Stigma, HIV Vulnerability, and Reproductive Health Inequities among LGBT Youth in Jamaica

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Abstract

HIV remains a central reproductive health concern, particularly in regions where stigma and structural inequities undermine access to healthcare. Young transgender women and sexually diverse men in Jamaica face disproportionate HIV risk due to overlapping vulnerabilities including poverty, criminalisation, and social discrimination. This paper examines the intersection of stigma, HIV vulnerability, and reproductive health outcomes within this population. By integrating qualitative insights with reproductive medicine frameworks, we highlight how structural barriers influence access to contraception, fertility planning, pregnancy-related care, and prevention of mother-to-child transmission (PMTCT). Policy reforms and targeted interventions are proposed to reduce inequities and improve reproductive health outcomes for marginalised groups.

Keywords: HIV, transgender women, PMTCT, LGBT

Introduction

HIV remains one of the most significant challenges in the field of reproductive medicine, not only because of its direct impact on maternal and fetal outcomes, but also due to the wider social and structural inequities that shape health access and decision-making [1]. In the Caribbean, and particularly in Jamaica, HIV prevalence continues to be disproportionately high among key populations such as young transgender women and sexually diverse men. These groups face compounded vulnerabilities that extend beyond virological risk, encompassing stigma, poverty, and criminalisation that together restrict their access to essential reproductive health services [2].

Within reproductive medicine, HIV is best understood not solely as an infectious disease, but as a reproductive health issue with broad implications [3]. It affects fertility planning, the uptake of contraception, the course of pregnancy, and the prevention of mother-to-child transmission (PMTCT). Despite advances in biomedical interventions, the persistence of stigma and discrimination in healthcare systems often prevents individuals from accessing timely testing, counseling, and treatment. This creates a critical gap between medical potential and lived reality, leaving many at risk of poor reproductive outcomes [4].

Addressing these challenges requires a framework that links social inequities with reproductive health outcomes. This paper aims to examine the intersection of stigma, HIV vulnerability, and reproductive healthcare access among young LGBT populations in Jamaica [5]. By integrating sociostructural insights with reproductive medicine perspectives, we seek to highlight how inequities undermine fertility intentions, pregnancy outcomes, and the broader reproductive autonomy of marginalized groups. Ultimately, this analysis underscores the urgent need for inclusive, stigma-free reproductive health services that recognize HIV as both a medical and social determinant of reproductive well-being [6].

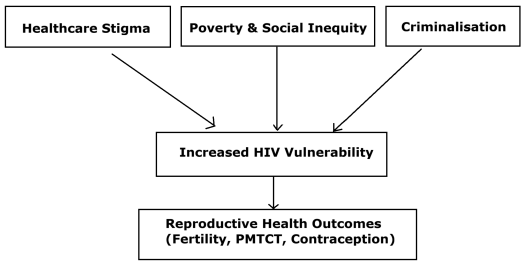

Figure 1: Conceptual model of stigma, HIV risk, and reproductive health outcomes.

Background and Literature Review

HIV and Reproductive Health

HIV has profound implications for reproductive health, extending beyond its role as an infectious disease to directly influencing fertility, pregnancy, and contraceptive decision-making. Among individuals living with HIV, fertility intentions are often shaped by concerns about transmission risks, the safety of pregnancy, and the potential for stigma in healthcare settings [7, 8]. Studies have shown that both men and women may delay or forgo parenthood due to fears of vertical or horizontal transmission, highlighting the importance of integrating reproductive counseling into HIV care. For transgender women and sexually diverse men, these challenges are compounded by limited access to affirming reproductive services, further restricting their ability to plan and pursue parenthood [9].

Pregnancy in the context of HIV requires careful clinical management, as untreated infection significantly increases the risk of adverse outcomes, including intrauterine growth restriction, preterm delivery, and stillbirth [10]. In addition, the use of antiretroviral therapy (ART) during pregnancy has been shown to dramatically reduce viral load, thereby decreasing transmis-

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sion risk and improving maternal health. Ensuring universal access to ART and continuous antenatal monitoring remains a cornerstone of reproductive medicine in HIV-affected populations [11].

A critical component of HIV-related reproductive care is the prevention of mother-to-child transmission (PMTCT). Without intervention, the vertical transmission rate can range between 15–45%, but with effective ART, safe delivery practices, and appropriate infant feeding strategies, this risk can be reduced to less than 5%. The success of PMTCT programs demonstrates the essential link between HIV management and reproductive health outcomes, underscoring the role of reproductive medicine in safeguarding both maternal and infant well-being. However, gaps persist in access, adherence, and equitable implementation, particularly in settings marked by social inequities and stigma [12]. These challenges are especially evident in the Caribbean, where structural barriers continue to undermine the potential of PMTCT initiatives to fully eliminate vertical transmission of HIV.

Table 1: Hypothetical Framework: Stigma and Reproductive Health Outcomes

Factor	Impact on Reproductive Health
Stigma in healthcare	Avoidance of HIV/contraceptive services
Poverty	Increased reliance on survival sex; reduced contraceptive access
Criminalisation	Fear of disclosure, limited reproductive counseling
Social inequity	Higher HIV risk, poor maternal/infant outcomes

Stigma, Discrimination, and Healthcare Access

The intersection of stigma, poverty, and criminalisation has been widely conceptualised within a syndemics framework, which highlights how multiple social and structural inequities interact synergistically to exacerbate health vulnerabilities [13]. In the context of HIV and reproductive health, stigma manifests at several levels: institutional discrimination within healthcare systems, interpersonal prejudice from providers, and internalised stigma that discourages individuals from seeking care. When combined with the structural barriers of poverty and the criminalisation of same-sex relationships in Jamaica, these forces create a hostile environment that severely limits access to essential reproductive services [14].

For lesbian, gay, bisexual, and transgender (LGBT) populations, these barriers are particularly pronounced in reproductive health [15, 16, 17]. Existing studies have documented that LGBT individuals often experience dismissal of reproductive concerns, denial of fertility counseling, and inadequate provision of contraceptives within healthcare settings. Transgender women may encounter misgendering or outright exclusion from services, while sexually diverse men face heightened surveillance around HIV testing without corresponding attention to broader reproductive needs. Such experiences reinforce cycles of avoidance, late presentation, and reduced uptake of interventions such as prevention of mother-to-child transmission (PMTCT) and antiretroviral therapy (ART). In this way, stigma and discrimination are not peripheral issues but central determinants of reproductive health outcomes among marginalised populations [18].

Methodological Approach

This study employed a community-based qualitative research design to explore the intersection of stigma, HIV vulnerability, and reproductive health outcomes. A combination of in-depth interviews, focus group discussions, and key informant interviews was utilised to capture both personal experiences and broader community perspectives. This approach ensured that the voices of participants were foregrounded while also situating individual narratives within a wider social and structural context.

The study population consisted of young transgender women and sexually diverse men between the ages of 18 and 30 residing in Kingston, Jamaica. These groups were purposively selected due to their heightened vulnerability to HIV infection and their frequent marginalisation within reproductive health services. Recruitment was facilitated through local community-based organisations that provide support to LGBT populations, ensuring both trust and cultural relevance in participant engagement.

Data collection followed a semi-structured format, allowing for the exploration of key themes while preserving space for emergent issues raised by participants. All interviews and discussions were audio-recorded with informed consent and subsequently transcribed verbatim. Thematic coding was conducted using an inductive–deductive framework: deductive codes were derived from existing literature on syndemics and reproductive health, while inductive codes emerged directly from participant narratives. Data analysis was iterative, with preliminary findings shared with community partners for validation, thereby strengthening the credibility and authenticity of the results.

Findings

Stigma and HIV Vulnerability

Participants consistently described experiences of discrimination in healthcare settings, ranging from subtle acts of dismissal to overt hostility. Transgender women reported frequent misgendering, breaches of confidentiality, and in some cases outright refusal of care. Sexually diverse men similarly described being stereotyped as inherently promiscuous or treated primarily as vectors of HIV, rather than as individuals with broader reproductive health needs. These interactions fostered deep mis-

Table 2: Summary of Key Findings on Stigma, HIV, and Reproductive Health among LGBT Youth in Kingston, Jamaica

Theme	Findings	Reproductive Health Implications
Stigma and HIV Vulnerability	- Discrimination and hostility in healthcare - Misgendering and stereotyping - Delayed or avoided HIV testing	- Late HIV diagnosis reduces ART initiation - Missed opportunities for reproductive counselling - Reduced uptake of PMTCT interventions
Access to Contraception and Fertility Services	- Gaps in contraceptive provision - Fertility counselling often absent or inadequate - Exclusion of transgender women from fertility preservation options	- Increased risk of unintended pregnancies - Limited reproductive autonomy - Disrupted fertility planning and decision-making
Transactional Sex and Reproductive Outcomes	- Economic precarity driving survival sex - Limited power in condom negotiation - Reliance on transactional relationships for income and housing	- Higher exposure to HIV and STIs - Increased unintended pregnancies - Compromised contraceptive use and negotiation

trust in the healthcare system and reinforced patterns of avoidance.

The consequences of such stigma extended directly to HIV prevention and reproductive service use. Many participants delayed HIV testing due to fear of judgment or exposure, leading to late diagnosis and reduced opportunities for timely initiation of antiretroviral therapy. Others avoided clinics altogether, relying instead on informal networks or self-medication, further distancing themselves from structured reproductive health services. In this way, healthcare stigma emerged as both a direct and indirect driver of heightened HIV vulnerability.

Access to Contraception and Fertility Services

The study also revealed significant gaps in reproductive counseling and contraceptive provision for LGBT populations in Kingston. Participants noted that discussions of fertility or contraception were often absent from their clinical encounters, reflecting a broader assumption that sexual and gender minorities do not require such services. Transgender women, in particular, reported being denied information on fertility preservation or contraceptive options compatible with hormone therapy. For sexually diverse men, reproductive counseling was often narrowly framed around HIV risk without addressing issues of family planning or reproductive intentions.

These barriers had tangible effects on participants' reproductive trajectories. Some expressed ambivalence or resignation about their ability to pursue parenthood in the future, citing both healthcare stigma and lack of resources as limiting factors. Others reported discontinuing or avoiding contraceptive use due to negative encounters with providers, thereby increasing the risk of unintended pregnancies in contexts of heterosexual or transactional relationships. Such findings underscore how systemic exclusion perpetuates reproductive inequities, even in populations already disproportionately affected by HIV.

Transactional Sex and Reproductive Outcomes

Economic precarity and social exclusion pushed many participants into transactional or survival sex, which functioned simultaneously as a source of income and a site of reproductive vulnerability. Several transgender women described engaging in sex work as one of the few viable means of economic survival in Kingston, while sexually diverse men similarly reported exchanges of sex for shelter, food, or financial security. In these contexts, condom negotiation was often constrained by power imbalances and economic dependence, leaving participants unable to consistently protect themselves against HIV or other sexually transmitted infections.

Transactional sex also intersected with broader reproductive outcomes. Participants recounted instances of unintended pregnancies resulting from unprotected encounters, highlighting the limited availability of contraceptive options and the absence of supportive reproductive counseling. Beyond physical outcomes, these experiences carried profound psychological burdens, reinforcing cycles of stigma, secrecy, and marginalisation. The interplay between survival strategies and reproductive health risks thus illustrates how structural inequities manifest in intimate and bodily domains, further complicating efforts to achieve reproductive justice for marginalised populations in Jamaica.

Discussion

This analysis situates participants' narratives within a reproductive medicine framework that recognises HIV as both a biomedical condition and a determinant of reproductive trajectories [19]. The findings demonstrate that stigma within healthcare systems—compounded by poverty and criminalisation—constrains access to timely HIV testing, antiretroviral therapy, contraception, fertility counselling, and pregnancy-related care [20]. In reproductive medicine terms, these constraints impede primary prevention (condoms, PrEP), secondary prevention (early diagnosis and ART initiation), and tertiary prevention (PMTCT and management of pregnancy outcomes). They also attenuate reproductive autonomy by narrowing the range of feasible choices regarding fertility intentions, family planning, and parenting [21].

Integrating these results with syndemics theory clarifies how mutually reinforcing social conditions shape clinical outcomes. Stigma reduces service uptake; economic precarity increases reliance on transactional sex; criminalisation heightens fear and concealment [22]. Together, these dynamics elevate the probability of condomless sex, delay engagement with care, and limit access to affirming reproductive services. For transgender women, gaps in fertility preservation counselling and compatible contraceptive options with gender-affirming care further illustrate how reproductive medicine often remains cisnormative, leaving critical needs unaddressed [23].

Policy and Practice Implications

Provider training and accountability. Reproductive health providers should receive structured training in sexual and gender diversity, trauma-informed care, and confidentiality. Facility-level policies (e.g., non-discrimination statements visibly posted; complaint and redress mechanisms; standardised

intake forms capturing gender identity respectfully) can translate training into practice.

Stigma-reduction and service integration. Embedding stigma-reduction interventions within antenatal, family planning, and HIV clinics can improve patient experience and retention. Integrating contraception, fertility counselling (including fertility preservation for transgender people), HIV testing/ART, and PMTCT within the same service nodes reduces attrition and travel costs.

Accessible prevention and contraceptive choice. Ensuring reliable access to condoms, lubricants, and PrEP, alongside a full contraceptive method mix tailored to patient context (including interactions with hormone therapy), supports both HIV prevention and reproductive goals. Community distribution and mobile/outreach models can mitigate facility avoidance.

Legal and structural reforms. Decriminalisation of same-sex practices and clear human-rights protections would reduce the fear that currently deters health-seeking. Partnerships with community organisations can expand safe housing, economic opportunities, and navigation support, addressing upstream drivers of survival sex and care disengagement.

Ethical Considerations: Reproductive Justice and Equity

A reproductive justice lens emphasises the right to have children, not have children, and to parent in safe, supportive environments. For young transgender women and sexually diverse men, justice requires more than infection control; it demands equitable access to fertility information, contraception, and pregnancy care free of stigma. Ethically, reproductive medicine should affirm diverse family formations, protect confidentiality, and prioritise patient agency—particularly where criminalisation and poverty heighten vulnerability. Equity-focused quality improvement (e.g., routine equity audits, disaggregated outcomes monitoring) can make these commitments measurable and actionable.

Conclusion

This study documents how healthcare stigma, economic precarity, and criminalisation converge to shape HIV vulnerability and constrain reproductive options for young transgender women and sexually diverse men in Kingston, Jamaica. Participants described delayed HIV testing, avoidance of clinics, gaps in contraceptive and fertility counselling, and constrained condom negotiation within transactional sex—pathways that translate social inequities into adverse reproductive outcomes.

For policy-makers and health systems: institutionalise non-discrimination policies, mandate provider training, and integrate HIV prevention, contraception, fertility counselling, and PMTCT. For clinicians: adopt trauma-informed, gender-affirming practices; proactively discuss fertility intentions and contraceptive preferences; ensure access to condoms, lubricants, and PrEP. For community partners: expand safe housing, economic supports, and peer navigation to reduce reliance on survival sex and facilitate continuous care.

Longitudinal studies should track how stigma-reduction, integrated service models, and legal reforms alter reproductive and HIV outcomes. Intervention trials testing bundled packages (stigma-reduction + integrated reproductive/HIV care + economic support) are warranted, with implementation science methods to optimise scale-up.

Reframing HIV as a reproductive health issue clarifies that improving maternal–fetal outcomes, preventing vertical transmission, and supporting fertility intentions are inseparable from dismantling stigma and inequity. Advancing reproductive justice for marginalised populations is therefore not ancillary to reproductive medicine—it is central to its mission.

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