https://doi.org/10.52645/MJHS.2025.4.11

UDC: 316.647.8:614.253

REVIEW ARTICLE

OPEN ACCESS

Stigmatization in medicine: impact on patients, healthcare providers, and ethical standards of care

Inga Anisei-Cojocaru*, Liliana Rogozea

Department of Fundamental, Preventive and Clinical Disciplines, Faculty of Medicine, *Transilvania* University of Brașov, Romania

ABSTRACT

Introduction. Stigmatization is a social phenomenon that adversely affects not only access to care but also the quality of medical services. In the medical context, stigma occurs when patients – or even healthcare professionals – are treated differently, with prejudice or a lack of empathy, due to certain traits, conditions, or social affiliations.

Material and methods. We conducted a narrative review of stigma in healthcare settings. Searches were performed in PubMed/MEDLINE and Google Scholar, and complemented by consulting official public-health websites (WHO, ECDC, UNAIDS, Romanian MoH/NIPH) for the period 1 Jan 2000 – 27 Jul 2025 (English/Romanian). Search strategies combined terms related to stigma/discrimination, healthcare/quality of care, and vulnerable groups, with backward- and forward-citation tracking. Two reviewers screened against predefined criteria (peer-reviewed studies, reviews, authoritative institutional reports). Opinion pieces, non-healthcare contexts, duplicates, and inaccessible full texts were excluded, and evidence was synthesized qualitatively.

Results. Stigma in healthcare appears as discriminatory behavior that fosters exclusion, leading to delayed diagnoses, treatment abandonment, and loss of trust in the system. Vulnerable groups – such as people living with HIV/AIDS, those with mental disorders, LGBTQ+ individuals, substance users, the homeless, and ethnic minorities – are most affected. HIV-positive patients often face avoidance, while those with psychiatric conditions may be seen as “unpredictable” or dangerous. Such attitudes harm patients’ health, deepen inequities, and erode the core ethics of equity and respect. Stigma undermines the patient–provider relationship, discouraging preventive care and adherence to treatment, and can cause complete disengagement. For providers, stigma fosters “dehumanization,” unconscious bias, and skewed clinical decisions, leading to substandard care. Healthcare workers experiencing their own health issues may internalize stigma, avoid seeking help, and compromise the care they deliver.

Conclusions. Health-related stigma is widespread and takes multiple forms, profoundly degrading the quality of medical care and hindering patients’ access to services. Medical stigma generates serious systemic consequences: patients delay seeking treatment, avoid interacting with the health system, suffer emotional distress and burnout, and face extreme difficulty with social reintegration. These realities underscore the need for strategic interventions in professional education, legislation, and public awareness to combat stigma in healthcare.

Keywords: social stigma, prejudice, vulnerable populations, quality of healthcare, mental health, health personnel.

Cite this article: Anisei-Cojocaru I, Rogozea. L. Stigmatization in medicine: impact on patients, healthcare providers, and ethical standards of care. Mold J Health Sci. 2025;12(4):79-86. https://doi.org/10.52645/MJHS.2025.4.11.

Manuscript received: 29.07.2025

Accepted for publication: 09.11.2025

Published: 10.12.2025

***Corresponding author:** Inga Anisei-Cojocaru, MD
Department of Fundamental, Preventive and Clinical Disciplines,
Faculty of Medicine, *Transilvania* University of Brașov, Romania
29 Eroilor Boulevard, Postal Code 500036, Brașov, Romania.
e-mail: anisei.inga@gmail.com Tel: +40 740 413 209

Key messages

What is not known yet about the issue addressed in the submitted manuscript

Stigmatization in healthcare remains a subtle yet powerful barrier to equitable access to quality care, and its full impact on patient outcomes and provider behavior is insufficiently understood in Eastern European contexts.

Authors' ORCID IDs
Inga Anisei-Cojocaru – https://orcid.org/0009-0009-4101-6619
Liliana Rogozea – https://orcid.org/0000-0001-9551-9910

The research hypothesis:

Stigma within medical systems significantly undermines trust, delays access to care, and compromises treatment adherence.

The novelty added by the manuscript to the already published scientific literature

This article synthesizes current evidence on health-related stigma, focusing on HIV, mental health, and internal stigma among healthcare providers, while highlighting structural gaps and presenting concrete strategies for stigma reduction in healthcare.

Introduction

In an era of remarkable technological and scientific advances in medicine, the relationship between patients and the healthcare system remains paradoxically marked by vulnerability and inequity. One of the least discussed yet highly influential forms of imbalance is stigmatization – a social phenomenon that affects not only access to care but also the quality of medical treatment itself. This subtle but frequent form of discrimination impacts the dignity and well-being of patients and is seldom addressed in depth.

Broadly defined, stigma is a social process by which certain individuals are negatively labeled and excluded based on real or perceived attributes deemed deviant from social norms. Sociologist Erving Goffman described "stigma" as an attribute that deeply discredits an individual in the eyes of society, reducing them "from a whole and usual person to a tainted, discounted one" [1]. In other words, stigma is a "deeply discrediting" trait that diminishes a person's social identity. In healthcare, this process takes on an especially grave connotation: prejudices arise not only from the general society but sometimes from those entrusted with care and life preservation. Stigma can be external (imposed by others) or internal, when an individual internalizes shame and withdraws from necessary care. Stigmatization, as an expression of shame, is often described as having four components: labeling the affected person, generalizing that label to all patients with the same condition, defining them as an "inferior" group, and thus leading to discrimination.

In medicine, stigma involves a distinct power dynamic and vulnerability between patient and healthcare provider. Stigmatization in medicine occurs when patients – or even healthcare professionals – are treated differently, with prejudice or a lack of empathy, because of a particular attribute, illness, or social affiliation. This often-unconscious process creates a climate of exclusion and shame that can have dire consequences: delayed diagnosis, interruption of treatment, patient alienation, and erosion of trust in the health system. Stigma in healthcare can be expressed through biased attitudes, behaviors, or clinical decisions influenced by prejudice against certain categories of patients: those with mental illnesses, substance use disorders, HIV/AIDS, LGBTQ+ patients, people with obesity, or individuals from marginalized ethnic groups. Such stigmatization may occur at the individual level (during doctor–patient interactions) and at the institutional level (through policies or practices that perpetuate inequality) [2]. Indeed, far from being an isolated phenomenon, medical stigma has serious consequences: stigmatized patients tend to avoid the medical system, not follow recommended treatments, or suffer in silence, thereby worsening their health status. Moreover, stigma affects healthcare professionals as well. Due to a culture of silence and pressures of perfectionism, providers can fall victim to stigma themselves – particularly regarding their own mental health – which further perpetuates harm within the system.

This study aims to explore the phenomenon of stigma in medicine from a comprehensive perspective, analyzing the causes of medical stigmatization, the most affected categories of people, the consequences on the doctor–patient relationship, and possible solutions to reduce this harmful behavior. In a patient-centered healthcare system, understanding and combating stigma should become a professional and ethical priority. In a world where health is considered a fundamental right, it is essential to recognize how prejudices can sabotage this right, especially when the humanistic and ethical aspects of medical care are sometimes neglected.

Material and methods

We conducted a narrative review on health-related stigma in healthcare settings. Searches were run in PubMed/MEDLINE and Google Scholar, complemented by targeted consultation of official public-health websites (World Health Organization, European Centre for Disease Prevention and Control, UNAIDS, Romanian Ministry of Health/National Institute of Public Health). The coverage period was 1 January 2000 – 27 July 2025, and publications in English and Romanian were eligible. Search strings combined controlled vocabulary and free-text terms for stigma/discrimination, healthcare/quality of care, and vulnerable groups, with condition/population modifiers (e.g., HIV, mental health, healthcare workers). Reference lists of included papers and their forward citations were screened to extend retrieval.

We included peer-reviewed original studies, reviews, and authoritative institutional reports examining stigma within healthcare settings and reporting empirical findings, conceptual frameworks, or policy-relevant evidence. We excluded editorials and opinion pieces without data, items unrelated to healthcare settings, duplicates, non-English/Romanian publications, and records without accessible full text. Titles, abstracts, and full texts were independently screened by two reviewers (I.A.-C., L.R.), with disagreements resolved by discussion; data were charted on setting, population, stigma type, outcomes (e.g., access, quality of care, adherence), and implications. Owing to heterogeneity in designs and outcomes, evidence was synthesised qualitatively; no meta-analysis or formal risk-of-bias assessment was undertaken.

Results

Overall manifestations of stigma in healthcare

Stigmatization in the medical field arises when patients – or even medical staff – are subjected to discriminatory, empathy-lacking, or prejudice-based treatment due to an illness, personal trait, or membership in a certain social group. Although often unintentional, such attitudes foster an environment of exclusion and shame, which can have serious effects: delays in establishing diagnoses, treatment abandonment, social isolation, and loss of confidence in health services. In healthcare settings, certain patient populations are consistently exposed to a higher risk of stigma, both from medical personnel and from society at large. Among the most affected groups are people living with HIV/AIDS, patients with mental health disorders, members of the LGBTQ+ community, substance users, the homeless, and ethnic or racial minorities. These groups are often viewed through the lens of negative stereotypes, leading to systemic discrimination, limited access to quality medical services, and deterioration of the therapeutic relationship. For example, HIV-positive patients may be avoided or treated with reluctance by healthcare workers, while patients with psychiatric disorders might be seen as uncontrollable or "dangerous" even in the absence of acute symptoms. Such attitudes not only harm the physical and mental health of patients but can also perpetuate social and health inequities, undermining fundamental principles of medical ethics such as equity, respect, and non-discrimination. A global framework on health-related stigma emphasizes that stigma within health facilities is a significant barrier to care and must be addressed to uphold ethical standards in medicine.

The doctor–patient relationship is an essential pillar of medical practice, built on trust, open communication, and mutual respect. Stigmatization – manifesting as negative attitudes, prejudices, or discriminatory behaviors – profoundly alters this relationship, with major consequences for the quality of medical care. The damage to the therapeutic alliance extends beyond the immediate clinical encounter to public health at large: patients who do not trust the system are less willing to participate in screening programs, preventive services, or vaccination campaigns. For example, in communities with high stigma, transmissible diseases such as HIV or tuberculosis may remain underdiagnosed and undertreated because affected individuals avoid engagement with health services. Research indicates that stigma and prejudice can deter people from utilizing healthcare even when they need it, illustrating how stigma can be as harmful as the diseases it is attached to.

From the patient's perspective, the perception or experience of discrimination by healthcare providers can lead to avoidance of the health system, delayed presentation for medical consultations, or outright refusal of treatment. Numerous individuals living with HIV, mental illness, or conditions associated with social stigma (such as hepatitis C, obesity, or substance dependence) report feeling judged, ignored, or treated superficially in their interactions with medical staff. These experiences erode patients' trust in medical advice and can result in poor adherence to treatment or even complete disengagement from care [3, 4]. When patients anticipate stigma, they may postpone seeking care until conditions worsen or avoid disclosing critical information about their health, leading to suboptimal outcomes.

From the healthcare provider's perspective, stigmatization can lead to the dehumanization of patients, compromising the provider's ability to act with empathy, ethics, and fairness. Implicit biases – often unrecognized by the clinician – can negatively influence clinical decisions: stigmatized patients might receive fewer diagnostic investigations, more cursory examinations, or be excluded from cutting-edge treatments. This creates a vicious cycle in which the stigmatized patient receives inferior care, and the clinician forfeits professional objectivity. For instance, studies have documented that patients who are marginalized (by HIV status, mental illness, etc.) sometimes receive less thorough work-ups or are managed less aggressively due to provider biases. Such practices not only harm individual patients but also contravene evidence-based medicine and fairness. In essence, stigma in the clinic can subvert the standards of care, leading to health disparities among already vulnerable groups [5].

Stigma in HIV care

Stigma surrounding HIV/AIDS remains one of the largest barriers to achieving global HIV control. It impedes testing, disclosure, and treatment adherence, leading to late diagnoses and limited treatment access. HIV-related stigma and discrimination are consistently cited as major obstacles to ending the AIDS epidemic [6]. Many people are reluctant to get tested for HIV or to reveal a positive status, to use prevention methods like PrEP, or to take life-saving HIV treatment specifically because of stigma and fear of negative reactions. According to the first-ever global People Living with HIV Stigma Index report (covering 25 countries and over 31,000 participants), 85% of people living with HIV acknowledged experiencing internalized stigma, and 25% reported actual discrimination by healthcare personnel. In Romania, a national study in 2022 (HIV Outcomes Romania, in collaboration with the *Matei Balș* Institute) involving 1,050 people with HIV found a stigma prevalence of 39.9% compared to the general population. Nearly half (48.4%) of respondents believed that women with HIV are more stigmatized, and 59.5% felt that children living with HIV also experience significant stigma [7]. HIV stigma is often intersectional, overlapping with prejudice related to other marginalized identities. People living with HIV frequently face multiple layers of stigma stemming from factors such as ethnicity, sexual orientation, gender identity, or moral judgments attached to behaviors or conditions (e.g., drug use, sex work, poverty). In 64 low- and middle-income countries, the prevalence of stigmatizing attitudes toward people with HIV ranges from about 13% (in Rwanda) to 91% (in Samoa), demonstrating vast global variability. Importantly, higher levels of societal stigma correlate with significantly lower rates of HIV testing uptake.

Stigma in healthcare settings directly affects patient care for those with HIV. In a large European survey of 3,272 patients across 54 countries, 26% reported fear of being treated differently by healthcare professionals if their HIV status was known, 23% had been outright denied care or faced treatment delays due to HIV status, and 33% felt they were treated poorly in healthcare facilities because of being HIV-positive. Within medical facilities, 66% of HIV patients reported encountering direct discrimination from staff, and about 30% delayed testing or disclosure of their status due to fear of stigmatization [8]. These findings illustrate how stigma can permeate clinical interactions, resulting in substandard care and patient disengagement. Despite a global commitment to eliminate HIV-related discrimination in healthcare settings – and the availability of validated tools to measure stigma and evidence-based interventions to reduce it – efforts to incorporate stigma-reduction activities broadly into healthcare remain limited. Training of healthcare workers has proven effective in closing knowledge gaps that can perpetuate HIV stigma, but training alone does not address other factors (such as entrenched attitudes and institutional cultures) that produce and reinforce stigma. Innovative approaches, such as applying quality improvement methods to stigma reduction, have been suggested to identify root causes of discrimination at both individual and system levels and to create contextually appropriate, evidence-based responses. One study demonstrated that a quality improvement intervention in healthcare settings can significantly reduce HIV-related stigma and discrimination by targeting structural drivers and workflow changes [9]. Ultimately, stigma against patients with HIV leads to a significant degradation in quality of care, affecting communication, trust, and treatment adherence. When healthcare workers harbor biases against a group of patients, those patients may receive superficial, incomplete, or delayed care, directly compromising health outcomes.

It is imperative to intensify efforts to address HIV-related stigma and discrimination. This includes highlighting its harmful effects to policymakers capable of amending discriminatory laws that perpetuate stigma, as well as implementing community-led monitoring to document and tackle stigma in healthcare and other community settings. High levels of internalized stigma among people with HIV underscore the importance of access to mental health support. Without such support, individuals with HIV are more likely to refuse or discontinue treatment and to experience mental health problems. Mental health services are especially critical for HIV-positive people who are also gay, transgender, sex workers, or people who use drugs, particularly youth in these groups.

Stigma in mental healthcare

Despite mental health conditions affecting nearly one in five people worldwide, an estimated 70-90% of individuals with mental illness report encountering social or professional stigma, and around 60% do not seek help for this reason. Stigma creates a deep barrier that prevents millions from accessing necessary care and impedes recovery. Among the most damaging stereotypes about people with mental illness is the belief that they are unpredictable and dangerous. Public perception of violence risk is often exacerbated by sensationalized media portrayals: both entertainment media and news outlets tend to present exaggerated, distorted representations of psychiatric disorders, reinforcing ideas of unpredictability, danger, and violence. Such portrayals significantly influence public attitudes, leading to widespread misconceptions about mental illness. As a result, a large segment of the population believes that people with mental disorders are not trustworthy and feels uncomfortable with the idea of working or living alongside them. Alarmingly, healthcare professionals are not immune to stigmatizing views – negative attitudes toward mental illness, including conditions like schizophrenia, are also found among medical providers themselves.

Healthcare professionals have considerable influence in shaping health-related attitudes among both the general public and patients. Medical students, in particular, are a critical group to focus on, as they are future health professionals and there is an opportunity to correct stigmatizing attitudes during their education. Studies using instruments such as Link's Social Distance Scale have found that medical students may exhibit moderately negative attitudes, with prevalent social distance and stereotypes toward patients with mental illness. Notably, international medical students showed more unfavorable attitudes compared to Romanian students in one comparative study [10]. Stigma among health providers is not always conscious; often, medical staff operate under culturally or socially ingrained unconscious biases. These biases can affect diagnosis, the clinician–patient interaction, and therapeutic decisions. For instance, a patient with a mental health disorder might not receive the same thorough evaluation or timely treatment for a concurrent medical condition if the provider's biases lead them to attribute symptoms to the psychiatric illness or to assume the patient is less capable of adherence.

In Romania, a systematic review from 2023 highlighted that public stigma toward mental illness is higher than in some other European countries [11]. The researchers reported numerous adverse effects of stigma, including reluctance to seek help or to engage and remain in treatment, as well as an overall increase in comorbidity and mortality among those with mental illness. Stigma also leads to fewer opportunities for education, employment, and social interaction, as well as difficulties in obtaining housing for affected individuals [11]. In light of these concerns, the World Health Organization (WHO) and many international alliances have underscored the importance of reducing both public and structural stigma through anti-stigma interventions and advocacy for policy change [12]. Currently, mental health services in Romania are available only in certain regions of the country, and collaboration with other health institutions remains limited. This lack of coordination contributes to the discrimination faced by people with mental disorders, impeding their equitable access to care. The overwhelming evidence points to an urgent need to prioritize health professionals as a primary target for anti-stigma interventions.

Findings also reveal two essential aspects: an absence of a clear theoretical framework for addressing community-level stigma and a very small number of publications on this topic in the local context. These gaps can themselves be interpreted as manifestations of structural stigma – they reflect, at least in part, insufficient funding and the undervaluing of mental health compared to other medical fields. The consequences are numerous: existing interventions tend to be isolated, poorly coordinated, and inadequately communicated, resulting in limited long-term impact. Ultimately, all these factors contribute to the perpetuation of stigma and discrimination against people with psychiatric disorders. Structurally, the mental healthcare system in Romania is underfunded and inefficient, which in itself leads to discriminatory outcomes. For example, the absence of psychiatry departments in many general hospitals can be seen as a sign of a stigmatizing structure that segregates mental healthcare, implying it is less of a priority or should be kept separate from "general" medicine. This structural shortcoming exacerbates inequitable care and reinforces stigma.

Stigma among healthcare professionals

Stigmatization within the medical system is not only an external phenomenon affecting patients but also an internal one, impacting healthcare professionals themselves. Medical personnel can be both sources and targets of stigma, especially when they suffer from mental health conditions, infectious diseases (such as HIV or hepatitis), or belong to marginalized social groups. Studies have shown that health professionals who experience depression, anxiety, or burnout often avoid seeking help, fearing that they will be perceived as incompetent or weak by their peers and superiors [13, 14]. This internalized and institutionalized stigma leads to underdiagnosis and lack of treatment for mental health issues among medical staff, directly affecting the quality of care provided to patients. For instance, a significant number of medical students and practitioners report mental health problems but choose not to access support services due to anticipated stigma or career repercussions [14, 15]. In a multi-institutional U.S. survey of medical students, many self-reported psychological distresses yet were reluctant to formally seek help, highlighting the stigma attached to mental health within medical culture [15]. Many clinicians fear that disclosing a need for mental health support could jeopardize their careers – for example, they worry about potential loss of their medical license or discrimination in the workplace if their struggles become known. One survey of female physicians found that most would avoid seeking mental health treatment out of concern that having a documented diagnosis could tarnish their professional record [14]. This deeply rooted "culture of silence" exacerbates risks for both healthcare providers and patients. Providers face a professional and personal paradox: despite being trained to care for others' health, their own health (particularly mental health) is often ignored or minimized. When these professionals suffer from depression, anxiety disorders, stress-related conditions, or burnout, they risk not only personal distress but also becoming targets of stigma from colleagues, the institution, or through self-stigmatization. Self-stigma is one of the most dangerous forms because it deters individuals from seeking the psychological support they need. Moreover, many providers fear that admitting to such issues could carry punitive consequences for their careers – such as being deemed unfit for duty or facing bias in promotion – reinforcing their silence [14].

On the other hand, stigma can also manifest between colleagues. For example, HIV-positive healthcare workers may be excluded from team activities or relegated to demeaning professional roles by their peers. In the absence of clear anti-discrimination policies at the institutional level, this peer-driven stigma persists and contributes to a toxic work culture. During the COVID-19 pandemic, frontline healthcare workers were frequently stigmatized by the public, being seen as "disease carriers." This societal stigma led to social isolation and significant emotional difficulties for many providers. The consequences of unaddressed internal stigma in the health professions are profound. Lack of intervention results in the worsening of providers' mental health symptoms, increases the likelihood of medical errors, and erodes empathy in patient care. Disturbingly, there is also a consistently documented increased risk of suicide among medical professionals – especially physicians, and notably female physicians – which has been linked to the pressures of stigma and not seeking timely care. Instead of being a place of support, the hospital environment can become one of emotional isolation, where vulnerability is hidden behind a veneer of professionalism.

To combat this internalized stigma, it is essential to promote an institutional culture that recognizes mental health as an integral component of professional well-being. Confidential psychological support programs for staff, training in mental health awareness, and internal campaigns to reduce stigma can encourage healthcare workers to seek help without fear of judgment. For example, some hospitals have introduced confidential counseling services and peer support groups for clinicians, resulting in increased utilization of mental health resources by staff. Educating healthcare teams about burnout and depression as common, treatable issues can normalize help-seeking. Additionally, clear anti-stigma and anti-discrimination policies at the workplace – accompanied by enforcement mechanisms – are necessary to change the "hidden curriculum" that a "real" professional must always be resilient and without personal vulnerabilities. Only by acknowledging and treating this internal stigma can the medical system become a safer, more empathetic, and more functional space for both providers and patients.

Discussion

Combating stigma in healthcare requires a coherent, multidimensional approach that targets individual, institutional, and systemic levels. Firstly, continuous education and training of healthcare workers on topics such as cultural diversity, empathetic communication, and recognition of implicit biases are essential to prevent discriminatory behaviors in clinical practice. Sensitizing medical students and professionals to stigma issues can foster empathy and self-awareness, which are crucial for changing attitudes. Secondly, at the institutional level, implementing clear anti-stigma policies – accompanied by mechanisms for monitoring and reporting discriminatory incidents – helps create a safe and inclusive environment for all patients. This may include formal protocols to address patient complaints of discrimination, regular staff training on ethics and patient rights, and leadership commitment to a zero-tolerance stance on stigma. Thirdly, at the structural level, integrating services for marginalized groups (such as people living with HIV, those with mental health disorders, or ethnic minorities) into general healthcare systems can reduce the fragmentation of care and promote equitable access [16]. For example, ensuring that mental health services are available within primary care settings or that HIV care is integrated into general clinics helps normalize these services and reduce "othering" of patients. Public awareness campaigns are also pivotal: partnerships with media, educational institutions, and community organizations can dispel myths and reduce social prejudice by promoting science-based information and messages of empathy. For instance, national anti-stigma media campaigns have been used to humanize people with mental illness or HIV, showing success in improving public attitudes in various countries. Equally important is the involvement of affected communities in designing and implementing stigma-reduction initiatives. Engaging people who have experienced stigma in co-creating programs and policies leads to solutions that are more relevant, credible, and sustainable in the long term [17]. These human rights–centered and socially just approach ensure that interventions address the real needs and concerns of those most impacted by stigma. In summary, a multifaceted strategy – combining education, policy, community engagement, and structural reform – is critical to meaningfully reduce health-related stigma.

To illustrate, several recent programs have demonstrated efficacy in reducing stigma and improving access to care. These examples suggest that effective anti-stigma strategies blend targeted education, participation of vulnerable groups, and rigorous evaluation, yielding significant improvements at both institutional and individual levels:

- *Human Rights Curriculum in Medical Education (Moldova):* Beginning in 2023, *Nicolae Testemițanu* State University of Medicine and Pharmacy in Chișinău, in partnership with UNAIDS and with financial backing from the Embassy of Sweden, introduced "Human Rights in Healthcare" as a compulsory course across all faculties. Rather than being a standalone course, this content is integrated into clinical disciplines such as gynecology, surgery, and infectious diseases. Students are trained in topics including patient confidentiality, communicating with HIV-positive patients, and ethical self-evaluation. Preliminary results are promising: anonymous evaluations indicate a significant increase in medical students' empathy and awareness of patients' rights following the curriculum's implementation [18].
- *ADAPT-ITT Stigma Intervention Adaptation (Tanzania):* In Dar es Salaam, Tanzania, a group of researchers adapted an existing HIV stigma-reduction program using the ADAPT-ITT framework to also address stigma associated with people who use drugs (PWUD). The process was highly participatory, directly involving patients and clinical staff. Key steps included initial formative research, development of a tailored manual, stakeholder workshops, and pilot testing of the adapted intervention. The resulting program aimed to change healthcare providers' attitudes and create a more inclusive, non-judgmental environment, ultimately improving retention of PWUD in HIV treatment. By broadening the focus of an HIV stigma intervention to encompass drug-use stigma, the program recognized the intersecting prejudices that often impede care. Early outcomes suggest improved clinician attitudes and better engagement of PWUD in care [19].
- *Anti-Stigma Training for Healthcare Workers (Bangladesh):* A training program in Bangladesh targeted over 300 healthcare professionals working in adolescent health and reproductive health services. The curriculum included dedicated sessions on HIV-related stigma, LGBTQ+ identities, and common stereotypes regarding sexuality. The training was delivered as a two-day course, with a follow-up reinforcement session six months later. The impact was significant: providers' attitudes toward HIV-positive patients and sexually active youth became markedly more accepting. For example, the proportion of trainees who believed that people with HIV "should feel ashamed" dropped from 35% before training to 16% after training. Likewise, patient satisfaction among young clients rose from 63% pre-intervention to 98% post-intervention, indicating that the changes in provider attitudes translated into improved patient experience [20]. This example underlines how focused education, combined with follow-up support, can substantially reduce stigmatizing beliefs and improve the quality of care.

Notably, stigma can hinder healthcare effectiveness in less direct ways as well. Patients who anticipate judgment or discrimination may withhold important information about their health behaviors or conditions, compromising the accuracy of clinical assessments and public health data

[21]. For instance, someone at risk for HIV might not disclose certain behaviors to a doctor out of shame, leading to missed opportunities for testing or prevention. Such gaps in data can distort public health strategies that rely on honest reporting of risk factors. Stigma also has the potential to erode trust in the healthcare system and in public health authorities, which becomes especially critical in contexts such as pandemics, where community cooperation is essential. During the COVID-19 pandemic, for example, stigmatization of medical personnel and of patients who contracted the virus impeded the implementation of public health measures and increased the public's reluctance to undergo testing or vaccination. Fear of being stigmatized led some to avoid testing for COVID-19 or to hide symptoms, thereby hampering disease control efforts. These instances highlight that reducing stigma is not only a moral or ethical imperative but also a strategic necessity for the effective, equitable, and sustainable functioning of health systems.

Conclusions

Stigmatization in healthcare is a pervasive phenomenon, manifested in multiple forms and profoundly affecting the quality of medical care and patient access to services. Patients belonging to stigmatized groups – such as people living with HIV, individuals with mental health disorders, substance users, or ethnic minorities – often face prejudice and even denial of care. Medical stigma leads many patients to delay seeking treatment or to avoid the health system entirely due to fear of judgment or prior discriminatory experiences. This avoidance behavior contributes to late diagnoses, poor treatment adherence, and worsening health outcomes. In parallel, stigmatization inflicts significant emotional distress on patients (including feelings of shame and low self-worth) and complicates their social reintegration. Stigma in healthcare also violates the principle of equity in access to services and can have system-wide repercussions by undermining trust in medical institutions and public health initiatives.

Addressing health-related stigma is imperative. Strategic interventions in medical education, such as incorporating anti-stigma and empathy training, can prepare healthcare professionals to recognize and counteract their biases. Clear policies and legislation against discrimination in healthcare settings are needed to provide accountability and protect both patients and providers. Furthermore, sustained public awareness and advocacy campaigns are essential to challenge societal prejudices and normalize seeking care for all individuals, regardless of their condition or background. Reducing stigma in healthcare is not only a matter of ethics and human rights but also a critical step toward improving clinical outcomes and strengthening health systems. By fostering an inclusive and compassionate healthcare environment, we can ensure better quality of care, enhance patient trust and engagement, and promote the fundamental principle of health equity.

Competing interest

None declared.

Contribution of authors

IAC conceived the study, conducted the literature review and analysis, and drafted the manuscript. LR supervised the research as academic coordinator, contributed to the study design and data interpretation, and critically revised the manuscript. Both authors reviewed and approved the final version of the manuscript.

Ethics approval

Not needed for this study

Acknowledgements and funding

The authors express their gratitude to the *Transilvania* University of Brașov, Faculty of Medicine, for providing academic support and access to scientific resources during the preparation of this article. Special thanks are also extended to the *Nicolae Testemițanu* State University of Medicine and Pharmacy, Chișinău, Republic of Moldova, for institutional support in facilitating the publication process. No external funding was received.

Provenance and peer review

Not commissioned, externally peer-reviewed.

References

1. Goffman E. Stigma: notes on the management of spoiled identity. Englewood Cliffs, N.J.: Prentice-Hall; 1963. 147 p.
2. Thornicroft G, Mehta N, Clement S, Evans-Lacko S, Doherty M, Rose D, et al. Evidence for effective interventions to reduce mental-health-related stigma and discrimination. Lancet. 2016;387(10023):1123-1132. doi: 10.1016/S0140-6736(15)00298-6.
3. Phelan JC, Link BG, Dovidio JF. Stigma and prejudice: one animal or two? Soc Sci Med. 2008;67(3):358-367. doi: 10.1016/j.socscimed.2008.03.022.
4. Earnshaw VA, Chaudoir SR. From conceptualizing to measuring HIV stigma: a review of HIV stigma mechanism measures. AIDS Behav. 2009;13(6):1160-1177. doi: 10.1007/s10461-009-9593-3.
5. Nyblade L, Stockton MA, Giger K, Bond V, Ekstrand ML, Lean RM, et al. Stigma in health facilities: why it matters and how we can change it. BMC Med. 2019;17(1):25. doi: 10.1186/s12916-019-1256-2.
6. Phillips H. High rates of HIV stigma revealed by first ever Stigma Index global report. 2023 Dec 21. In: Be in the KNOW [Internet]. Brighton: Avert; 2023 [cited 2025 Jul 27]. Available from: https://www.beintheknow.org/news-and-blogs/high-rates-hiv-stigma-revealed-first-ever-stigma-index-global-report
7. Barbosu CM, Avirvarei C, Manciuc C, Dye T. Stigma-associated attitudes and practices among Romanian clinical providers. HIV Med. 2025;26(3):390-398. doi: 10.1111/hiv.13742.
8. Gesesew HA, Gebremedhin AT, Demissie TD, et al. Significant association between perceived HIV-related stigma and late presentation for HIV/AIDS care: systematic review and meta-analysis. PLoS

One. 2017;12(3):e0173928. doi: 10.1371/journal.pone.0173928.

9. Ikeda DJ, Nyblade L, Srithanaviboonchai K, Agins BD. A quality improvement approach to the reduction of HIV-related stigma and discrimination in healthcare settings. BMJ Glob Health. 2019;4(3):e001587. doi: 10.1136/bmjgh-2019-001587.
10. Popescu CA, Buzoianu AD, Suciu SM, Armean SM. Attitudes toward mentally ill patients: a comparison between Romanian and international medical students. Clujul Med. 2017;90(4):401-406. doi: 10.15386/cjmed-776.
11. Mănescu EA, Henderson C, Paroiu CR, Mihai A. Mental health-related stigma in Romania: systematic review and narrative synthesis. BMC Psychiatry. 2023;23:662. doi: 10.1186/s12888-023-05147-3.
12. World Health Organization (WHO). Comprehensive mental health action plan 2013-2030 [Internet]. Geneva: World Health Organization; 2021 [cited 2025 Jul 27]. Available from: https://iris.who.int/handle/10665/345301.
13. Henderson C, Noblett J, Parke H, Clement S, Caffrey A, Gale-Grant O, et al. Mental health-related stigma in health care and mental health-care settings. Lancet Psychiatry. 2014;1(6):467-482. doi: 10.1016/S2215-0366(14)00023-6.
14. Gold KJ, Andrew LB, Goldman EB, Schwenk TL. "I would never want to have a mental health diagnosis on my record": a survey of female physicians on mental health stigma. Gen Hosp Psychiatry. 2016;43:51-57. doi: 10.1016/j.genhosppsych.2016.09.004.
15. Dyrbye LN, West CP, Satele D, Boone S, Tan L, Sloan JA, Shanafelt TD. The impact of stigma and personal experiences on the help-seeking behaviors of medical students with burnout. Acad Med. 2015;90(7):961-969. doi: 10.1097/ACM.0000000000000655.
16. Stangl AL, Earnshaw VA, Logie CH, Van Brakel W, Simbayi LC, Barré I, et al. The health stigma and discrimination framework: a global, cross-cutting framework to inform research, intervention development, and policy on health-related stigmas. BMC Med. 2019;17(1):31. doi: 10.1186/s12916-019-1271-3.
17. Earnshaw VA, Kalichman SC. Stigma experienced by people living with HIV/AIDS. In: Liamputtong P, editor. Stigma, discrimination and living with HIV/AIDS: a cross-cultural perspective. Dordrecht: Springer; 2013. p. 23-38. doi: 10.1007/978-94-007-6324-1_2.
18. Joint United Nations Programme on HIV/AIDS (UNAIDS). Towards stigma-free healthcare for people living with HIV in Moldova [Internet]. Geneva: UNAIDS; 2025 May 23 [cited 2025 Jul 27]. Available from: https://www.unaids.org/en/resources/presscentre/featurestories/2025/may/20250523_moldova
19. Mlunde LB, Saalim K, Mbwambo JK, Kiwia P, Fitch E, Manyama W, et al. Adapting a health facility HIV stigma-reduction participatory training intervention to address drug use stigma in HIV care and treatment clinics in Dar es Salaam, Tanzania. Harm Reduct J. 2024;21(1):65. https://doi.org/10.1186/s12954-024-00965-4.
20. Haberland NA, McCarthy KJ, Brady M. A systematic review of adolescent girl program implementation in low- and middle-income countries: evidence gaps and insights. *J* Adolesc Health. 2018;63(1):18-31. doi: 10.1016/j.jadohealth.2017.11.294.
21. Logie CH. Lessons learned from HIV can inform our approach to COVID-19 stigma. J Int AIDS Soc. 2020;23(5):e25504. doi: 10.1002/jia2.25504.