

Indicator name
Extent to which communities stigmatize women and girls with SRHR problems
Aggregable indicator
No
Indicator type (quantitative/qualitative)
Qualitative
Thematic area of engagement
Promoting sexual and reproductive health and rights
Related objectives in the Gender Action Plan III
Overall thematic objective: Women and girls in all their diversity access universal health and fully enjoy their health and sexual and reproductive rights Specific thematic objective 1: Enabled legal, political and societal environment allowing women and girls to access quality sexual and reproductive health (SRHR) care and services and protecting their sexual and reproductive rights
Technical Definition
This indicator intends to measure if and how the communities stigmatize women and girls that suffer of problems related to their sexual and reproductive health and rights sphere. The following definitions apply: - <u>Stigma</u> is experienced when an individual or group is identified as being different from a perceived norm and subjected to labelling, shame, disapproval and discrimination.¹ Because the overall stigma process incorporates several other elements, such as labeling and stereotyping, the stigma concept is broader than discrimination. The stigma concept encompasses multiple statuses and characteristics, such as gender, sexual orientation, disability, HIV status, obesity, and race and ethnicity. It is a social determinant of population health and can be a central driver of morbidity and mortality at a population level.² - <u>Sexual and reproductive health and rights problems of women and girls</u> refer to the harmful consequences of violations of women's and girls' sexual and reproductive health and rights. These take many forms, including: denial of access to services that only women and girls require; poor quality services; subjecting women's access to services to third party authorisation; forced sterilization, forced virginity examinations, and forced abortion, without women's prior consent; female genital mutilation (FGM); and early and forced marriage.³ This indicator intends to specifically track stigmatisation of pregnant teenagers, women with fistula, rape survivors, and women living with infertility, HIV, or mental health problems, among others.
Rationale
Sexual and reproductive health and rights (SRHR) refer to the right of every individual to have full control over, and decide freely and responsibly on matters related to their sexuality and sexual and reproductive health, free from discrimination, coercion and violence. Women's sexual and reproductive health is related to multiple human rights, including the right to life, the right to be free from torture, the right to

¹ Hussein J, Ferguson L. (2019): [Eliminating stigma and discrimination in sexual and reproductive health care: a public health imperative](#). *Sexual and Reproductive Health Matters*. Published online 2019 Dec 27

² Hatzenbuehler M. L., Phelan J.C., Link, B.G. (2013): [Stigma as a Fundamental Cause of Population Health Inequalities](#), *American Journal of Public Health*. Published online, 2013 May.

³ OHRHR, [Sexual and reproductive health and rights](#)

health, the right to privacy, the right to education, and the prohibition of discrimination and stigma.

Stigma thwarts, undermines, or exacerbates several processes (i.e., availability of resources, social relationships, psychological and behavioural responses, stress) that ultimately lead to adverse health outcomes. Stigma and discrimination can often be directed towards those people living in vulnerable situations and linked to intersectional factors of age (particularly for adolescents and older people), disability, race, sex, gender, gender expression, sexual orientation and sex characteristics, as well as marital status. Problems related to the sphere of sexual and reproductive health are also a root cause of stigma in many communities around the world. For example, individuals who seek specific kinds of sexual and reproductive health care or services, such as for HIV, sexually transmitted infections, abortion, contraception, sexual dysfunction or transgender health, are particularly affected.⁴ Some groups can be particularly at risk of stigma, as those that this indicator intends to target such as, pregnant teenagers, women with fistula, rape survivors, women living with infertility, HIV or mental health problems.

Adolescent pregnancies are a global problem occurring in high-, middle-, and low-income countries. Several factors contribute to adolescent pregnancies and births. In many societies, girls are under pressure to marry and bear children early. In least developed countries, at least 39% of girls marry before they are 18 years of age and 12% before the age of 15. In many places, girls choose to become pregnant because they have limited educational and employment prospects. Often, in such societies, motherhood is valued and marriage or union and childbearing may be the best of the limited options available. Early pregnancies can also result from sexual violence. Social consequences for unmarried pregnant adolescents may include stigma, rejection or violence by partners, parents and peers. Girls who become pregnant before the age of 18 years are more likely to experience violence within a marriage or partnership.⁵

Today, one in three women under 50 has experienced physical and/or sexual violence by a partner, or non-partner sexual violence – violence which affects their physical and mental health in the short and long-term.⁶ Survivors of sexual violence are frequently condemned and socially excluded. Myths about rape may translate into stigmatisation, diminish disclosure, prevent help-seeking from support structures and worsen mental health. Areas of conflict or organised violence remain the evident hotspots of sexual victimisation. Female victims often face spousal abandonment and stigma within the family or community including a diminished social status, worsened family relations, loss of children's respect or an increase in insults and beatings in the household.⁷

Two-to-three million women worldwide live with a genital fistula, with Asian and sub-Saharan African countries accounting for the greatest percentage. Genital fistula is a devastating health problem due to the stigma associated with constant incontinence and bad-odour. Some women may not even be aware that they are suffering from a known, treatable condition - they simply believe that they are cursed. Too often, they are ridiculed by their neighbours and cast out of their families because of their smell. Many hide themselves in shame. Community education and outreach are vital to finding and treating the vast backlog of women suffering with fistula.⁸

Although both women and men can experience infertility, women in a relationship with a man are often perceived to suffer from infertility, regardless of whether they are infertile or not. Infertility has significant negative social impacts on the lives of infertile couples and particularly women, who frequently experience violence, divorce, social stigma, emotional stress, depression, anxiety and low self-esteem. In some settings, fear of infertility can deter women and men from using contraception if they feel socially pressured to prove their fertility at an early age because of a high social value of

⁴ [Hussein J, Ferguson L. \(2019\): Eliminating stigma and discrimination in sexual and reproductive health care: a public health imperative. Sexual and Reproductive Health Matters. Published online 2019 Dec 27](#)

⁵ [WHO, Adolescent pregnancy](#)

⁶ [WHO, Ten top issues for women's health](#)

⁷ [Schmitt S., Robjantab K., Elbertab T., Koebachab A. \(2021\): To add insult to injury: Stigmatization reinforces the trauma of rape survivors – Findings from the DR Congo. SSM Population Health, Vol 13, March 2021.](#)

⁸ See [Fistula Foundation](#)

childbearing. In such situations, education and awareness-raising interventions to address understanding of the prevalence and determinants of fertility and infertility is essential.⁹

HIV stigma and discrimination affect the emotional well-being and mental health of people living with HIV. People living with HIV often internalize the stigma they experience and begin to develop a negative self-image. They may fear they will be discriminated against or judged negatively if their HIV status is revealed. HIV stigma is rooted in a fear of HIV, misconceptions about how HIV is transmitted and what it means to live with HIV today.

Evidence suggests that women are more prone than men to experience anxiety, depression, and somatic complaints – physical symptoms that cannot be explained medically.¹⁰ Although the international community has pledged to address mental health problems related to sexual and reproductive health, too many women and men still suffer their deleterious effects.

Data source and calculation

Reporting covers cooperation, development and humanitarian (if applicable) initiatives, and investment frameworks funded by the EC (INTPA, NEAR, FPI, ECHO) and EEAS.

EUMS may provide information related to their interventions through their contributions to GAP III reports or through the EUDs, e.g., in cases of joint dialogue (i.e., as part of joint programming or TEI).

Data sources:

The intervention's monitoring and reporting systems, e.g., inception, interim and final reports from implementing organisations (including governments, international organisations, national and international civil society organisations, private sector, etc.), ROM reviews and evaluations.

Administrative records from health centres, hospitals, schools, SRHR services within the scope of the EU intervention as well as the data available at the Ministry/regional department of Health/Women's Affairs/Education and the national/regional statistics offices.

Surveys/interviews conducted and budgeted by the intervention can also be relevant data sources.

Baseline and endline studies conducted and budgeted within the EU intervention. These studies can be conducted as part of the gender country profile and/or gender sector analysis, or be based on existing official reports and published data. Baseline and endline studies should be conducted using the same data collection methodology.

Calculation:

- Analysis of results of community surveys by skilled gender and human rights specialists with expertise in the different SRHR related problems.
- Change in community's beliefs and behaviours over SRHR problems of women and girls.
- Change in knowledge, skills and attitudes of public and private SRHR services governance bodies and staff.

Worked examples

In the framework of the Support to Civil Society, Local Authorities and Human Rights call for proposal, the EU supports civil society organisations' initiatives to strengthen SRHR services in remote areas, including community awareness on SRHR.

1. In Country A, an intervention focuses on supporting women living with fistula getting treatment.
 - ⇒ The results of the end-term survey in the community show 67% increase in community's acceptance of fistula as a solvable maternal health problem.
2. In country B, an intervention focuses on promoting prevention, diagnosis and treatment of STIs, including HIV, in specialised health centres, including private health services.

⁹ [WHO, Infertility](#)

¹⁰ [WHO, Ten top issues for women's health](#)

⇒ The evaluation qualitative assessment shows 55% decreased stigma against women living with HIV as compared to the initial baseline based on the survey conducted at the start of the project. ⇒ By the end of project 75% of women living with HIV assisted by the project declared increased self-confidence. ⇒ 15% of unemployed women living with HIV assisted by the project found a job. 3. In <u>country C</u>, an intervention supports civil society organisations lobby and advocacy network to stop violence against women and girls. ⇒ At the end of the project 72% of supported families declared that survivors of rape are not guilty for the violence they suffered. ⇒ 52% of rape survivors declared they felt accepted by the community.
Baseline
Data from official counterparts (i.e., national women's machinery, national gender observatories, line ministries/authorities, statistical institutes, etc.). Data from international and national organisations working on SRHR or other independent non-state actors. If baseline data are lacking, a mapping can be done at the start of the intervention using surveys/interviews. The baseline can be 0 when the indicator is achieved with the EU funded intervention.
Disaggregation
N/A
Availability and Timeliness
Information should become available annually, depending on the duration of the intervention.
Related DAC CRS code
121 – Health, General / 12196 – Health statistics and data 122 – Basic Health / 12261 – Health education / 12281 – Health personnel development 123 – Non-communicable diseases (NCDs) / 12340 – Promotion of mental health and well-being / 12350 – Other prevention and treatment of NCDs 130 – Population Policies/Programmes & Reproductive Health / 13010 – Population policy and administrative management / 13096 - Population statistics and data / 13020 – Reproductive health care / 13040 – STD control including HIV/AIDS / 13081 – Personnel development for population and reproductive health
Associated SDGs
SDG 3 Ensure healthy lives and promote well-being for all at all ages Target 3.1, Indicator 3.1.2 (see Metadata) Target 3.3, Indicator 3.3.1 (see Metadata) Target 3.4, Indicator 3.4.2 (see Metadata) Target 3.7, Indicators 3.7.1 (see Metadata), 3.7.2 (see Metadata) Target 3.8, Indicator 3.8.1 (see Metadata) SDG 5 Achieve gender equality and empower all women and girls. Target 5.1, Indicator 5.1.1 (see Metadata) Target 5.2, Indicators 5.2.1 (see Metadata), 5.2.2 (see Metadata) Target 5.3, Indicator 5.3.1 (see Metadata), 5.3.2 (see Metadata) Target 5.6, Indicators 5.6.1 (see Metadata), 5.6.2 (see Metadata) Target 5.c, Indicator 5.c.1 (see Metadata)

Other issues

The gender country profile and/ or gender sector analysis can be relevant sources of information for establishing baselines.

If there is no gender analysis available at the EUD, it is recommended to look at the analysis undertaken by EU Member States or other trusted partners (UN, World Bank, human rights national and regional mechanisms, etc.) as well as the [national-level reviews](#) carried out in 2019 by UN Women and the partner countries to assess progress made and challenges encountered in the implementation of the Beijing Declaration and Platform for Action.

Special attention should be paid to following up on partner country institutions reached with EU support.