Stigma in Abortion, Poverty and Foster Care:

common themes and ways forward

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July 2025

CSGD Position Paper #2

Centre for the Study of Global Development – CSGD

The Open University

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Abstract

This CSGD position paper explores how stigma manifests and operates across the fields of reproductive health, poverty alleviation and child welfare. Drawing on interdisciplinary research and policy engagement by CSGD-affiliated researchers we identify commonalities in how stigma shapes policy, service provision, and lived experiences of those affected by abortion, poverty and foster care. In light of these commonalities, this paper argues that stigma acts as a structural barrier that exacerbates inequalities and restricts access to services. We call for an integrated, cross-sectoral approach to addressing stigma, informed by lived experiences and policy reforms. This is crucial for ensuring commitment to reducing social exclusion and improving outcomes for marginalised populations.

Acknowledgments

We are grateful to Owolabi Paul Adelana for his invaluable support in developing this paper.

1. Introduction

Stigma is a pervasive social force that shapes how societies judge, label, and treat people who do not fit into accepted norms. Goffman (1963) described stigma as a discrediting trait that reduces individuals from whole normal people to discounted others. Later scholars expanded on this idea by moving beyond personal attributes.

To illustrate, in expanding Goffman's concept and applying it in the context of sexualities, Herek (2009) described stigma as stemming from meanings that society attributes to a given characteristic, meanings which become 'embedded in a culture's collective knowledge and the policies and practices of its institutions' Stigma can manifest itself institutionally, indirectly affecting individuals and as a felt stigma or perceived stigma, in terms of physical and psychological violence (Brandelli Costa et al, 2017).

Kurzban and Leary (2001) redefined stigma as a process of social exclusion rather than mere identity devaluation. Link and Phelan's influential contribution (2001) show ways in which stigma works as a broad system of power and control. Together, these perspectives demonstrate how stigma operates through and within systems of power and institutional structures, to limit individuals' access to opportunities, resources, and full social inclusion.

Moreover, contemporary theorists have argued for the importance of recognising intersectionality—the ways in which multiple axes of identity and oppression (such as gender, race, and class) converge to shape lived experiences of stigma—and situating stigma within broader sociopolitical contexts where power is unevenly distributed (Tyler, 2020; Collins et al, 2021).

The consequences of stigma are far-reaching. Stigma manifests through structural inequalities, stereotypes, prejudice, and discrimination, while institutions reinforce stigma by restricting rights (Herek, 2007). Stereotypes, widely known but not always believed, shape prejudice and unconscious bias (Allport, 1954; Devine, 1989; Greenwald & Banaji, 1995). Prejudice can lead to discrimination at institutional and interpersonal levels (Major & O'Brien, 2005). Stigmatised individuals frequently encounter everyday discrimination, including poorer service in shops or being perceived as unintelligent (Williams et al., 1997). At the individual level, stigma can lead to internalised shame, reduced self-esteem, and a reluctance to seek help (Roelen, 2020).

Based on research and policy engagement by researchers affiliated with the Centre for the Study of Global Development (CSGD) at The Open University, UK, this paper critically examines how stigma manifests and is reproduced in relation to three policy areas, namely reproductive health, poverty alleviation, and child protection, and proposes an agenda for moving forward. These policy domains are deeply embedded in and framed by moral, political, and institutional discourses, and are often sites where individual circumstances are pathologised rather than understood within structural constraints. By interrogating how stigma manifests and is mobilised across these areas, we aim to foreground the mechanisms through which societal institutions not only reflect, but actively enforce, normative judgments, thus perpetuating marginalisation and social exclusion.

The discussion in this paper draws on key literature, work undertaken by and a podcast conversation[1] between four CSGD-affiliated researchers (Ayomide Oluseye, Carrie Purcell, Keetie Roelen, Justin Rogers) working across the three policy areas. Generative AI was used in support of the literature review and analysis of the podcast conversation; all references were duly checked.

2. Stigma in abortion, poverty and foster care

In this section, we offer a brief overview of considerations regarding stigma in the domains of reproductive health and abortion, poverty and welfare, and child protection and foster care as emergent from key literature.

2.1 Reproductive health and abortion

Abortion is widely recognised as a critical component of health care. Yet, the default in many societies is to frame it as problematic and highly stigmatised. From a stigma perspective, abortion is seen as a negative trait that makes individuals appear "inferior" to societal ideals of womanhood (Kumar et al., 2009), based on an assumption that abortion is morally wrong and socially unacceptable (Norris et al., 2011). This shapes the environment in which abortion care is sought, delivered and received (Purcell et al, 2020).

Abortion stigma is not solely about individual attitudes but is embedded in the policies and practices that restrict access and shape service provision. As Kumar

[1] The Sex, Research & Resistance Podcast. (2024, July 3). *Untangling the Web: Stigma in abortion, poverty and foster care (Parts 1 & 2)* [Audio podcast]. Spotify.
Part 1: https://open.spotify.com/episode/1u7jGtOlgZ0eZxwgU22HWf;
Part 2: https://open.spotify.com/episode/2JszUSoSkxScWcb7X6wpiS

et al., (2009) have shown, abortion stigma creates invisible barriers that complicate the decision-making process for those seeking reproductive health services. Notably, they document that negative connotations attached to abortion not only affect public attitudes but also shape regulatory frameworks. These frameworks tend to unfairly disadvantage those who seek abortions by, for example, exceptionalising abortion as somehow different to other areas of healthcare (Millar, 2023). This can also render abortion seekers vulnerable to further discrimination.

2.2 Poverty and welfare

Poverty, similarly, is laden with stigmatisation. People in poverty are positioned as blameworthy for their economic conditions. Stigma is compounded by prevailing narratives that individualize responsibility for poverty rather than recognizing structural inequities (Roelen, 2020). This results in poverty-induced shame that is common denominator across the globe (Walker, 2014) and can hold people back from advancing their wellbeing from material and non-material points of view. In terms of policy, poverty stigma often results in punitive measures that further marginalize the affected populations rather than providing supportive pathways out of hardship (Soss et al., 2011). The stigmatisation of poverty thus creates an environment where policies are geared toward surveillance and control, rather than empowerment and assistance.

2.3 Child protection and foster care

Foster care, as a critical component of child protection, is similarly imbued with stigma. This has been confirmed by previous research highlighting that children and young people in foster-care experience stigma (Rogers, 2017). Children in foster care and the families connected to the system frequently encounter negative assumptions about their worth and capability. Hurlburt et al., (2004) highlight that children in foster care and their families often face compounded stigma—not only are they seen as coming from dysfunctional backgrounds, but they are also stereotyped as being inherently problematic. Such stigmatisation can influence the allocation of resources and the design of interventions within the child welfare system. The resulting policies may inadvertently reinforce the marginalization of these families, rather than offering comprehensive support that considers their unique challenges.

Taken together, the challenges faced by individuals navigating abortion, poverty, and foster care are not merely the sum of isolated adversities. Instead, they are part of an interlocking system where stigma reinforces and compounds inequality

(Tyler, 2020). This paper argues that addressing stigma through an integrated, cross-sectoral framework is not only critical for reforming policy but also for ensuring social justice and equity for marginalised populations.

3. Commonalities in stigma experiences across abortion, poverty and foster care

Based on the podcast conversation between the four CSGD-affiliated researchers, during which they drew on their own work and available evidence, we identify various commonalities of the causes and manifestations of stigma across three policy areas.

3.1 Stigma management

Individuals internalise stigma and manage their identities to navigate societal perceptions. For example, children in foster care engage in identity work to conceal their care status, fearing judgement and discrimination. The effort required to manage this identity is both emotional and strategic, as disclosing one's foster care experience can lead to social exclusion. Similarly, people experiencing poverty commonly adopt strategies to avoid being labelled as poor, such as investing in clothing and selfcare (also referred to as dis-identifiers) to align with societal expectations. However, this response can paradoxically reinforce stigma, as outsiders may perceive these expenditures as irresponsible rather than as attempts to integrate into society. In addition, Silence is a commonly observed coping strategy in relation to abortion stigma. Those who undergo abortion may avoid discussing their experiences due to fear of judgement. This secrecy further entrenches and perpetuates stigma, as abortion remains framed as a moral failing rather than a routine healthcare practice.

These examples highlight a paradox: while individuals seek to distance themselves from stigma through identity management, their efforts can inadvertently reinforce stigmatizing structures and practices. The burden of managing and resisting? stigma falls on individuals rather than on the systems that perpetuate it.

3.2 Role of frontline workers

Across all three contexts—abortion, poverty, and foster care—service providers play a crucial role in either reinforcing or challenging stigma. Frontline workers are both influenced by and contribute to the dominant stigmatizing narratives within their respective fields.

In abortion care, healthcare providers may hesitate in their interactions with patients, fearing they might say the wrong thing. Additionally, some face backlash from colleagues who disapprove of their involvement in abortion care. Furthermore, entrenched stigma perpetuates the exceptionalisation of abortion in healthcare which can limit provision. This highlights that stigma is embedded within the medical (and legal) structures governing abortion provision, reproducing the idea of abortion as a contested space, where stigma influences professional relationships and patient experiences. The absence of institutional training and support for abortion both evidences and perpetuates stigmatisation, with resistance or destigmatisation efforts often relying on the good will of individual practitioners, making them unsustainable in the long term.

Similarly, in the context of poverty reduction interventions, welfare officers often operate within a framework that views people in poverty as needing to be monitored, controlled, or even punished. Policies such as conditional cash transfers reinforce the idea that individuals in poverty cannot be trusted to act responsibly unless incentivised or coerced.

This concern also applies to foster care, forcing children with care experience to manage their stigmatised identities in interactions with others. While frontline workers in social services may attempt to support children in care, they too are constrained by a system that often associates care-experienced individuals with poor educational outcomes or criminal behaviour.

The need for systemic change, rather than solely relying on the goodwill of individual workers, emerges as a unifying theme across all three discussions.

3.3 Stigma and language

Language is a crucial factor in the perpetuation of stigma, with the use of certain terminologies contributing to shame and exclusion across all three policy areas.

In relation to abortion, choice of words often inadvertently reinforces stigma. For instance, terms like “late-term abortion” or “repeat abortion” carry implicit judgement, making it harder for individuals to frame their experiences in a neutral or positive way. Deliberate shifts in language—such as using “pregnant person” instead of “mother”—are not just a semantic issue but a critical intervention in reducing stigma, recognising that not all abortion seekers identify as mothers or as women.

Similarly, poverty-related terminology shapes public attitudes and ideas about what causes or perpetuates poverty. For example, the phrase "intergenerational transmission of poverty" implies that poverty is a kind of disease passed down through families, thus placing blame on individuals rather than on structural inequalities. Alternative phrases like "poverty over time" or "longitudinal poverty" help reframe the issue in a way that reduces stigma and highlights systemic causes rather than personal failure.

In the case of foster care, children in care are often labelled in ways that reinforce negative stereotypes. Media and policy discourses frequently emphasise poor outcomes for care-experienced people rather than celebrating their achievements, contributing to a narrative that frames them as disadvantaged and incapable. The absence of positive counter-narratives means that young people in care often have to work extra hard to manage their identities and counteract societal assumptions.

3.4 Stigma as a conduit for social exclusion

Stigma leads to social exclusion, reinforcing cycles of marginalisation. People in poverty may avoid welfare services due to stigma while abortion stigma may prevent open dialogue, which perpetuates views of abortion as uncommon or exceptional. Foster care youth experience social isolation due to the stigma surrounding their background.

Social exclusion is not only a consequence or outcome of stigma but also a mechanism for its reproduction. When individuals withdraw from services or social interactions due to stigma, their marginalisation deepens, making it harder for them to challenge negative stereotypes. In terms of welfare, for example, when people refuse to claim benefits to avoid stigma, their economic situation worsens, reinforcing the stereotype of poverty as a personal failure. For young people in foster care, avoiding discussions about their background can limit their ability to form social connections. Similarly, abortion stigma silences those who have terminated pregnancies, preventing the formation of collective advocacy efforts, and constraining its visibility as a commonplace and legitimate pregnancy outcome.

Relatedly, another commonality across these contexts is how stigma translates into concrete discrimination, limiting individuals' access to resources and opportunities. Abortion stigma manifests institutionally through restrictive laws, limited healthcare access, and the need for 'buffer zones' to protect abortion clinic

users and staff from harassment. In relation to poverty, landlords refuse to rent to welfare recipients, reinforcing stereotypes of the poor as undeserving. Similarly, there are examples in the UK of housing associations explicitly barring care-experienced individuals from applying for housing.

Hence, discrimination operates as both a product and reinforcement of stigma, a cycle which makes it harder for marginalised individuals to escape the conditions that lead to their stigmatisation in the first place. Advocacy efforts, such as the push for care experience to be recognised as a protected characteristic, can help challenge these institutionalised barriers. Legislative change -including the decriminalisation of abortion – and a reshaping of how healthcare systems, welfare and social policies are designed are also crucial.

3.5 Stigma is systemic

It follows that stigma is not only an internalised psychological experience, but a product of broader societal structures. Abortion stigma can be considered an exercise of power, where gendered norms and legal frameworks position abortion as deviant, reinforcing secrecy and silence. Similarly, poverty stigma is embedded in economic and social systems that perpetuate discrimination against the poor, such as in access to housing and welfare benefits. In relation to foster care, stigma emerges from societal assumptions about children in care, which lead to lowered expectations and direct discrimination, such as exclusion from housing opportunities.

Across all three policy areas, stigma generates oppression and marginalisation, that are perpetuated through laws, policies, and social narratives. In each context, stigma serves to maintain the dominance of certain groups by devaluing those who do not conform to normative expectations attributed to a given characteristic, whether that is economic status, or norms of gender, parenting and family structures. —This shared structural dimension challenges dominant conceptualisations of stigma that focus solely on individual experiences. Instead, stigma might be more productively viewed as a tool of oppression (see also Tyler, 2020). As such, stigma requires systemic change rather than merely helping individuals cope with negative perceptions at a surface level.

4. Conclusion and ways forward

In drawing on key literature, work by four CSGD-affiliated researchers and a podcast conversation between these researchers, this paper points to

considerable overlap in issues of stigma across the policy areas of reproductive health, poverty alleviation and child protection. While the particular causes and manifestations of stigma may differ, several important commonalities cut across these examples.

Stigma thrives in silence and isolation; yet breaking it requires more than an individually focused response. The shared experiences of structural oppression, identity management, discrimination, and social exclusion highlight that stigma is a societal issue, not an individual failing. To address stigma, interventions must focus on systemic change rather than individual resilience. Only by confronting the root causes of stigma can a more equitable society where abortion, poverty, and foster care are recognised as part of the human experience, rather than sources of shame, be created. Addressing stigma in abortion, poverty, and foster care requires advancing an interdisciplinary research agenda and promoting collaborative policy reform, stakeholders can move toward a future in which stigma is not an insurmountable barrier but a challenge that can be systematically dismantled for the sake of social justice and equity.

In view of this, we suggest the following ways forward:

i. Incorporating the voices of those most affected by stigma is essential. Participatory research can illuminate the everyday realities of individuals navigating these intersecting challenges. By focusing on lived experiences, research can inform more humane and effective policy measures that reflect the true needs of marginalised populations.

ii. Studies would benefit from employing mixed methods approaches to capture the complex interplay of stigma across different policy sectors. Longitudinal research that tracks the impacts of intersecting stigmas on health outcomes, economic stability, and child welfare can provide critical insights into causal mechanisms and intervention points.

iii. Establishing collaborative networks among scholars from public health, social policy, child welfare, and economics can foster an interdisciplinary dialogue that enriches our understanding of stigma. These networks can serve as incubators for innovative research projects and pilot programs that test integrated interventions, thereby contributing to evidence-based policy reforms.

iv. Policymakers must recognize that interventions in one domain can have transformative effects on others. Integrated policy initiatives that address reproductive health, poverty alleviation, and child protection simultaneously should be prioritized. Such reforms could include destigmatizing public health campaigns, revising welfare policies to reduce punitive measures, and training child welfare professionals to recognize and mitigate their own biases.

v. Broader social change is necessary to transform the deep-seated attitudes that fuel stigma. Educational initiatives that challenge stereotypes and promote understanding across diverse sectors can play a pivotal role. These programmes should be designed to reach a wide audience—from policy influencers to community leaders—ensuring that the conversation around stigma is both inclusive and action-oriented.

References

Allport, G. W. (1954). The Nature of Prejudice. Reading, MA: Addison-Wesley.

Brandelli Costa, A., Pasley, A., Machado, W. d. L., Alvarado, E., Dutra-Thomé, L., & Koller, S. H. (2017). The experience of sexual stigma and the increased risk of attempted suicide in young Brazilian people from low socioeconomic group. *Frontiers in Psychology*, 8, 192. https://doi.org/10.3389/fpsyg.2017.00192

Collins, P.H., da Silva, E.C.G., Ergun, E., Furseth, I., Bond, K.D., Martínez-Palacios, J. (2021). Intersectionality as Critical Social Theory: Intersectionality as Critical Social Theory. *Contemp Polit Theory*, 20(3), 690–725. https://doi.org/10.1057/s41296-021-00490-0

Devine, P. G. (1989). Stereotypes and prejudice: Their automatic and controlled components. *Journal of Personality and Social Psychology*, 56(1), 5–18. https://doi.org/10.1037/0022-3514.56.1.5

Greenwald, A. G., & Banaji, M. R. (1995). Implicit social cognition: Attitudes, self-esteem, and stereotypes. Psychological Review, 102(1), 4–27. https://doi.org/10.1037/0033-295X.102.1.4

Goffman, E. (1963). Stigma: Notes on the Management of Spoiled Identity. New York, NY: Simon & Schuster.

Herek, G. M. (2009). Hate crimes and stigma-related experiences among sexual minority adults in the United States: Prevalence estimates from a national probability sample. *Journal of Interpersonal Violence*, 24(1), 54–74. https://doi.org/10.1177/0886260508316477

Herek, G. M. (2007). Confronting sexual stigma and prejudice: Theory and practice. *Journal of Social Issues*, 63, 905–925.

Hurlburt, M., Knapp, S., & Garland, A. F. (2004). Child welfare and poverty: Can we separate the two? *Child Welfare, 83*(3), 269–293.

Kumar, A., Hessini, L., & Mitchell, E. M. (2009). Conceptualizing abortion stigma. *Culture, Health & Sexuality, 11*(6), 625–639.

Kurzban, R., & Leary, M. R. (2001). Evolutionary origins of stigmatisation: The functions of social exclusion. *Psychological Bulletin, 127*(2), 187–208. https://doi.org/10.1037/0033-2909.127.2.187

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27*, 363–385.

Major, B., & O'Brien, L. T. (2005). The social psychology of stigma. *Annual Review of Psychology*, 56, 393–421.

Millar, E. (2023). Abortion stigma, abortion exceptionalism, and medical curricula. Health Sociology Review, 32(3), 261-276. https://doi.org/10.1080/14461242.2023.2184272

Norris, A., Bessett, D., Steinberg, J. R., Kavanaugh, M. L., De Zordo, S., & Becker, D. (2011). Abortion stigma: A reconceptualization of constituents, causes, and consequences. *Women's Health Issues, 21*(3), S49–S54. https://doi.org/10.1016/j.whi.2011.02.010

Purcell, C., Maxwell, K., Bloomer, F., Rowlands, S., & Hoggart, L. (2020). Toward normalising abortion: findings from a qualitative secondary analysis study. Culture, Health & Sexuality, 22(12), 1349–1364. https://doi.org/10.1080/13691058.2019.1679395

Roelen, K. (2020) Receiving Social Assistance in Low- and Middle-Income Countries: Negating Shame or Producing Stigma? *Journal of Social Policy*, 49(4), 705-723. https://doi.org/10.1017/S0047279419000709

Rogers, J. (2017). 'Different' and 'devalued': Managing the stigma of foster-care with the benefit of peer support. *British Journal of Social Work*, *47*(4), 1078-1093.

Soss, J., Fording, R. C., & Schram, S. F. (2011). *Disciplining the poor: Neoliberal narratives of economic hardship*. University of Chicago Press.

Tyler, I. (2020). Stigma: The machinery of inequality. Zed Books

Walker, D. (2014) *The Shame of Poverty*. Oxford: Oxford University Press.

Williams, D. R., Yu, Y., Jackson, J. S., & Anderson, N. B. (1997). Racial differences in physical and mental health: Socio-economic status, stress and discrimination. *Journal of Health Psychology*, 2(3), 335–351. https://doi.org/10.1177/135910539700200305

Suggested citation: Adelana, O. P., Roelen, K., Oluseye, A., Purcell, C. and J. Rogers (2025). Stigma in Abortion, Poverty and Foster Care: common themes and ways forward. CSGD Position Paper #2. Milton Keynes: Centre for the Study of Global Development, The Open University.

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