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Ethical Dimension of Stigmatization in Public Health

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Highlights

- Health-related stigmatization is a social process that involves the formation or reinforcement of negative social representations of certain groups of individuals, who are labelled based on health problems considered preventable or within their control.

- Behaviours, lifestyles, living conditions or other personal characteristics are attached to a moral evaluation which designates “good” or “bad” diseases, and “good” or “bad” patients. These persons are considered responsible and blamed for the risk to their health and, if applicable, for the risk to which they expose other persons. Persons so targeted suffer damage to their identity which, in extreme cases, is reduced to the health problem or characteristic. Whether real, anticipated, or perceived, stigmatization vilifies individuals and groups; it results in or worsens their social disqualification.

- The consequences of damaged identity and social disqualification vary in terms of form and intensity. For example, they may affect a person’s self-representation (loss of self-esteem), increase vulnerability to health problems, limit access to care and services or result in unjustified, different treatment (workplace or housing discrimination, etc.).

- Ethical reflection about stigmatization generally answers the question: “To what extent, and under what conditions, can public health activities be ethically justified when they are associated with stigmatization or or when do they risk reinforcing it?”

- Thus, the ethical dimensions of stigmatization relate to, each in turn, personal responsibility and autonomy, respect for dignity and non-maleficence, harm to others, equity and beneficence. The relationship between these dimensions will be clarified using a tool available in the Annex, which will foster reflection on public health actions that might directly or indirectly cause stigmatization. The tool enables identification of the values at issue and, when there is tension between them, identifies the values that take precedence in a given situation through an arbitration process. The solution chosen should reflect the precedence of values and an activity will be considered justifiable or reasonable to the extent that it is compatible with the value identified as the most important.

1 Background

In 2003, the secretariat of the Comité d'éthique de santé publique (CESP) produced a document aimed at exploring the phenomenon of stigmatization that can emerge in the context of monitoring activities (Bouthillier & Filiatrault, 2003). This was a response to concerns expressed by professionals working in the field of public health. The need to pursue and expand this line of enquiry was revived by the examination of certain files submitted to the Committee over the course of 2011. This document provides an account of this most recent round of reflection; it includes an updated discussion of work aimed at defining health-related stigmatization, and work focused on the ethical dimensions associated with this concept. A tool developed previously to support the Committee's deliberations is made available here to public health professionals. Finally, the present version of this document provides an update of the suggested literature on this subject and aims to simplify and harmonize the content presented.

Stigmatization, or the risk of stigmatization, is a very real concern for people working in public health, particularly in monitoring. Through an analysis of statistics on delinquency and urban violence, Noseda (Noseda, 2001) highlights the problem with classification and the methodological limitations linked to the interpretation of statistics. She points to the risk that the production of numerical data, in this context, can accentuate "the stigmatization of neighbourhoods whose image is already heavily connoted" [translation]. Massé, for his part, writes that "the association of the Inuit population with alcoholism or suicide is a clear example of ethnic labelling that emerged after the results of epidemiological surveys were mediatized. Labelling can also affect neighbourhoods; targeting certain disadvantaged neighbourhoods for the implementation of programs aimed at preventing the abuse and neglect of children is just as likely to stigmatize the inhabitants of the area" [translation] (2012:10).

According to Massé, this risk of stigmatization stems from the normative nature of the public health endeavour. "This normativity inherent to public health results in the general population associating certain social subgroups with health practises that are now burdened with negative connotations (for example: junk food and obesity, at-risk sexuality and sexually transmitted diseases, driving in a state of intoxication and preventable morbidity)" [translation] (Massé, 2012 :9). Indeed, stigmatization is recognized as one of the undesirable consequences of obesity (International Association for the Study of Obesity, 2010).

Stigmatization is a particularly acute problem because it can exacerbate pre-existing social and health inequalities. Thus, subgroups with a significant proportion of members who have certain health problems are often the subject of prior social devaluation. Persons in the most disadvantaged environments, for example, are already less well regarded socially. They are likely to be even more severely judged when they have a health problem associated with behaviours that are themselves disapproved of socially, all the more so if these also affect the health of their children. In other words, public health action is already in dangerous territory, with regard to the risk of stigmatization, when it affects groups with characteristics that are perceived negatively by society.

In general, stigmatization appears undesirable because it harms the persons stigmatized (damage to self-esteem, loss of social status, various forms of discrimination, etc.) and exacerbates social inequalities in health. Stigmatization also appears to have counterproductive effects on public health activities, by distancing those who are stigmatized from certain services, such as HIV screening. Thus understood, stigmatization creates discomfort for most public health stakeholders and justifies their concerns regarding this phenomenon.

Despite these various expressions of concern related to stigmatization, the concept retains some ambiguity. This is all the more relevant given that, despite expressions of discomfort regarding the harms associated with stigmatization, the latter is a social phenomenon that would be difficult to eliminate. Moreover, there are other ways to view stigmatization. This is the case with certain authors for whom the effects of stigmatization are not all negative: stigmatized populations can join forces to defend their rights and demand recognition of their human dignity; this was the case with movements for the defence of homosexuals, for example. Other authors argue that the fear of stigmatization may motivate people to avoid or modify high-risk behaviours. Bayer (Bayer & Stuber, 2006; Bayer, 2008; Bayer & Fairchild, 2015) goes so far as to connect the process of stigmatization with efforts to denormalize tobacco use, suggesting that stigmatization could be justifiable as a strategy for getting individuals to modify behaviour that is harmful to their health. Thus, there is a balance to be sought between the positive and negative aspects of the risk of stigmatization associated with certain public health measures (Weiss et al., 2006). Moreover, Bayer and Fairchild as well as Callahan (Callahan, 2013) argue, with regard to this, that the lessons drawn from the denormalization of tobacco should be applied to the fight against obesity.

The first objective of this text is to better define the concept of stigmatization. Therefore, the first section of the text presents an overview of how the concept has evolved, in order to identify the elements associated with the risk of stigmatization in public health. A second objective is to identify the ethical dimensions associated with the concept of stigmatization. Subsequently, the third section of the text focuses on the presentation of a tool designed to aid reflection and support decision-making concerning the use of public health measures that carry a risk of stigmatization. A few comments on the use of this tool are presented prior to conclusion.

2 Stigmatization

To meet the objective of determining whether a risk of stigmatization is associated with a public health activity or problem, it is necessary to develop a shared understanding of the concept in question. Based on the literature consulted, this section identifies the components of the concept, so that the presence of a risk of stigmatization linked to public health activities can be assessed as precisely as possible.

2.1 Documentary research method

A search was performed using Google Scholar and specifying the following terms: *stigma* and *stigmatization*, combined with the terms *ethics*, *conceptualization*, *definition*, *public health* and *theory;* in French, the term “stigmatisation” was paired with “santé publique.” Encyclopedic works were also consulted. A breakdown of results led to the establishment of three broad categories of documentation: empirical studies on the experience of stigmatization applied to specific cases (e.g.: obesity, HIV, mental illnesses, tobacco); theoretical proposals, usually aimed at positioning the concept of stigmatization within a particular discipline; and, finally, texts that examine its ethical dimensions, often in relation to specific health problems. Work was primarily focused on the latter two categories of documentation, as these more specifically met the objectives of this document.

For the update of this document, some follow-ups to key studies that guided the drafting of the first version were identified using the tools provided for this purpose in Google Scholar. Their integration into the present version depended on the significance of the elements they introduced. The texts thus selected focused mainly on ethical dimensions of stigmatization and stemmed from debates prompted by the position taken by Bayer on this issue.

2.2 History

Since the early 1960s, the problem of stigmatization has been of interest to various research and intervention environments, which have sought to better understand it and to alleviate its negative effects. Despite the numerous studies that have been devoted to it, the concept remains difficult to delineate (Deacon, 2006; Link & Phelan, 2001). As Courtwright points out (2013), the concept has been addressed, in turn, from perspectives as diverse as institutional and cultural norms, personal traits, the interpersonal and intrapersonal processes that characterize it, and its political and economic consequences.

The work of Goffman (Goffman, 1963) has constituted an essential reference for the development of research on stigmatization. Following his line of thought, much of the work on stigmatization was developed in the field of social psychology, where the main focus was the personal interactions that characterize the phenomenon and the psychological consequences for persons who are stigmatized. However, as noted by Pescosolido et al. (2008), Goffman’s particular analytical focus — i.e. the interactions between stigmatizer and stigmatized — does not promote an understanding of the social and cultural origins of the phenomenon. The introduction of a sociological perspective, in particular, makes it possible to position stigmatization within a broader social, economic and political context.

This perspective is best illustrated by the contributions of Link and Phelan (2001) on the one hand, and of Deacon (2006) on the other. Each of these authors proposes a model that characterizes stigmatization as a social process, which occurs within the context of a power relationship. Deacon's model is based on her work on HIV and AIDS; thus, a health situation already forms the basis for her conception of its components. As for Link and Phelan, their work addresses a more general level. The work of these authors, and mainly that of Deacon, constitutes the foundation for the first step in the decision support tool proposed further on. It should be mentioned that the components of these two authors' models have not been the subject of major revisions in recent years (Pescosolido & Martin, 2015).

2.3 Principal characteristics

While the work of Goffman (1963) constituted its foundation, the model developed by Link and Phelan (2001) marked a critical step in the conceptualization of stigmatization, by defining it as a social process. A discussion of their model is thus deemed relevant here. They describe the process with reference to five essential components.

According to these authors, the process begins with the categorization of differences between humans (skin colour, religion, professional activity, health status, etc.). This categorization gives rise to the labelling of people (Whites, Blacks, Muslims, etc.). Dominant cultural beliefs lead to the establishment of a link between labelled persons and undesirable, negative characteristics. Negative stereotyping occurs; i.e. labelled persons are reduced to this label, which is "loaded" with negative connotations. The persons thus labelled and stereotyped are considered "separate": a distance is established between "us" and "them." The persons who are labelled, stereotyped and set apart find themselves socially disqualified and disregarded. This loss of social status is accompanied by consequences of variable intensity, which may even include structural discrimination.

The fifth component of the process is the power relationships that allow the process of stigmatization to unfold. For Link and Phelan (2001), this process is only possible because social, economic and political power is exercised through norms whose respect it ensures, in particular through the identification of differences, the construction of stereotypes and the categorization of groups that are set apart from the majority, and this power is what enables the enactment of disapproval, rejection, social exclusion and discrimination. This fifth element is described in greater detail a little further on in the text.

2.4 Health-related model

Several authors have focused on the stigmatization associated with specific health problems. Based on her work on stigmatization, HIV and AIDS, Deacon (2006) proposed an understanding of the process of stigmatization rooted in a health context. The five components or characteristics of this process are as follows:

1. The **illness** (or health problem) that is subject to stigmatization is viewed as **preventable** and **controllable by the persons** affected;
2. The **behaviour** that caused the illness or is associated with the health problems is perceived as immoral or deserving of some form of **disapproval**;
3. The persons affected are associated with a **socially differentiated group**. In the terminology of Link and Phelan (2001), this would be a group that has been labelled and stereotyped and set apart based on existing social constructions of the "other";

4. Such persons are **blamed** for their illness; they are considered **responsible**;
5. Such persons experience a **loss of social status** and suffer various types of **disadvantages**, whether the stigmatization is real, anticipated or perceived.

For Deacon (2006), stigmatization is a process that is enacted by individuals in response to a real, perceived or imagined risk, and that draws on existing social representations rooted in power relationships. Stigmatization is more than a simple negative judgment one person makes about another; it directly implies membership in, or association with, a particular group, one that is often already socially disadvantaged. In the case of persons infected by HIV or with AIDS, for example, the fact that the virus first spread within the gay community gave rise to the severe stigmatization experienced by these persons; they were identified as representative of a threat from a hitherto unknown communicable disease directly associated with their sexual behaviour, one that had fatal consequences. On the other hand, certain health problems, such as mental disorders, for example, while they may not be defined as preventable or controllable by the persons affected, nevertheless inspire fear and, with or without basis, are often stigmatized.

Stigmatization tends to correlate to typical divisions between social groups, often assailing those who are already vulnerable. The effect of stigmatization can therefore be cumulative (Deacon, 2006). The consequences can take a variety of forms and vary in intensity, affecting both the person or group stigmatized and those close to them. One can, for example, observe various disadvantages related to their health, access to care, social relationships, etc. However, some can develop potentially positive responses to stigmatization, such as the resistance and activism engaged in by gay rights groups, in the context of the HIV and AIDS crisis. In addition, as mentioned above, authors such as Bayer (2008) point out that the desire to escape stigmatization can prompt people to avoid or change behaviours that pose a risk to their health, such as smoking, and this represents a positive consequence.

In addition, stigmatization can also have negative consequences for stigmatizers. For example, with regard to the prevention of health problems, and particularly infectious diseases, the manner in which stigmatizers hold stigmatized groups at a distance could lead them to conceal certain risk factors to which they might be exposed, and possibly create a false sense of security (Deacon, 2006).

Thus, the occurrences and consequences of stigmatization can take several forms. It can also be understood according to whether it is 1) enacted, as in cases of discrimination, 2) anticipated, through fear of being judged for having an illness associated with undesirable behaviour, or 3) internalized, when stigmatized persons integrate into their thinking, and even reproduce, negative judgments about the groups to which they belong (Hood & Friedman, 2011). It can also be 4) perceived, when most people consider that the persons targeted do in fact merit disapproval, or 5) received, when the persons targeted actually suffer the negative consequences of stigmatization (Pescosolido & Martin, 2015). These consequences, such as isolation, rejection, poor self-esteem, internalization of a negative self-image, stress and anxiety, affect health and well-being (Hood & Friedman, 2011). Such negative consequences can be experienced by people regardless of whether stigmatization is anticipated, internalized or clearly enacted.

While acknowledging the risk of stigmatization associated with health, Weiss (Weiss et al., 2006) points out that stigmatization should be distinguished from prudence. A public health measure, such as the isolation of persons with a contagious disease, for instance, can limit the spread of the disease and be carried out in a respectful manner, without, itself, becoming a stigmatizing process.

2.5 Social, cultural and political character

As indicated above, the social process of stigmatization occurs in the context of relationships of economic, social and political power (Link & Phelan, 2001). According to Scambler (Scambler, 2006), it is rare that an individual is simply stigmatized or exploited or oppressed; frequently, all of these occur together. Pescosolido and his collaborators (2008) advance an ecological model similar to that proposed by Bronfenbrenner (1979), in which they describe the characteristics or dynamics that can be observed at various complementary and interdependent levels; namely the *micro*, *meso* and *macro* levels.

The first level considers the characteristics of individuals, whether they are stigmatized or stigmatizing. Focused on individuals and their personal interactions, the *micro* level elements correspond to those examined by Goffman (1963): the characteristics that trigger the process of stigmatization — HIV infection or AIDS, mental illness, obesity, and so on — as well as the factors that influence their perception (transmissibility, visibility, personal responsibility, fear or threat felt by stigmatizers).

The *meso* level, for its part, comprises interactions between stigmatized persons and social groupings (communities, social networks, families), or between the stigmatized and institutions or agencies (in this example, health services). Social networks have the power to mitigate the stigmatization targeting their members, to the extent that the impact of the negative judgments directed at them can be offset by the possibility of mutual support (Pescosolido et al., 2008). However, other studies indicate that certain interaction contexts at the *meso* level, such as the family, can contribute to stigmatization. This can be the case for persons suffering from obesity, for example. Persons with mental disorders may also be rejected by their family, when the latter wishes to avoid suffering the consequences of stigmatization (Sartorius, 2006). Interactions between individuals and institutions or agencies can also inflect the phenomenon of stigmatization, either exacerbating or limiting the process (Weiss et al., 2006).

Finally, the *macro* level refers to the national, cultural and political context, including, among other things, the images conveyed by the media. In this regard, it is intuitively clear that the mass media have the power to create, modify or reinforce images — positive or negative — of groups, thus participating in the construction of their social representation. This supports the idea that stigmatization is a social construct that the mass media foster by reproducing certain ideas about certain groups. With respect to the national context, public policies, economic development and the socio-cultural context in which stigmatization occurs are all elements that can reflect, exacerbate or mitigate stigmatization.

3 Ethical dimensions of stigmatization in public health

As is evident from the description of the stigmatization process, this concept is inherently morally charged. It calls into question, collides with and creates tension between important values. Those most often evoked are human dignity, respect for persons and groups, autonomy, liberty, well-being, responsibility, equity, efficiency and health. These values are also central to public health and its strategies, such as the strengthening of individual potential.

Given that stigmatization constitutes a mechanism aimed at protecting the social order, health-related stigmatization implies that there is a health order to protect. In other words, health can be considered so significant that individuals who do not meet health norms risk social disqualification. Behaviours, lifestyles, living conditions or other personal characteristics are attached to a moral evaluation that helps define “good” or “bad” diseases, and “good” or “bad” patients.

Certain values are discussed predominantly in the literature on health-related stigmatization. Before addressing these, it should be noted that they do not comprise an exhaustive list of the values that may be relevant to any given situation. Each new situation examined must be the subject of a specific assessment; it is not a question of verifying whether or not pre-established values are at issue, but rather of identifying the values at issue by means of the assessment process itself. Nor does the subsequent discussion preassign an order of importance to the values indicated. These values proved most relevant to the development of a tool designed to assist in the examination of public health activities that carry a risk of stigmatization. The values considered are responsibility, autonomy, health protection, non-maleficence, beneficence, equity, dignity and respect for persons.

3.1 Moral responsibility and choices that influence health

In public health ethics, the issue of personal responsibility for one’s health is a thorny one, particularly because it is often used to argue in favour of reducing universal coverage of care and services (Wikler, 1987). In the literature on stigmatization, placing undue emphasis on personal responsibility — in reference to persons who are being judged, “the stigmatized” — is sometimes criticized for being reliant on individual-focused models of health-related human behaviour.

To simplify, the issue of responsibility can be represented on a continuum. At one extreme, we would consider individuals fully responsible for their choices and behaviour and, consequently, for their good or poor health, independently of any context. At the other end of the spectrum, behaviour would be completely determined by social or environmental forces, factors external to individuals, who would be assumed to have no control over these factors, and therefore have no responsibility for their actions.

Studies on the determinants of health and ecological approaches demonstrate the complex interplay of factors that influence all individual or collective decisions. From this perspective, behaviours and lifestyles can be understood as the result of a set of interactions between personal, environmental, structural, political, and other factors. This multiplicity of factors and levels of influence does not allow full responsibility to be assigned to any one source; neither solely to individuals, considered in isolation nor, conversely, solely to factors that are beyond their control. This reflects the range of capabilities and opportunities that combine in various manners for different individuals and social groups. Given this variability, the share of personal responsibility for adapting behaviour can hardly be the same for each individual. This is evidenced by the fact that the most socio-economically advantaged groups more quickly and more easily adopt recommendations related to diet or smoking, for example.

In medicine as in public health, some see it as the moral duty of each person to take individual responsibility for their health-related behaviour (Stuber et al., 2008). This current of thought is reflected to a degree in the field of health promotion, where one of the aims is to convince people to adopt healthy lifestyles, as is commonly stated. To the extent that many health promotion efforts are aimed at modifying behaviour, a leading role is assigned to individuals with regard to improving their health and the health of the population. Responsibility, in this context, implies respecting the health guidelines established by authorities; this is regarded more as a moral duty than as a value.

Comparing different cases helps illustrate how the level of individual responsibility varies according to the context and the type of behaviour at the source of a health problem. For example, intuitively, a different level of responsibility for adopting healthy lifestyles is assigned to persons from different socio-economic groups; those from more advantaged groups with a higher level of education are generally understood to have greater control over — and therefore greater responsibility toward — their health than persons from disadvantaged groups. In this sense, it is possible to conceive of responsibility as positioned on a continuum, and dependant on the circumstances under study.

3.2 Personal responsibility and autonomy

Acting in a responsible manner means acting in a way that is reasonable and prudent, while considering the consequences of our acts and omissions, along with our duties and obligations. To be responsible also means to acknowledge and to be held accountable for our choices and our actions. “The focus of the philosophical problem of responsibility is the conditions that determine accountability for our acts and omissions. […] The question of a person’s responsibility for an act or omission always arises within the context of sanctions — blame or praise with respect to morality, penalties with respect to criminal law — and philosophical reflection has closely linked the problem of responsibility to that of the justification of sanctions” [translation] (Neuberg, 2004). Thus, the concept of responsibility usually entails a response from others. More specifically, when a person performs an action that is considered reprehensible, some form of blame is expressed. The justification for blame presupposes that the person performing this action has done so voluntarily, with full awareness (Eshleman, 2009). For those who hold that personal responsibility is constrained by external forces beyond the control of individuals, blaming the latter for non-compliance with standards of health-related behaviour is tantamount to “blaming the victim” (Dougherty, 1993; Guttman & Salmon, 2004).

Reference to individual responsibility in public health evokes the value of autonomy. Denying individuals responsibility for behaviour that influences their health would be, according to Dougherty (1993), to deny their autonomy, their freedom of choice. Within the framework of a theory of deliberate action, the idea that we are “victims of social forces,” in the sense that these force us to act contrary to our preferences, is thought to be based on an erroneous conception of the relationship between the individual and the social (Pettit, 1996). Individuals are considered autonomous even if the context in which they make choices about their life partially escapes their control. The view here is that autonomy is only compromised when the conditions for exercising it are constrained, as in the case of coercion, incapacity, or lack of information. This does not mean that all choices are always available to us, but rather that the exercise of autonomy, understood as the capacity to make choices, is not fundamentally threatened when the contexts surrounding choices are sub-optimal.

As indicated in the previous section, the process of stigmatization is based on, among other things, the idea that persons are responsible, at least partially, for their problem or illness, and are therefore deserving of blame, due to their behaviour. Thus, individuals who smoke, drink alcohol, eat high-fat foods or have unprotected sexual relations are negatively judged and are blamed when their health

suffers or even simply because it could suffer. From this perspective, one could say that stigmatization attacks what is considered to be varying degrees of irresponsibility, depending on the problem in question. Indeed, although the reflective process may be considerably lacking in specificity, when comparing different cases, it is always possible to assess the level of responsibility attributable to individuals based on the type of behaviour at the source of the health problem in question.

3.3 Non-maleficence and respect for dignity

Studies on the effects of stigmatization have clearly demonstrated the negative health-related consequences for the persons affected. These include fear, anxiety, isolation and damaged self-esteem (Courtwright, 2013). Considering the value of non-maleficence, stigmatization seems at first glance to be unjustifiable due to its damaging effects on people's health, well-being and social inclusion; the more significant the potential consequences, the more unjustifiable the measures that carry a risk of stigmatization. It is in the pursuit of non-maleficence that efforts are made to prevent stigmatization or, at least, mitigate its negative consequences.

The severity of the stereotypes with which persons targeted by stigmatization may be associated also modulates its negative impact on their health and the extent to which it exacerbates social inequalities. Stereotyping and labelling comprise an ethical dimension, for one thing, because the attribution of the characteristics that form their basis is usually unfair. As Operario and Fiske (2001) point out, stereotypes over-generalize, wrongfully attribute, prescribe, and often condemn the behaviour and personal characteristics of targeted individuals (Operario & Fiske, 2001).

Massé identifies two potential results of the labelling process: amalgamation and essentialization. Amalgamation refers to when all persons who share the characteristic linked to the negatively connoted label "are considered *de facto* to be responsible for the associated health impacts, without consideration for their personal histories and specific living conditions" [translation] (Massé, 2012). Essentialization, on the other hand, refers to when the identity of individuals is reduced to the particular characteristics of the group to which they belong. This is recognizable as one of the processes underlying racism, for example.

The ethical dimension of stereotyping is evidenced by the unjust treatment of persons thus categorized. For example, persons living with HIV have been the victims of stereotyping that is strongly inflected by homophobia and moralism. The stereotypes, in this particular case, have been severe. It is intuitively clear that the stereotypes assigned to persons with HIV are more serious than stereotypes about smokers (for example, they pollute and disregard their health and the health of others [Greaves et al., 2010]). Consequently, it can be stated that the harm resulting from stereotyping is more significant for persons living with HIV than for smokers. Nevertheless, recent studies have shown that the stigmatization of smokers negatively affects their self-esteem, among other things (Burgess et al., 2009; Evans-Polce et al., 2015).

The sole fact of reducing persons to one specific characteristic or a combination of characteristics (being homosexual and HIV-positive, being obese and a consumer of junk food, being a parent in a disadvantaged environment and guilty of negligence) undermines their dignity as well as their personal and psychological integrity. The observable consequences for people's health, their well-being, their opportunities for social participation, and their access to various opportunities for skill development are proof that stigmatization harms the individuals it affects. It is also worth noting the tension between the risk of stigmatization and the public health strategy of strengthening individual

potential, a strategy that assumes the importance of self-esteem and the acknowledgement of each person's capabilities.

3.4 Harm to others

Non-maleficence can also be understood in another way. Potential damage to the health of others constitutes another ethical dimension of stigmatization in public health. In John Stuart Mill's classic text, *On Liberty* (Mill, 1859), harm to others is the condition that justifies coercive government intervention in the lives of individuals. The harm principle developed by Mill was of central importance in the fight against smoking because it formed the basis of the justification for protecting non-smokers from second-hand smoke, by means of various constraints imposed on smokers (Goodin, 1989). It is because second-hand smoke is a public health problem that the imposition of certain constraints on smokers is justifiable. Regarding such constraints, Bayer recently coauthored an article in which he denounced measures prohibiting smoking in certain public places in New York: according to the authors, "in the absence of direct health risks to others, bans on smoking in parks and beaches raise questions about the acceptable limits for government to impose on conduct" (Colgrove et al., 2011).

This suggests that harm to others constitutes, for Bayer, a necessary condition for the justification of coercive measures directed toward smokers. Other authors also consider this idea central to the rationale of the anti-tobacco campaign (Chapman, 2008). In the absence of justification based on demonstrable harm to the health of others, these measures would be unacceptable, especially since they are accompanied by negative consequences, including that of increasing the risk of stigmatizing smokers. According to the view of non-maleficence inspired by Mill's work and underlying Bayer's reasoning, the greater the harm to the health of others, the more justifiable it would be to stigmatize those who are the source of the problem. Accordingly, Bayer openly supports the stigmatization of smokers as a tobacco denormalization strategy. This idea is discussed a little further on.

3.5 Equity

As noted above, stigmatization occurs within the context of pre-existing power relationships. The fact that health-related stigmatization often overlays disparities of socio-economic status tends to exacerbate its negative consequences and reinforce social inequalities in health. Therefore, this variable should also be considered when seeking to assess the negative effects of stigmatization. For example, the group composed of men who have sex with men is overrepresented in the set of persons infected with HIV. Since, even today, this group is socially disadvantaged in some respects, stigmatization could be more intense in this case. As regards tobacco, although the mere fact of smoking exposes smokers to stigmatization (Graham, 2009; Graham, 2012; Evans-Polce et al., 2015), this does not appear to be exacerbated by a pre-existing social judgment of a specific group. Nevertheless, the fact that there is a greater proportion of smokers among groups with lower socio-economic status could mean that smokers in this group are more victimized by stigmatization, again reinforcing social inequalities in health.

Authors such as Bayer consider it potentially justifiable to implement health promotion activities that are stigmatizing and that temporarily exacerbate inequalities, provided they would contribute, in the longer term, to the health of those targeted. However, he notes that a certain degree of vigilance is required to ensure that the negative consequences do not outweigh the expected benefits (Bayer & Stuber, 2006; Bayer, 2008; Bayer & Fairchild, 2015). The logic of this position depends on a utilitarian calculation or, at least, on the concept of proportionality, where the benefits must clearly outweigh

the disadvantages. Naturally, the exacerbation of inequalities in health due to stigmatization is listed among the disadvantages.

3.6 Improving the population's health status

With reference to the subject of responsibility and blame, addressed earlier, Neuberg (2004) points out that sanctions are only of interest if they encourage individuals to exercise a certain degree of caution and care so as to prevent wrongdoing. According to some of the authors cited above, stigmatization can constitute a motivating factor that prompts individuals to change their behaviour and, in so doing, improve their health. This benefit is mainly reported by authors interested in anti-tobacco interventions that fall under the umbrella of the tobacco denormalization strategy. According to Bayer and Stuber (2006), this strategy makes use of stigmatization mechanisms, whether overtly or not, to effectively promote health. In the context of their analysis of American anti-tobacco policies, they point out that many of these policies sought to "marginalize" the consumption of tobacco products, or to characterize it as "abnormal" or "deviant." Recent studies demonstrate that smokers clearly feel the stigmatizing effects of denormalization policies (Bell et al., 2010b; Burgess et al., 2009; Evans-Polce et al., 2015).

The implicit idea here is that the success of the anti-tobacco campaign in recent years is due, at least in part, to stigmatization or denormalization. It is a short step from here to the conclusion that smokers stop smoking because they have been stigmatized, a step that both Bayer and Callahan (2013) do not hesitate to take. Drawing a parallel between denormalization and stigmatization raises concerns; these are not synonyms. Developed for the purpose of reducing smoking-related problems, denormalization can be defined as the set of actions and programs whose purpose is to strengthen the idea that tobacco use is not a socially desirable activity (Bell et al., 2010a). Although stigmatization is a response to deviation from a norm, or a way of behaving, not every deviation from a norm necessarily involves stigmatization. Therefore, it is difficult to attribute the success of tobacco denormalization policies solely to their stigmatizing nature (Goldberg & Puhl, 2013). Moreover, it is not clear that this strategy is applicable to other areas, such as obesity prevention, an area where stigmatization already occurs, but does not seem to have produced the expected effects (Tomiyama & Mann, 2013). If the expected benefits do not materialize, then Bayer and Callahan's strategy of using stigmatization to combat obesity must be called into question (MacDougall, 2013; Major et al., 2014).

4 Tool for ethical reflection on stigmatization

Ethical reflection about stigmatization generally answers the question: “To what extent, and under what conditions, can public health activities be ethically justified when they are associated with stigmatization or when do they risk reinforcing it?”

To answer this question, we must first be able to determine if the situation under study carries a risk of stigmatization. Next, we must identify which values are at issue in this situation.[1] Finally, when there is tension between the values at issue, we must determine which value takes precedence in the present situation. Arbitrating between the values at issue results in some of them being assigned greater importance, which is reflected in the solution chosen. An activity will be considered justifiable or reasonable to the extent that it is compatible with the value identified as the most important. Among the various alternative solutions that could be adopted (the choice of activities from among the scenarios or actions that could be carried out), those that also support secondary values will be preferred.

The analysis support tool presented here is intended to facilitate each of the above steps. It first aims to help determine whether there is a risk of stigmatization based on the elements associated with such a risk. Secondly, it aims to support the identification and analysis of ethical aspects related to the presence of a stigmatization risk; the goal is to assess whether the measure being examined is justifiable and reasonable, given the values at issue, and in particular the value that has been deemed most important in this situation.

The questions in the tool are generally formulated so as to focus on prevention. However, it is possible to adapt the line of questioning to the type of activity under review. For example, in the case of a project that involves monitoring the health status of a specific population, the goal would be to establish whether this population is already the target of some sort of social stigmatization (is it already the subject of negative stereotyping and is it socially set apart?).

The tool described here is included in the Annex in a form that can be used by interested parties.

[1] The present document does not aim to provide a detailed description of the ethical review process; the latter may also include a review of the norms at issue. The focus here is on the identification and analysis of the values at issue, because reflecting on stigmatization mainly involves reference to these.

4.1 Step 1: Establishing the risk

1. In general, is the illness[2] targeted by the project under study seen as **preventable?** Is the characteristic (e.g.: behaviour) targeted by the project or associated with the illness considered **controllable** by the persons affected?
2. Is the behaviour that caused the illness, or the condition that puts one at risk of illness, generally subject to **disapproval** (the persons affected are morally judged and are **blamed** for the illness or behaviour)?
3. Are the individuals or groups who have this illness or characteristic, or are targeted by the project, associated with **negative stereotypes** (for example, negative social representations associated with the illness or characteristic)?
4. Are the persons thus labelled and stereotyped **set apart** from the population as a whole? (Are they a socially differentiated group: "them" versus "us"?)
5. Do the persons affected experience a **loss of social status**, resulting in various psychological or social consequences, which sometimes include cases of substantive discrimination?

The situation carries a risk of stigmatization when the following conditions are met and are set within the context of a power relationship. The illness is seen as preventable and controllable by individuals, by virtue of the behaviour they adopt. The illness, behaviour or any other particular characteristic present in the population or subgroup concerned carries social significance that results in the labelling of persons, based on one or the other of these elements. The persons concerned are the subject of a negative moral judgment; consequently, they are exposed to social disapproval and risk being reduced to these negative characteristics or, in other words, stereotyped. Since these characteristics are undesirable, the persons who share them (or are presumed to share them) are set apart from the majority (who do not share these characteristics) in a "them" versus "us" dynamic. The persons thus labelled and stereotyped are socially devalued and suffer various types of consequences (psychological, social, etc.).

The answers to the questions in this first step will likely be nuanced. In many cases, for example, it is difficult to determine whether an illness or problem is completely preventable or totally controllable by individuals. Smoking or obesity, to name just two examples, cannot be understood as entirely controllable by the smoker or the obese person; in the first case, because smoking is an addiction and, in the second, because obesity cannot be explained without reference to the environmental and genetic factors that influence it. In addition, it may be difficult to associate individuals who have a condition or engage in socially undesirable behaviour with a specific, socially differentiated group. Referring again to the example of smokers or obese persons, such persons are observed to belong to various social groups and are not concentrated within a specific socio-economic group (although this observation is becoming increasingly less accurate in the case of smokers). Without a doubt, sharing such a characteristic (smoking, obesity) puts people at risk of being stigmatized, but not everyone will suffer the same consequences or experience them with equal intensity.

[2] The term "illness" is understood to also include the terms "health problem" or "health condition." The word "characteristic" encompasses personal characteristics that are not necessarily under a person's control, but which could be associated with negative social representations (e.g.: those attached to new migrants or gender).

4.2 Step 2: Ethical analysis of the situation

The second step aims to more precisely identify and analyze the ethical aspects of the situation to assess whether the interventions or measures are justified and whether, depending on the case, modifications should be considered. The list of elements to be considered in support of this analysis does not purport to be exhaustive; careful consideration of each specific situation may reveal other values at issue. The analysis assumes there is a risk of stigmatization or of exacerbating pre-existing stigmatization targeting some of the groups concerned (a project aimed at monitoring the health status of homeless persons, for example).

The questions proposed for this step refer back to the ethical dimensions presented in the previous section and, more directly, to the issues raised by Bayer (2008). They are intended to illustrate the harm and the benefits that would arise from any stigmatization associated with the public health activities under review. The first three questions focus on possible negative effects on the health and on the personal and social identity of the population subgroups at risk of stigmatization. In contrast, questions 4 and 5 relate to elements that could weigh in favour of some degree of stigmatization or mitigate its effects on the persons concerned. Finally, in the same vein, the last question seeks to determine if the at-risk behaviour can harm the health of others.

1. Are the **negative impacts of stigmatization on the health and well-being** of the persons concerned significant or could they be?
2. Are the **negative stereotypes** associated with the group(s) at risk of stigmatization severe and do they, therefore, risk causing any **harm** (damaged self-image, marginalization, social exclusion or discrimination)?
3. Do the project[3] under review and the risk of stigmatization associated with it exacerbate pre-existing social **inequalities**?
4. Can the proposed measures effectively **improve the health** of the persons targeted, including those that are or could be stigmatized?
5. What degree of **personal responsibility** can be attached to the behaviour at the source of the problem?
6. Does the behaviour (or any other characteristic) identified as the source of the problem cause health-related **harm to others**?

Through the ethical analysis of these elements, some of the values at issue can be identified. As mentioned above, the negative health impact of stigmatization on those targeted, the impact of stereotypes on their well-being and social integration, and the exacerbation of pre-existing inequalities are all elements that make measures carrying a risk of stigmatization less justifiable. On the other hand, beneficence and protection of the health of others could justify the public health measures under review, despite the associated risk of stigmatization. From a classical public health perspective, beneficence corresponds to the obligation to help improve the health of the population, including, in this case, groups who risk being stigmatized. In the situations considered here, this corresponds more specifically to the ability to encourage the modification of behaviours that pose a health risk, the same behaviours for which blame is assigned in the stigmatization process.

[3] The words “project” and, elsewhere, “measure” refer to any type of public health intervention, whether it be a monitoring plan, a survey, or a health promotion, prevention or protection measure.

The work of ethical reflection is to properly identify the values at issue and, especially, to establish which of these, given the circumstances, should guide decision making. The following diagram assists in weighing these values against each other to determine the reasonableness of public health activities thought to be at risk for stigmatizing certain population subgroups. It should be recalled that other values could be identified, and that a rigorous and open deliberative process makes it possible to prioritize these values, given the situation under review. For example, specific negative impacts could be identified that relate to equally specific values (liberty, autonomy, etc.).

Table 1 Determination of the reasonable, or proportional, nature of measures carrying a risk of stigmatization, based on the values at issue

Measures carrying a risk of stigmatization	
Less justifiable based on the values at issue ⟷	**More justifiable based on the values at issue**
Non-maleficence	**Beneficence**
Negative impact of stigmatization on the health and well-being of persons targeted	Potential for improvement of the population's health, including that of persons targeted by the risk of stigmatization
Negative impact of stereotypes on the social inclusion or exclusion of persons targeted	
Equity	**Protection of others**
Exacerbation of social inequalities in health	The illness or behaviour targeted causes harm to others (threat)
	Autonomy
	Share of personal responsibility attached to the behaviour in question

5 Reflection on the use of the tool

The tool proposed in this document is essentially the same one used to support deliberations by the Comité d'éthique de santé publique (CESP) on the *Plan régional de surveillance de la région de Montréal*. The results of this deliberation are not presented here, but can be consulted in the CESP's advisory report (Comité d'éthique de santé publique, 2012).

One of the main difficulties encountered in using the tool was that the questions do not lend themselves to absolute answers, that is, to being considered apart from other factors. For example, it can be difficult to assess the exact degree of control that a person might exercise over a particular behaviour. Assigning a share of personal responsibility can seem like a task mired in imprecision, given the inherent complexities of the subjects considered. The intuitions of the persons asked to deliberate on these questions vary. It is therefore important to stress that the tool's potential effectiveness is enhanced if it is used in a deliberative context involving persons with varying scientific or experiential backgrounds. In such a context, a reasonable consensus usually emerges that can serve as a basis for going forward. This was the case when the tool was used by the CESP.

The answers to questions in the tool, in particular those in the second step, do not supply a decisional algorithm; this is not the intended objective. When a risk of stigmatization was identified, there was no clear-cut path to assessing whether the proposed monitoring activities were justifiable. Identifying the values connected with the questions about potential harms and benefits facilitated this analysis; here again, the deliberative context enhanced the quality of the analysis.

During the ethical review process, the identification of values does not, by itself, determine their relative importance or ensure the reasonableness of the measures examined. Discussion should lead to a justifiable conclusion about which value should be given precedence in the current situation. This can guide decisions about whether or not to carry out the proposed activity or to introduce modifications that could mitigate the risk of stigmatization.

When using the tool, the CESP chose to solely examine the issue of stigmatization. The reflection process allowed the Committee to explore various scenarios to discern which was the most balanced, and the most justifiable, with respect to its benefits and disadvantages. The ethical review of public health policies, programs or actions can bring to light various concerns, one of which is the risk of stigmatization. Thus, the tool proposed here is one which can be integrated into a broader ethical review of public health actions.

6 Conclusion

The work of the CESP prompted it to design a tool to assist in reflecting on the presence of a risk of stigmatization and on the elements related to the potential justification of public health measures associated with such a risk. The concept of stigmatization carries ethical dimensions that receive little attention in the literature, yet more detailed discussion of these dimensions would allow for better assessment of the risk of stigmatization. For example, the concept of blame, and the underlying notion of personal responsibility, have been central to the concept since the work of Goffman (1963). Considering the social dimensions of stigmatization has made it evident that, in many cases, stigmatization coincides with and exacerbates pre-existing social inequalities. It follows that public health interventions, particularly those targeting groups identified as vulnerable, will doubtless be carried out in social contexts where the process of stigmatization is already a factor. Thus, since the risk of stigmatization is difficult to avoid in public health, we must be able to adequately assess its scope to determine whether actions are justifiable from an ethical, as well as from a scientific, standpoint.

One of the main goals of this document was to propose an understanding of the concept of stigmatization and to cast light on the ethical considerations intertwined with it. The notion of a dynamic process involving various components facilitates its differentiation from other ethical issues. In fact, a variety of public health measures can raise ethical concerns associated with autonomy, liberty, or non-maleficence — values that are also relevant to the risk of stigmatization — without necessarily being associated with this process. Thus, not everything is stigmatization and the examination of this risk does not exhaust all the ethical concerns that may be raised by public health practises. As Weiss and his colleagues have pointed out (2006), it is necessary to distinguish stigmatization from prudence, which calls for precautions to be taken in the face of certain health problems. Not all measures aimed at protecting the population from health threats will necessarily be associated with a risk of stigmatization.

For some authors, not all the effects of stigmatization are negative; it can also, in some cases, be a motivating factor that prompts people to make healthy choices. Some even go so far as to characterize stigmatization as a health promotion strategy. However, the question of whether it is legitimate for public health authorities to intentionally use the process of stigmatization, remains controversial. The parallel drawn between denormalization strategies and the process of stigmatization needs to be examined more thoroughly. Discourse surrounding empowerment and the strengthening of individual potential, with its focus on the importance of self-esteem, seems difficult to reconcile with a process that leads to shame, disapproval and social disqualification. In a context where efforts are being directed toward supporting social solidarity, tolerance of difference (combating homophobia, for example), and eliminating bullying, it seems necessary to reflect more deeply on such views.

References

Works Consulted

Bayer, R. (2008) "Stigma and the Ethics of Public Health: Not Can We But Should We" in *Social Science & Medicine,* 67: 463-72.

Bayer, R. & Stuber, J. (2006) "Tobacco Control, Stigma, and Public Health: Rethinking the Relations" in *American Journal of Public Health,* 96: 28-31.

Bayer, R. & A. Fairchild (2015) "Stigma: Time for a Hard Conversation" in *International Journal of Drug Policy*, 26, 2015, 613-614.

Bell, K., A., Salmon et al. (2010a) "Smoking, Stigma and Tobacco 'Denormalization': Further Reflections on the Use of Stigma as a Public Health Tool" A commentary on Social Science & Medicine's Stigma, Prejudice, Discrimination and Health Special Issue (67: 3) in *Social Science & Medicine,* 70: 795-99.

Bell, K., L., McCullough et al. (2010b) "'Every Space is Claimed': Smokers' Experiences of Tobacco Denormalisation" in *Sociology of Health & Illness,* 32: 914-29.

Bentham, J. (1859) "Principles of Penal Law" in *Works*, Bowring Editions.

Bouthillier, L., & F. Filiatrault (2003) *Exploration du phénomène de stigmatisation au regard des activités de surveillance de l'état de santé de la population*, Background paper. Montréal, Ministère de la Santé et des Services sociaux.

Bronfenbrenner, U. (1979) *The Ecology of Human Development*. New York: Harvard University Press.

Burgess, D. J., Fu, S.S. & van Ryn, M. (2009) "Potential Unintended Consequences of Tobacco-Control Policies on Mothers Who Smoke: A Review of the Literature" in *American Journal of Preventive Medicine,* 37 (2): S151-S158.

Callahan, D. (2013) "Obesity: Chasing an Elusive Epidemic" in *Hastings Center Report*, January-February 2013, 34-40.

Chapman, S. (2008) "Should Smoking in Outside Public Spaces be Banned? No" in *BMJ* 2008; 337:a2804.

Colgrove, J., Bayer, R. & Bachynski, K.E. (2011) "Nowhere Left to Hide? The Banishment of Smoking from Public Spaces" in *New England Journal of Medicine,* 364 (25): 2375-7.

Comité d'éthique de santé publique (2012) *Avis sur le Plan régional de surveillance de la région de Montréal 2011-2015*. Québec, INSPQ.

Courtwright, A. (2013) "Stigmatization and Public Health Ethics" in *Bioethics,* 27 (2): 74-80.

Deacon, H. (2006) "Towards a Sustainable Theory of Health Related Stigma: Lessons from the HIV/AIDS Literature" in *Journal of Community & Applied Social Psychology,* 16: 418-25.

Dougherty, C. J. (1993) "Bad Faith and Victimblaming: The Limits of Health Promotion" in *Health Care Analysis,* 1 (2): 111-19.

Eshleman A. (2009) "Moral Responsibility" in *Stanford Encyclopedia of Philosophy*, (Winter Edition), E. N. Zalta (Ed.), URL: http://plato.stanford.edu/archives/win2009/ entries/moral-responsibility/

Evans-Polce, R. J., Castaldelli-Maia, J. M. et al. (2015) "The Downside of Tobbaco Control? Smoking and Self-Stigma: A Systematic Review" in *Social Science and Medicine*, 145, 2015, 26-34.

Goffman, E. (1963) *Stigma: Notes on the Management of Spoiled Identity*, Prentice Hall.

Goldberg, D. S., & R., Puhl, M. (2013) "Obesity Stigma: A Failed and Ethically Dubious Strategy" in *Hastings Center Report*, May-June 2013, 5-6.

Goodin, R. E. (1990) *No Smoking: The Ethical Issues*. Chicago: University of Chicago Press.

Graham, H. (2009) "Why Social Disparities Matter For Tobacco-Control Policy" in *American Journal of Preventive Medicine,* 37 (2S): S183-S184.

Graham, H. (2012) "Smoking, Stigma and Social Class" in *Journal of Social Policy, 41 (1):83-99*.

Greaves, L., Oliffe, J.L. et al*.* (2010) "Unclean Fathers, Responsible Men: Smoking, Stigma and Fatherhood" in *Health Sociology Review,* 19 (4): 522-33.

Guttman, N. & Salmon, C. (2004) "Guilt, Fear, Stigma and Knowledge Gaps: Ethical Issues in Public Health Communication Interventions" in *Bioethics,* 18 (6): 531-552*.*

Hood, J. E. & Friedman, A. L. (2011) "Unveiling the Hidden Epidemic: A Review of Stigma Associated with Sexually Transmissible Infections" in *Sexual Health,* 8 (2): 159-170.

Link, B. G. & Phelan, J.C. (2001) "Conceptualizing Stigma" in *Annual Review of Sociology,* 27: 363-385.

MacDonald, D. R. (2013) "Obesity and Blame: Elusive Goals for Personal Responsibility" in *Hastings Center Report*, May-June 2013, 8-9.

Major, B., Hunger, J.M. et al. (2014) "The Ironic Effects of Weight Stigma" in *Journal of Experimental Social Psychology*, 51, 2014: 74-80.

Massé, R. (2012) "Stigmatisation sociale et santé publique : les enjeux éthiques" in *La Santé de l'homme,* No. 419, Institut national de prévention et d'éducation pour la santé.

Mill, J. S. (1859) *On Liberty*. Batoche Books Ltd., URL: https://socialsciences.mcmaster.ca/econ/ugcm/3ll3/mill/liberty.pdf

Neuberg, M. (2004) "Responsabilité" in *Dictionnaire d'éthique et de philosophie morale*, Quadridge/PUF, pp. 1679-87.

Noseda, V. (2001) Les "sauvageons" et les statistiques : le problème du classement dans l'interprétation des statistiques sur la délinquance et les "violences urbaines." Article presented during the V^{e} rencontre de Théo Quant (annual colloquium), Laboratoire ThéMa, Université Franche-Comté (France), URL: http://thema.univ-fcomte.fr/theoq/pdf/2001/TQ2001%20ARTICLE%2033.pdf

Nussbaum, M. (2004) *Hiding from Humanity: Disgust, Shame and the Law*, Princeton, NJ: Princeton University Press.

Operario, D., & Fiske, S.T. (2001) "Stereotypes: Content, Structures, Processes, and Context" in *The Blackwell Handbook of Social Psychology: The Intergroup Processes*, R. Brown & S. Gaetner (Eds.), pp. 22-44.

Pescosolido, B. A., Martin, J.K. et al. (2008) "Rethinking Theoretical Approaches to Stigma: A Framework Integrating Normative Influences on Stigma (FINIS)" in *Social Science & Medicine,* 67: 431-40.

Pettit, P. (1996) *The common mind: An Essay on Psychology, Society, and Politics*, Oxford University Press, USA.

Sartorius, N. (2006) "Lessons from a 10-year Global Programme Against Stigma and Discrimination Because of an Illness" in *Psychology, Health & Medicine,* 11 (3): 383-8.

Scambler, G. (2006) "Sociology, Social Structure and Health-related Stigma" in *Psychology, Health & Medicine,* 11 (3): 288-95.

Stuber, J., Meyer, I. & Link, B. (2008) "Stigma, Prejudice, Discrimination and Health" in *Social Science Medicine,* 67 (3): 351-7.

Tomiyama, A., J. & Mann, T. (2013) "If Shaming Reduced Obesity, There Would Be No Fat People" in *Hastings Center Report*, May-June 2013, 4-5.

Weiss, M. G., Ramakrishna, J. & Somma, D. (2006) "Health-related Stigma: Rethinking Concepts and Interventions " in *Psychology, Health & Medicine,* 11 (3): 277-87.

Wikler, D. (1987) "Who Should be Blamed for being Sick? "In *Health Education & Behavior,* 14 (1): 11-25.

World Health Organization, Department of HIV/AIDS (2011) *A new health sector agenda for HIV/AIDS: global health sector strategy on HIV/AIDS, 2011-2015,* WHO_HIV_11.03_eng.pdf, Geneva: WHO, 12 pp.

Website accessed

International Association for the Study of Obesity (IASO). http://www.iaso.org/

Annex

Tool for Analyzing the Risk of Stigmatization in Public Health

TOOL FOR ANALYZING THE RISK OF STIGMATIZATION IN PUBLIC HEALTH

Stigmatization raises ethical concerns in particular because of its consequences for the individuals and groups affected and because of the social divide it sustains. The risk of stigmatization is, however, present in many of the contexts in which public health action takes place. Thus, the latter can exacerbate, and even foster, the process of stigmatization.

This tool is intended to support ethical reflection on public health projects or interventions that risk contributing to the stigmatization of certain population groups. It was developed within the context of work carried out by the Comité d'éthique de santé publique (CESP) to assist in its deliberations. Its dissemination to public health professionals aims to raise their awareness of this concern and to equip them to address any perceived risk of stigmatization associated with their work. The theoretical foundations for its development are presented in this document. It should be stressed that the risk of stigmatization is not the only ethical concern requiring reflection that may be raised by a project.

Project being examined for risk of stigmatization

In a few lines, describe the project being examined and the various measures it comprises. Determine how the project is or could be associated with a risk of stigmatization and which groups this risk concerns.

Step 1: Establishing the risk of stigmatization

In accordance with widely cited studies (Deacon, 2006; Link & Phelan, 2001), stigmatization is understood here as a social process involving various components. This first step includes six questions inspired by these studies that will enable you to determine whether the situation you are examining carries a risk of stigmatization.

1) In general, is the illness[4] targeted by the project under study seen as **preventable?** Is the characteristic (e.g.: behaviour) targeted by the project or associated with the illness considered **controllable** by the persons affected?

2) Is the behaviour that caused the illness, or the condition that puts one at risk of illness, generally subject to **disapproval** (the persons affected are morally judged and are blamed for the illness or behaviour)?

3) Are the individuals or groups who have this illness or characteristic, or who are targeted by the project, associated with **negative stereotypes** (for example, negative social representations associated with the illness or characteristic)?

4) Are the persons thus labelled and stereotyped **set apart** from the population as a whole? (Are they a socially differentiated group: “them” versus “us”?)

[4] The term “illness” is understood to also include the terms “health problem” or “health condition. ”The word “characteristic” encompasses personal characteristics that are not necessarily under a person’s control, but which could be associated with negative social representations (e.g.: those attached to new migrants or gender).

5) Do the persons affected experience a **loss of social status**, resulting in various psychological or social consequences, which sometimes include cases of substantive discrimination?

_____

_____

_____

IS THERE A RISK OF STIGMATIZATION? _____

The situation carries a risk of stigmatization when the following conditions are met and are set within the context of a power relationship. The illness is seen as preventable and controllable by individuals, by virtue of the behaviour they adopt. The illness, behaviour or any other particular characteristic present in the population or subgroup concerned has a social significance that results in the labelling of persons, based on one or the other of these elements. The persons concerned are the subject of a negative moral judgment; consequently, they are exposed to social disapproval and risk being reduced to these negative characteristics or, in other words, stereotyped. Since these characteristics are undesirable, the persons who share them (or are presumed to share them) are set apart from the majority (who do not share these characteristics) in a “them” versus “us” dynamic. The persons thus labelled and stereotyped are socially devalued and suffer various types of consequences (psychological, social, etc.).

Step 2: Analyzing the situation from an ethical perspective

If the existence of a risk of stigmatization has been confirmed, this second step aims to establish whether the project (or, more specifically, one of its components) might foster or reinforce this definite or potential risk and, if applicable, whether this is justifiable from an ethical perspective. The questions that follow, inspired in particular by the work of Bayer (2008), focus on factors that constitute either benefits or disadvantages tied to the interventions associated with a risk of stigmatization.

1) Are the **negative impacts of stigmatization on the health and well-being** of the persons concerned significant or could they be?

2) Are the **stereotypes** associated with the group(s) at risk of stigmatization severe and do they, consequently, risk causing any **harm** (damaged self-image, marginalization, social exclusion or discrimination)?

3) Do the action being considered and the associated risk of stigmatization exacerbate pre-existing social **inequalities**?

4) Can the proposed measures effectively **improve the health** of the persons targeted, including those that are or could be stigmatized?

5) What degree of **personal responsibility** can be attached to the behaviour at the source of the problem?

6) Does the behaviour (or any other characteristic) identified as the source of the problem cause health-related **harm to others**?

_____

_____

_____

RESULT OF REFLECTION

- Are the proposed measure(s) justifiable or reasonable given the risk of stigmatization associated with them?
- What are the arguments in support of this answer?
- If applicable, are there suggestions on how to adjust the measures to reduce the risk of stigmatization or mitigate its negative consequences?

REFLECTION ON THE JUSTIFIABLE OR UNJUSTIFIABLE NATURE OF THE PROPOSAL BEING EXAMINED

The questions proposed for this second step refer back to the ethical dimensions presented in the previous section and, more directly, to the issues raised by Bayer (2008). They are intended to illustrate the harm and the benefits that would arise from any stigmatization associated with the public health activities under review. The first three questions focus on potential negative effects on the health and on the personal and social identity of the population subgroups at risk of stigmatization. In contrast, questions 4 and 5 examine the positive effects of the measures on the persons at risk of stigmatization. Could the health status of the latter be improved? Could they reduce their risk of illness if they are prompted to modify the behaviour in question? Finally, the last question seeks to determine if the at-risk behaviour can harm the health of others.

The ethical analysis of these elements allows some of the values at issue to be identified. The negative health impact of stigmatization on those targeted, the impact of stereotypes on their well-being and social integration, and the exacerbation of pre-existing inequalities are all elements that make measures carrying a risk of stigmatization less justifiable. On the other hand, beneficence and protection of the health of others could justify the public health measures under review, despite the associated risk of stigmatization. From a classical public health perspective, beneficence corresponds to the obligation to help improve the health of the population, including, in this case, groups who risk being stigmatized. In the situations considered here, this corresponds more specifically to the ability to encourage the modification of behaviours that pose a health risk, the same behaviours for which blame is assigned in the stigmatization process.

The work of ethical reflection is to properly identify the values at issue and, especially, to establish which of these, given the circumstances, should guide decision making. The following diagram assists in weighing these values against each other to determine the reasonableness of public health activities thought to be at risk for stigmatizing certain population subgroups. It should be recalled that other values could be identified, and that a rigorous and open deliberative process makes it possible to prioritize these values, given the situation under review. For example, specific negative impacts could be identified that relate to equally specific values (liberty, autonomy, etc.).

Table 1 Determination of the reasonable, or proportional, nature of measures carrying a risk of stigmatization, based on the values at issue

Measures carrying a risk of stigmatization	
Less justifiable based on the values at issue ⟷	**More justifiable based on the values at issue**
Non-maleficence	**Beneficence**
Negative impact of stigmatization on the health and well-being of persons targeted	Potential for improvement of the population's health, including that of persons targeted by the risk of stigmatization
Negative impact of stereotypes on the social inclusion or exclusion of persons targeted	
Equity	**Protection of others**
Exacerbation of social inequalities in health	The illness or behaviour targeted causes harm to others (threat)
	Autonomy
	Share of personal responsibility attached to the behaviour in question

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