. Physical abuse also translated into poorly practiced routine clinical procedures, for example, . . . performing medical procedures, such as an episiotomy, without anesthesia, and repeating pelvic examinations carelessly and without providing an explanation. (Santiago, 2018, Mexico, p. 6, [17])



Discussion

Summary of the evidence

This scoping review synthesized the North American scientific literature to provide critically needed information on intersectional and individual-level experiences of GBS within health care settings, and how those experiences of GBS impact health care-related outcomes. Findings across 13 quantitative studies provided mixed evidence for both the prevalence of experiences of GBS in health care (ranging from 7.8% to 53%) and whether GBS is associated with health care-related outcomes. Importantly, few articles tested the association between GBS and health care-related outcomes, indicating a critical gap in our understanding of this phenomenon. The quantitative studies did, however, provide preliminary evidence demonstrating GBS is likely intersectional, with HIV serostatus, race/ethnicity, and medical or mental illness and/or military sexual trauma, being identified as potentially important factors in experiences of GBS within health care, and that critical consciousness and depression may be potential intervenable targets within GBS processes. This quantitative synthesis, however, highlights that further study is warranted for fully understanding the intersectional and complex relationship between GBS and health care.

Among 14 qualitative studies, there was agreement that GBS negatively impacts health care experiences and outcomes. Specifically, findings from this synthesis demonstrated that GBS is rooted in societal expectations surrounding both womanhood and manhood and that stigma is amplified for those occupying intersecting marginalized social positions (*e.g.*, race/ethnicity, HIV serostatus, and mental health). Interestingly, despite our aim of exploring individual-level experiences of GBS, these results further underscore the need for intersectional approaches by highlighting how individual-level experiences of GBS are inextricably linked to the structures, systems, and interpersonal environments (*e.g.*, societal norms and expectations) in which individuals are situated.^{13,14,18,58} The qualitative literature also demonstrates that GBS can take many forms, ranging from a loss of agency (*e.g.*, disempowerment, misinformation, and patronization/dismissal) to forced/coerced procedures and GBV. These accounts illustrate a dearth of gender-responsive (*i.e.*, women-centered) services and a need for gender bias training among providers, both of which may improve care for women. It is recommended that gender-responsive care models, such as

the Woman-Centered HIV Care Model,⁵⁹ be employed to improve health care-related outcomes.

The varied findings observed across the quantitative studies suggest that current approaches may not adequately capture GBS related to health care, particularly for women occupying intersecting social positions. This could be due, in part, to the large variability in GBS measures employed across studies. This variability in GBS measurement mirrors the variability noted in other stigma research,^{17,60} and further emphasizes the need for scientific coordination regarding the operationalization, standardization, and validation of GBS measures. Consequently, future research should draw from the existing published qualitative literature and intersectional measures of stigma to better develop measures of GBS. Accurately capturing GBS, and the intersectional nature of stigma, could lay the foundation for the development and evaluation of tailored interventions targeting GBS and associated health care-related harms.

Limitations

This scoping review was limited in a few important ways. First, only articles published in English were included due to language limitations among the study team. Twenty-six non-English articles were excluded, including articles in Spanish ($n = 9$) and French ($n = 5$); two official languages spoken in North America that could have potentially biased our findings. However, English is still the most widely spoken language in North America, and the inclusion of articles from three North American countries allowed us to avoid overgeneralizing our findings given that experiences of gender, stigma, and health care vary across sociogeographical contexts. Furthermore, although the heterogeneity of the GBS measures employed limits the robustness of the current review's findings,⁶¹ we exposed existing gaps in the scientific literature. To protect against bias, inclusion and exclusion criteria were determined prior to analysis, independent raters screened for inclusion, applied codes, and assessed study quality,⁶² and themes and codes were developed iteratively and agreed upon by scientists with qualitative research experience.

Implications

To the best of our knowledge, this is the first scoping review of intersectional and individual-level GBS in North America as it relates to health care. The results of current synthesis contribute valuable insights into



the experiences of women, and in some contexts men, with the gendered social norms that produce heightened levels of stigma, reduced agency, and abuse within health care contexts. Importantly, this synthesis identified that experiences with GBS negatively impact participants' engagement with, or experiences within, health care, and that critical consciousness, depression, and women-centered care may be potentially critical areas for intervention and future research on this phenomenon. This review also identifies potential methodological weaknesses in the existing quantitative measurement of GBS as it relates to health care. Current approaches to assessing GBS are not only lacking consistent operationalization and well-validated measures but also have not been designed to capture the unique experiences of GBS in health care settings, or as it intersects with other marginalized social positions. As such, the lack of consensus in the conclusions across the quantitative studies highlights the need for nuanced and intersectional approaches to GBS- and health care-related research. This information could be crucial for developing gender-responsive treatments and interventions to reduce stigma within health care, thereby promoting greater safety, health, and well-being for women, a group disproportionately impacted by stigma- and health-related harms.

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Author Contributions

S.A.M.P.: Conceptualization, data collection, analysis, and writing—original draft preparation. J.M.: Data collection, analysis, and writing—original draft preparation. K.J.H.: Resources, supervision, and writing—reviewing and editing. I.Y.: Data collection, analysis, and writing—reviewing and editing. C.H.L.: Conceptualization and writing—reviewing and editing. C.R.:

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Conflict of Interest

The authors declare that they have no conflicts of interest.

Supplementary Material

Supplementary Table S1

Supplementary Table S2

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Abbreviation Used

ACB = African, Caribbean, and Black
 GBS = Gender-based stigma
 GBV = Gender-based violence
 HIV = Human immunodeficiency virus
 HR = Human rights



Abbreviation Used (Cont.)

IQR = Interquartile range
PRISMA-ScR = Preferred reporting items for systematic reviews and
meta-analyses extension for scoping reviews

PTSD = Post-traumatic stress disorder
SD = Standard deviation
VA = Veterans affairs
WLHIV = Women living with HIV

