

## **Stigma and power in health care for people affected by blood-borne viruses: Normative expectations and buried processes**

### **Authors:**

Treloar C<sup>1</sup>, Cama E<sup>1</sup>, Holland A<sup>2</sup>, Brener L<sup>1</sup>, Broady T<sup>1</sup>

<sup>1</sup>Centre for Social Research in Health, UNSW Sydney, <sup>2</sup>School of Psychological Science, University of Bristol, Bristol, UK

**Background:** The need to address stigma in health care has been a focus within the blood-borne virus (BBV) field for decades. Definitions of stigma include a focus on power but research on stigma in health care often does not include focused analyses of power. This study examined key informants' perspectives of BBV stigma and power in health care.

**Method:** Semi-structured interviews were conducted with 24 key stakeholders identified as experts on stigma. Participants were working in community and not-for-profit organisations, research, policy, and within health care. Analysis focused on two aspects of stigma (using Link and Phelan's conceptualisation of stigma power and Tyler's analyses of inequality and stigma): (1) norms and cultural stereotypes of aspects of BBV that reflect stigma in health systems; (2) hidden processes of stigma power.

**Results:** Key informants' narratives highlighted the reciprocal relationships between normative beliefs and social systems. Normativities (shared cultural understandings of the way "it ought to be", the "natural order") were deeply embedded in the "taken for granted" logics and practices of health systems which, in turn, supported health worker attitudes that served to stigmatise people affected by BBVs. Challenges to this assumed "natural order" could be ignored or disregarded using stereotypes of disgruntled individuals who are perceived to not have a legitimate right to make claims against powerful structures. To disrupt stigma power relations in health services, participants emphasised complaints mechanisms and centring people with lived/living experience in health systems.

**Conclusion:** People affected by BBVs can challenge accepted normative beliefs which are embedded in health systems. Health systems must be built on principles of equity and access, and held accountable by quality and safety standards, to have the best practice foundations from which to legitimise the need for change and create new normativities with stigma reduction built into accreditation standards.

**Disclosure of Interest Statement:** CT has received speaker fees from Gilead. This work was funded by NSW Ministry of Health.