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An evolutionary concept analysis: stigma among women living with hepatitis C

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Abstract

Background Stigma is a complex social phenomenon that leads to marginalization and influences the course of illness. In the context of hepatitis C virus (HCV), stigma is a well-documented barrier to accessing care, treatment, and cure. In recent years, HCV rates among women have increased, resulting in an urgent need to address stigma and its harmful effects. The purpose of this concept analysis was to investigate stigma in the context of women living with HCV using Rodgers' evolutionary method.

Methods PubMed, CINAHL, Scopus, Medline, PsycINFO, and Nursing and Allied Health were used to identify articles describing HCV stigma among women. Articles from peer-reviewed journals and geographic locations, published between 2002–2023, were included in the analysis. As specified in Rodgers' evolutionary method, articles were analyzed with a focus on the concept's context, surrogate and related terms, antecedents, attributes, examples, and consequences.

Results Following screening, 33 articles were selected for inclusion in the analysis. Discrimination and marginalization were identified as surrogate and related terms to stigma; and antecedents of stigma were identified as limited knowledge, fear of diagnosis, and disclosure. Prevalent attributes of stigma in the literature were described as feelings of decreased self-worth, negative stereotyping, and fear of transmission. Importantly, HCV stigma among women is unique in comparison to other forms of infectious disease-related stigma, primarily due its impact on women's identity as mothers and caregivers. Stigmatization of women living with HCV resulted in negative consequences to personal relationships and healthcare access due to decreased health-seeking behaviours. Although access to HCV treatment has changed considerably over time, a temporal analysis could not be completed due to the limited number of articles.

Conclusions Stigma in the context of women living with HCV has its own unique antecedents, attributes, and consequences. This enhanced understanding of stigma among women living with HCV has the potential to inform improved and more effective approaches to care, which will be required to reach HCV elimination. Furthermore, this analysis identifies stigma layering and stigma in the direct-acting antiviral treatment era as areas for more in-depth future inquiry.

Keywords Hepatitis C virus, Stigma, Women

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Background

Stigma is a complex concept that can impact disease progression and contribute to the marginalization of populations [1]. Research on stigma is rooted in sociology with foundational conceptualization by Erving Goffman [2], who described stigma as undesired differentness. Stigmatization of individuals with infectious diseases has been well documented throughout history, during outbreaks of plague, cholera, yellow fever, and tuberculosis, where communities would cast-off individuals who were infected or who were thought to be infected [3]. Indeed, marginalization of individuals with perceived or actual infections persists in current times for people living with HIV, Ebola virus disease, Zika virus, COVID-19, and most recently, Mpox (formerly known as Monkeypox) [3–5]. As such, individuals' perceptions of stigma and discrimination from healthcare services and providers have been described as a significant barrier to their access of healthcare, which ultimately has negative consequences on health seeking behaviour; leading to increased transmission of infectious diseases [6, 7].

In the context of hepatitis C virus (HCV), approximately 71 million people live with HCV globally [8]. Chronic HCV remains a leading cause of infectious morbidity and mortality, with untreated HCV resulting in liver fibrosis, cirrhosis, liver failure, and hepatocellular carcinoma [8]. HCV is transmitted through blood-to-blood contact, with the use of shared substance use equipment and unsterile medical procedures [9] as the major drivers globally among adults. Despite the introduction of curative HCV treatments, the number of viremic infections worldwide has not changed, and few countries are on track to achieve the World Health Organization goal of HCV elimination as a public health threat by 2030 [10]. Over the last twenty years, there have been major advances in HCV therapy with the advent of well-tolerated all oral medications called direct-acting antivirals (DAAs), which have cure rates of over 95% in just 8 or 12 weeks [11]. Despite having highly effective treatments, there is a need for increased screening efforts primarily due to the asymptomatic nature of the disease and as the result of the stigmatization of risk factors associated with the acquisition of HCV [12, 13]. In terms of linking positive individuals to care, people living with HCV often experience high levels of stigma in healthcare settings, and this is a significant barrier for individuals accessing prevention, testing, care, and treatment services [14]. As described in *The Blueprint to inform hepatitis C elimination efforts in Canada*, developing destigmatizing approaches for health professionals providing HCV care is a vital step in providing patient-centred care and achieving HCV elimination in Canada [15].

In recent years, rates of HCV among women have been increasing. In fact, a recent analysis of global prevalence demonstrated that among women aged 15–49 years old in 2019, prevalence is 0.78%, corresponding to 14 860 000 women living with HCV [16]. Previous conceptualizations have examined HCV stigma, with the connection to drug use, sexual “behaviours”, transmission, and chronic disease [1, 17]. However, there is a paucity of literature conceptualizing stigma in the context of women living with HCV specifically. Women have traditionally experienced longstanding biases in healthcare as a result of historically limited research in areas related to women's health issues [18]. Additionally, in the community, many women living with HCV are subject to intersectional barriers not experienced by men, including practices rooted in gendered power dynamics that place women at increased risk of HCV acquisition [19]. These include being the second person injected, needing assistance injecting, and needing to negotiate harm reduction with risk of violence [20, 21].

The aim of this concept analysis is to define HCV stigma among women, and to clarify its defining attributes, antecedents, and consequences. Rodgers' evolutionary method for concept analysis was selected, because this method maintains that concepts are constantly evolving and are influenced by the context in which they are used [22]. The goal of using Rodgers' method is to indicate directions for further research [23]. Through the examination of HCV stigma in the context of women, this paper seeks to enhance the understanding of factors that perpetuate HCV stigma among women and support the development of destigmatizing approaches to care that meet the specific needs of women.

Methods

Rodgers' method for an evolutionary concept analysis was selected to guide this analysis because it recognizes the evolving nature of concepts within social constructs [22]. Rodgers' method involves six nonlinear stages which are flexible in nature [22]. The analysis is completed in three phases which include the initial phase, the core analysis phase, and the further analysis phase [23]. The phases of Roger's method for an evolutionary concept analysis are summarized in Table 1.

The initial phase

Choice of concept

Stigma in the context of women living with HCV was selected for this concept analysis. Rodgers' method emphasizes the importance of selecting concepts that are significant to serving a purposeful human goal [23]. Therefore, as the prevalence of HCV among women is increasing, and women have lower treatment uptake, it is

Table 1 Rodgers' method for evolutionary concept analysis

The Initial Phase	Choice of concept for analysis	Identify the concept of interest including related and surrogate terms.
	Select an appropriate setting and sample	Select an appropriate setting and sample for data collection.
	Collection of material	Collect relevant data to identify the attributes, antecedents, and consequences of a concept.
The Core Analysis Phase	Analyze data	All articles selected for analysis are read in entirety. Articles are read a second time with a focus on the concept's attributes, antecedents, and consequences.
	Select an exemplar of the concept	If appropriate, a case study may be presented to exemplify the concept.
The Further Analysis Phase	Identifying the implications and hypotheses for further development of the concept	Asks questions and develops hypotheses for further research.

pertinent to understand women's unique experience with HCV-related stigma [16, 19]. Further analyzing this concept has the potential to bring clarity to women's unique experience with stigma which in turn can support efforts towards global HCV elimination.

Sample and setting

Rodgers' method for evolutionary concept analysis suggests selecting an appropriate data sample through a literature review [22]. The sample consisted of articles published in English between January 1, 2002–December 31, 2023 to capture the current understanding of stigma in the context of woman living with HCV. Articles from global peer-reviewed journals from many disciplines were included in the analysis. For feasibility reasons, further criteria included that the full-text article be published in English. Databases included PubMed, CINAHL, Scopus, Medline, PsycINFO, and Nursing and Allied Health. The following combination of search terms were utilized 'hepatitis C AND stigma AND women', 'hepatitis C AND stigma AND woman', 'hepatitis C AND stigma AND female', 'hepatitis C AND stigma AND gender', and 'hepatitis C AND stigma AND sex'.

Collection of material

Initial searches yielded 1651 results; and all titles and abstracts were screened. Following title/abstract review, 51 articles underwent full-text review. Only articles that reported disaggregated findings among women living with HCV were included. Following the full-text reviews, 33 articles met the criteria for inclusion in the concept analysis (Fig. 1). The articles included in the concept analysis are summarized in Table 2. In alignment with Rodgers' evolutionary method, the initial articles selected for inclusion in the analysis are read in their entirety [22]. Subsequently, the articles were re-read, this time with a focus on the concepts context, surrogate and related terms, antecedents, attributes, and consequences [22, 23].

Results

The core analysis phase

Stigma as the concept of interest

Stigma has its conceptualization roots in sociology and the work of Erving Goffman [24]. Goffman (1968) states that the term stigma originates from the ancient Greeks, who used it to describe a mark left on someone's body, such as a burn or a cut, which was used as a visual representation of one's negative moral status as a criminal or a slave. Before the 1800s, stigma took on a positive connotation in the sacred space, where it became associated with the suffering of Christ (Goffman, 1968). The current understanding of the term stigma traces back to the latter half of the nineteenth century when it was used to describe the harmful properties of some illnesses (Goffman, 1968). The concept of stigma was defined for the first time as a societal problem by Goffman, where stigma is defined as a socially devalued attribute [24]. Recent conceptualizations of stigma emphasize the importance of considering the experience of the stigmatized individual, and recommendations suggest taking an individualized approach to conceptualizing stigma [25–27]. Using an individualized approach, various ideas and notions exist regarding the meaning of stigma. For example, Link and Phelan [27] argue that variety in the conceptualization of stigma is justified if its context is clearly defined.

The reviewed literature on the concept of stigma among women living with HCV consisted primarily of semi-structured interviews and surveys to capture women's experiences and perceptions of stigma. Research examining stigma in the context of women living with HCV is present across multiple disciplines, including nursing, medicine, health sciences, social sciences, and public health. Of the literature reviewed, only one article presented an explicit definition of stigma [25]. Stigma was defined as *'a social process involving the segregation of individuals and social groups, based on socially valued and devalued attributes that are contingent on inequities in social, economic, and political power'* [25]. Another article defined stigmatization as *'attitudes expressed by*

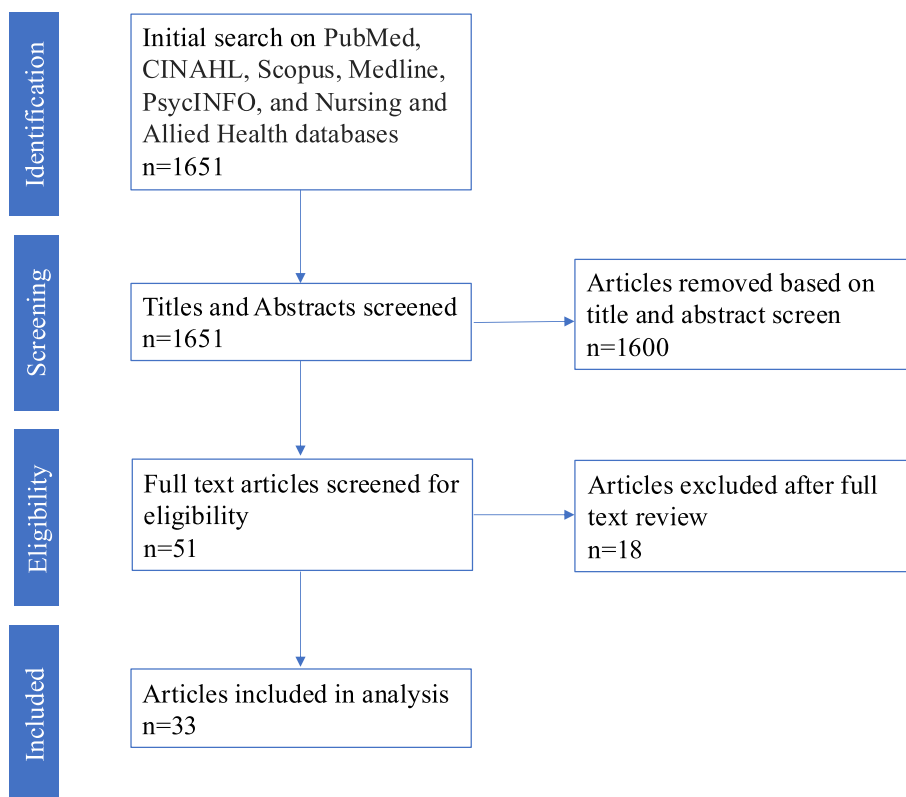


Fig. 1 Process for article identification and inclusion

a dominant group which views a collection of others as socially unacceptable’ [28]. While there is no unanimous definition for stigma presented in the literature, there is consensus amongst the disciplines that stigma is a perceived phenomenon that stigma is shaped by social constructs and negatively impacts the affected individual’s physical and emotional well-being.

Surrogate/related terms

Surrogate terms are described by Rodgers’ as expressions that convey a concept’s idea through words other than the identified concept [22, 23]. Surrogate terms could be used instead of the identified concept, but may also be used to describe the concept [22]. The literature revealed that surrogate term for that stigma and/or stigmatization was discrimination. Twenty five of the thirty-three articles analyzed utilize the term discrimination. The literature uses stigma and discrimination interchangeably as barriers to HCV care and treatment [13, 29, 30]. Marginalization is also noted to appear in the literature but is used to describe women’s social exclusion as it relates to HCV and substance use, which in turn had negative consequences on support and treatment [30–34].

Antecedents

Rodgers’ evolutionary method describes antecedents as the events or conditions that occur before the concept occurs [22]. The most discussed antecedents to stigma for women living with HCV included limited knowledge, fear of diagnosis, and disclosure of HCV status.

Limited knowledge

The literature identifies limited knowledge as a driver for stigma among women living with HCV. In addition, the public’s limited knowledge regarding HCV transmission routes and prevention strategies contributes to the stigma experienced by women living with HCV [14, 35, 36]. Society’s negative perception of sex and sexual health is described as a critical contributor to the public’s lack of knowledge on sexually transmitted and blood-borne infections (STBBIs) such as HCV, as they are considered taboo and stigmatized topics [25, 37]. The literature also identified healthcare providers’ limited knowledge of women’s specific health issues as a contributor to stigma [31, 35]. Women identify public education on transmission as a strategy to reduce stigmatization and improve quality of life for women living with HCV [14].

Table 2 Articles selected for evolutionary concept analysis of stigma among women living with HCV

	Reference	Year	Region	Database
1	Armishaw & Davis	2002	AUS	CINAHL
2	Adekunle et al	2022	USA	Scopus
3	Hatashita & Cooper	2020	CAN	Scopus
4	Olsen et al. (1)	2013	AUS	Scopus
5	Banwell et al	2005	AUS	Scopus
6	Crockett & Gifford	2004	AUS	Scopus
7	Gifford et al	2003	AUS	Scopus
8	Grundy & Beeching	2004	UK	Scopus
9	Platt & Gifford	2003	AUS	Scopus
10	Rodriguez et al	2023	France	Scopus
11	Jones et al	2023	USA	Scopus
12	Olsen et al. (2)	2013	AUS	MEDLINE
13	Strauss & Teixeira	2006	US	MEDLINE
14	Temple-Smith et al	2004	AUS	Nursing & Allied Health
15	Zickmund et al	2003	USA	Nursing & Allied Health
16	Conrad et al	2006	AUS	Nursing & Allied Health
17	Donaldson et al	2023	UK	Nursing & Allied Health
18	Massah et al	2017	Iran	PubMed
19	Saine et al	2020	USA	Scopus
20	Jiwani et al	2013	Pakistan	Scopus
21	Rafique et al	2014	Pakistan	CINAHL
22	Habib & Adorjany	2003	AUS	CINAHL
23	Kostić et al	2016	Serbia	PubMed
24	Whitaker et al	2011	Ireland	PubMed
25	Dunne & Quayle	2002	Ireland	PsycINFO
26	Sherbuk et al	2020	USA	MEDLINE
27	Martínez-Pérez et al	2021	Kyrgyzstan	MEDLINE
28	Kagan et al	2023	AUS	MEDLINE
29	Värmå et al	2020	Sweden	Scopus
30	Medina-Perucha et al	2019	UK	PsycINFO
31	Dowsett et al	2020	Canada	Scopus
32	Harris & Rhodes	2013	UK	Scopus
33	Zuchowski et al	2015	USA	Scopus

Fear of diagnosis

Fear of a diagnosis was noted in the literature as an antecedent to stigma amongst women living with HCV, and women experienced internalized stigma and a lowered sense of self-worth as the result of being afraid of receiving an HCV diagnosis [25]. In one study, women were noted to avoid needle exchange programs for fear of being tested and receiving a positive HCV diagnosis [38]. This analysis highlights that to evade internalized stigma from receiving an HCV diagnosis, women will avoid screening for HCV [13, 39].

Disclosure

The most referred to antecedent in the literature is disclosure, and 25 of the 33 articles analyzed, cited disclosure of HCV status as an antecedent to stigma. Disclosure of HCV status changes how individuals view themselves and how they are viewed by others [39, 40]. Individuals discuss the impact of disclosure on personal relationships and relationships with their healthcare providers [34]. Some women stated they would prefer to lie to people about the result of their test, rather than disclose a positive for fear of stigmatization [37]. Women also experience more fear than men in the context of disclosure. Women were noted to speak to its potential negative impact on their personal lives and sense of self, where men did not voice concern regarding the experience of disclosure on their personal relationships or sense of self [31]. Some women express fear that disclosure could result in intimate partner violence [41]. In fact, disclosure is so impactful that women learn how to be discrete during self-disclosure to avoid stigma [33]. Additionally, women indicate that stigma occurs after disclosure, even after they have undergone treatment, post-treatment, and cure, disclosure resulted in stigmatising comments, excess infection control, and withheld access to healthcare treatment and practitioners [42].

Attributes

Attributes are distinctive features of the concept found in the literature that facilitate the identification of the concept in unique situations [22, 23]. Attributes are important to consider as they guide the identification and classification of the concept within its unique context [22, 23]. The attributes of stigma for women living with HCV include decreased feelings of self-worth, negative stereotyping, and fear of transmission.

Feelings of decreased self-worth

A defining attribute of stigma among women with HCV is decreased feelings of self-worth. Women's feelings of worthlessness made them feel "dirty" and not worthy of living [14, 25]. One woman stated, "Yeah, I feel I've got dirty blood running through me at the moment. So I'm having a bit of a wall on me at the moment because of it" [25]. It was noted that women intertwined their self-identity with their HCV diagnosis and no longer felt worthy enough to engage in health-protective behaviour [25]. Women who initiate treatment discuss regaining their self-worth once they have treated their HCV [43].

Negative stereotyping

A commonly noted attribute of stigma for women living with HCV is the negative stereotyping that occurs through the association of HCV with injection substance use, sex work, and sexual orientation [44]. Individuals are stereotyped as dirty and deserving of infection regardless of how they acquired the virus [25, 29, 30, 32, 33, 43]. The literature indicated that women living with HCV are stereotyped by friends, family, and healthcare providers; resulting in social rejection, isolation, and worsening health outcomes [25, 30].

Fear of transmission

Women are burdened by the fear of transmission. Unique to the experience of women is the fear of perinatal transmission or household transmission to their young children [14, 45]. One woman expressed the devastation of learning that her daughter acquired HCV through vertical transmission [46]. Other women describe not having children due to fear of transmitting HCV to their child [30, 45]. Despite low rates of vertical transmission, women discussed that their fears of transmission during pregnancy were intensified by their healthcare providers' lack of reassurance about what would happen to the child [31]. Work by Hatashita and Cooper [45] describe that women need to be extremely careful when they are menstruating, including the experience of locking up their razors and nail clippers to protect their children from HCV. Additionally, women are quoted as warning friends and family about sharing utensils with them for fear of HCV transmission [31].

Consequences

Consequences are the events and outcomes resulting from a concept. Stigma is associated with detrimental consequences to relationships and healthcare access for women with HCV [22]. The consequences of stigma for women with HCV are fluid and may change over time.

Relationships

The stigma associated with HCV is noted to cause significant problems in personal and sexual relationships for women; with examples of relationships ending or reduced sexual contact [47]. The consequences of stigma exist within various types of relationships, specifically with intimate partners, family and friends, social networks, and healthcare providers. With respect to sexual transmission, women acknowledge the risk of transmission is low, but still fear transmitting HCV to their partners [47]. Women with HCV discuss feeling contaminated and lack confidence in their sexual desirability and ability to enjoy sexual intercourse [47, 48]. Some women even discuss changing their sexual practices with partners

[39]. Additionally, women express fear of being left or being harmed as a result of disclosing their HCV status to partners [35, 41, 49]. Outside of intimate partner relationships, women experience overt stigmatization from friends and family, often resulting in the end of these relationships [25, 50]. One woman describes her mother telling her not to share soap with the rest of the family. Another woman described that her family would not hug or touch her [30]. Additionally, women experience altered relationships with their healthcare providers; reporting experiencing insensitive medical care, feeling singled out due to their HCV status, and receiving conflicting information from medical providers [30, 35].

Healthcare access

Stigma impacts the care women receive and their health-seeking behaviours. It is common for women with HCV to have negative healthcare experiences, including feeling unsupported, not having adequate information, treatments and health practitioners being withheld, and not being involved in their healthcare decisions [14, 42, 48]. Many women describe a focus on the disease rather than the person and feeling discriminated against by healthcare providers [13, 14]. In the healthcare setting, women describe a compounding effect of HCV stigma, and stigma from injection drug use regardless of how the individual acquired the virus [14, 51]. Stigma has shown to decrease the number of women accessing healthcare services and increase the number of women missing their scheduled appointments [36, 47]. These negative healthcare experiences lead women to limit their health-seeking behaviours, which ultimately culminates in detrimental impacts on HCV-related outcomes and overall health outcomes. The detrimental effects are amplified in rural communities where individuals face limited choices regarding healthcare providers [13].

Contextual application: a model case

The model case for this analysis was derived from the articles who utilized semi-structured interviews to gather data on the experiences and perspectives of women living with HCV [25, 30]. Multiple participants describe a similar trajectory through their journey with HCV and their experiences have been summarized into a model case using a fictitious name.

Patricia is a 28-year-old woman who has engaged in injection drug use since adolescence. Patricia began receiving opioid agonist therapy and stopped using injection drugs in her mid-twenties. Patricia now has a job and an apartment that she shares with her boyfriend, and she just found out she is pregnant. She was screened for HCV during her prenatal workup, and she was eventually diagnosed with chronic HCV. Upon receiving her

diagnosis, Patricia blamed herself for not being tested earlier, felt irresponsible, and not fit to be a parent. Patricia disclosed her HCV results to her boyfriend, who was supportive and understanding of her HCV status. Patricia's boyfriend was tested for HCV and was negative. Their prenatal provider educated the couple on the low risk of transmission associated with sexual intercourse. However, Patricia, afraid of transmitting HCV to her boyfriend and feeling unworthy of him, ends the relationship. After Patricia discloses her status to her family, it becomes clear that they have a poor understanding of HCV transmission and are concerned about sharing food. Later, during her labour and delivery admission to the hospital, Patricia requests pain medication. She overhears the Registered Nurse telling the Obstetrician she is "a junkie" and is "drug-seeking." Following the birth of her baby, child services is alerted at the request of the labour and delivery team.

At six months old, Patricia's infant becomes inconsolable and has an elevated temperature. Patricia is hesitant to take her child to the hospital because of her negative delivery experience. Patricia delays seeking healthcare services because she says they have already labeled her, and she is afraid they will question her parenting ability. Patricia wants to call her mom for advice on what she should do, but their relationship has not improved. In summary, Patricia had to experience the consequences of stigma because of her HCV diagnosis, which led her to feel stigmatized about her condition, causing strain in her relationships and impacting her health-seeking behaviours, including for her child.

Discussion

The further analysis phase

This analysis attempts to illustrate the features of HCV stigma by examining prominent attributes, antecedents, and consequences. The analysis also identified antecedents which included limited knowledge, fear of diagnosis, and disclosure of HCV status. In addition, prevalent consequences of stigma for women living with HCV were established, and described as impacts on personal and sexual relationships, and restricted access to healthcare services. A contextual case model highlights the attributes of stigma and their implications for women living with HCV and their health-seeking behaviours [25, 30]. The role stigma plays on identity as a mothers and caregiver was unique to HCV stigma among women.

Familial relationships, pregnancy, and motherhood were all central aspects of the experience of HCV stigma among women [35, 52]. Even prior to becoming a mother women would avoid getting pregnant or experience negative comments from healthcare providers that they should be careful to not get pregnant [35, 53]. Women

experience perceived stigma and avoid interacting with people or seeking healthcare for fear people will find out they have HCV and treat them differently [36]. Therefore, pregnancy and the prenatal period offer a crucial opportunity to implement strategies specifically aimed at addressing HCV stigma among women. During this time, safe and supportive care from healthcare providers can play a key role in keeping women and children engaged in care. Additionally, enhancing awareness and knowledge about HCV and its transmission risks can help prevent the perpetuation of stigma within the community.

To support the continued evolution of a concept, Rodgers' evolutionary method for concept analysis recommends identifying further areas of research [22]. This analysis recognises that women who identify as members of the LGBTQIA2S+ community and live with HCV have their own experience with stigma when compared with heterosexual women. Specifically, women living with HCV who are members of the LGBTQIA2S+ community identify as potentially experiencing stigma on three fronts including their HCV status, substance use, and as members of the LGBTQIA2S+ community [44]. The literature indicates that more lesbian and bisexual women had their HCV status disclosed without their permission, and more bisexual women experienced negative reactions from their family and new sexual partners than either heterosexual or lesbian women [44]. However, the literature exploring the role of HCV stigma among women in the LGTQIA2S+ community is extremely limited and further research is needed, especially in the current DAA era.

It was evident through this analysis that a significant source of HCV stigma experienced by women occurs in healthcare settings [13, 29, 30, 42, 54]. Healthcare providers are uniquely positioned as both educators and providers to combat stigma on individual, societal, and structural levels; especially in the context of HCV. Further research exploring the concept of HCV stigma would assist healthcare providers to develop strategies for interacting with women with HCV, increasing public education related to HCV, and addressing stigma in healthcare settings.

This analysis identified that women experience a phenomenon known as stigma layering in conjunction with their stigma related to HCV. This is described as stigma from multiple facets, including gender, race, religion, substance use, and sexual orientation [44, 47]. Layered stigma lead women to avoid screening and diagnosis [13]. Future research should further analyze the concept of stigma layering or compounded stigma.

Early DAA treatments, which were introduced in 2013, have greatly changed the landscape of HCV globally [55]. DAA treatments are well-tolerated oral

medications taken for 8 or 12 weeks with greater than 95% cure rates [11]. However, there were few articles that evaluated stigma in the DAA era, and additional primary studies are required to better understand this phenomenon. As a result it was not possible to complete a temporal analysis. However, of the literature that was included in this study, it was noted that post-cure women continue to experience stigma especially in the healthcare setting [42]. Examples of this included stigmatising comments, excessive infection control practices, and withheld treatments and procedures from healthcare providers [42].

Despite the thoroughness of the literature review, there are limitations to this study. This analysis was limited to articles whose full access was available online, as well as literature published in the English language. Only analyzing English literature could limit the cultural contexts encompassed within this analysis. In addition, it should be noted that this analysis is limited to published research, which primarily encompasses perspectives of individuals from Western countries.

Conclusion

Stigma in the context of infectious diseases has been well documented throughout history; however, as new viruses, treatments, and social conditions arise, the concept transitions into new conditions [3]. Previous literature has examined the concept of HCV stigma, but there is a paucity of literature where there is disintegrated data of HCV stigma in the context of women. Although HCV stigma among women share some features with the stigma of other infectious diseases, stigma in the context of women living with HCV is unique, particularly in its impact on women's identity as mothers and caregivers. This enhanced understanding of stigma among women living with HCV can be used to inform healthcare providers, educators, peer-support workers, and researchers to address personal, social, and structural barriers of HCV stigma among women. In addition, future research should further develop the concept of stigma layering and focus on a temporal analysis of HCV stigma in the DAA era.

Abbreviations

HCV	Hepatitis C virus
DAA	Direct-acting antivirals
HIV	Human immunodeficiency virus
AIDS	Acquired immunodeficiency syndrome
STBIs	Sexually transmitted infections and blood-borne infections

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Not Applicable.

Authors' contributions

C.M. and M.B. conceived and designed the study. C.M. retrieved the data, with supervision from M.B., Y.B.M., and P.T. C.M. analysed and compiled the data. C.M., M.B., Y.B.M., and P.T. wrote and edited the first draft of the manuscript. Resource

support was provided by M.B. All authors contributed thoughtful suggestions, as well as reviewed the manuscript and approved the final version.

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Availability of data and materials

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

Not applicable.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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