ABORTION STIGMA AROUND THE WORLD:

A synthesis of the qualitative literature

inroads

International Network for the Reduction
of Abortion Discrimination and Stigma

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Background

Stigma discredits individuals, communities and institutions and marks them as inferior (Goffman, 1963). Stigma is a major contributor to the social, medical and legal marginalization of abortion worldwide. Throughout the world, women do not have the right to make the crucially important and life-transformative decision: to carry a pregnancy to term or not. In spite of the fact that abortion is a very common experience during women's reproductive lives, stigma persists and abortion is seen as wrong or deviant. We find common root causes of abortion stigma that are linked to gender, sexuality and motherhood across different geographic and cultural contexts. Stigma manifests differently for different people, depending on cultural context and access to power and privilege. Consistently, abortion remains a contested issue in countries and regions as different as Nigeria, the United States, Kenya and Mexico and the Caribbean. Stigma can impact how, where and when women seek abortion care. It has been shown to contribute to health-care providers' unwillingness to provide services or influence how and where services are provided (Kumar, Hessini, & Mitchell, 2009). At its core, abortion stigma and resulting poor care, loss of status, and discrimination violates women's most basic human rights, including the right to be free from gender-based discrimination, the right to privacy and the right to the highest attainable standard of health (United Nations Human Rights Council, 2012).

In response to the consistent and impact of abortion stigma on every aspect of our social spheres, political lives, and health, the International Network for the Reduction of Abortion Discrimination and Stigma (inroads) formed in 2014 specifically to foster collaboration and coordination among those working to understand, mitigate and, ultimately, dismantle abortion related stigma and discrimination. This report provides a grounding in the fundamental concepts of abortion stigma and a synthesis of the qualitative literature around the world exploring the way abortion stigma manifests.

Understanding Abortion Stigma

In 2009, Kumar, Hessini and Mitchell propose a definition of abortion stigma as:

> "A negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood."

Building on this definition in 2013, Cockrill, et al., acknowledge the role that stigma plays with abortion providers, systems of care, communities, laws and policies and the media. The authors define abortion stigma as:
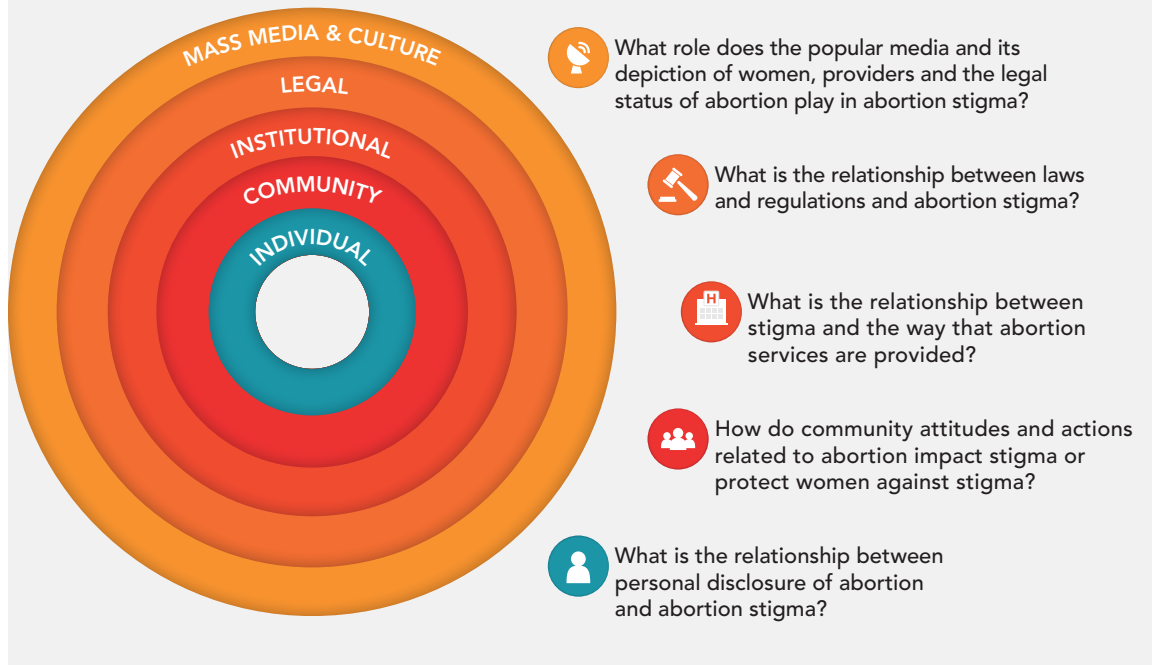
> "A shared understanding that abortion is morally wrong and/or socially unacceptable."

In efforts to conceptualize stigma in general, Link and Phelan (2001) offer a four-component model to describe the social process of stigma, which can be applied to abortion stigma . These stages can roughly be described as labeling, stereotyping, separating, and discrimination. As applied to abortion, this circular and non-hierarchical social process includes (Shellenberg et al., 2011):

- **Labeling:** Abortion is seen as an abnormal event. Women who have abortions and providers who offer abortion care are labelled as deviant. Behind these ideas is an oversimplification of pregnancy termination. Labeling abortion and those marked by it as abnormal hides how frequent and common abortion is.

- **Stereotyping:** Women who have abortions are linked to negative traits such as promiscuity, carelessness, selfishness, and having a lack of compassion for human life. Abortion providers stereotyped as cold, unfeeling, and motivated by greed or money.

- **Separating:** Women and providers are moved into a separate category, creating a false "us" versus "them" dichotomy. This separation serves to shame those marked by the stigma of abortion. Silence and fear of exclusion perpetuates this separation and participation in stereotyping.

- **Discrimination:** This social process of stigma leads to overt discrimination or status loss for women and providers.

Based on an understanding of how stigma operates in other fields, such as HIV and AIDS and mental health, a group of experts from the fields of law, health care, social sciences and community organizing advanced an ecological model (see Figure 1) of abortion stigma that illustrates the multiple levels at which stigma manifests (Hessini, 2014). This framework acknowledges that stigma manifests itself differently across geographic and cultural contexts. It is with this model that we explore the qualitative literature around abortion in this report.

Figure 1: Ecological Model of Abortion Stigma

What role does the popular media and its depiction of women, providers and the legal status of abortion play in abortion stigma?

What is the relationship between laws and regulations and abortion stigma?

What is the relationship between stigma and the way that abortion services are provided?

How do community attitudes and actions related to abortion impact stigma or protect women against stigma?

What is the relationship between personal disclosure of abortion and abortion stigma?

Individual level stigma is the experience (internalized, perceived and enacted) of stigma by individuals. Women who have abortions, people who support those women, and individuals involved in providing abortions all can experience individual level stigma.

Community level stigma refers to the social and cultural norms, attitudes and behaviors towards abortion (women and providers) that exist in communities.

Institutional level stigma refers to how policies and practices within health facilities, professional societies, and medical education institutions can have the effect of marginalizing abortion and the people who are involved in providing abortion care.

Stigma at the **legal** level includes how barriers to abortion and reproductive health care are written into laws, and how policymakers and institutions interpret those laws in ways that discriminate.

Stigma at the **mass media** and **cultural** level includes how abortion

care, providers and the people who have abortions are portrayed in the media, referred to in dominant discourse, and are made visible or invisible in popular culture.

Methods

Search strategy. From December 2014 through June 2015 a series of electronic and manual searches were carried out to yield qualitative and quantitative literature related to abortion and stigma. Librarians at Ipas, the host organization for inroads, conducted a search of peer-reviewed articles (using PubMed, Global Health, Web of Science, Academic Search Premier, PsychINFO, women's studies and law databases) published in 2005 or later with "abortion" and "stigma" in the title, abstract, or subject heading. All results were assessed for relevance by inroads staff.

Review. The inclusion process went through three stages of review: a title and abstract review to determine clear inclusion, a full paper review to identify applicability to the aims of this synthesis, and a methodological review to determine applicability within the inclusion criteria. The inclusion criteria were: 1) employed qualitative methodologies; 2) published in 2005 or later; and 3) reported thematic findings on abortion stigma. Only articles in English were reviewed for this synthesis.

Analysis. In order to conduct this synthesis for inroads members, we focused on the following study characteristics:

- Geographic location of the study

- Levels of abortion stigma and how stigma-manifests within and across the individual, community, institutional, legal, or mass media/cultural levels

- Ways that individuals who seek, support or provide abortions navigate the experience of stigma

Results

Identification, screening and eligibility

The literature search yielded 81 articles. Thirty-eight articles were excluded from this qualitative synthesis because they reported only quantitative findings or were commentaries or policy analyses. In total, 43 studies included: 38 qualitative studies and five mixed-method studies (see appendix for a full listing of studies included). Qualitative methods included: in-depth interviews, focus groups, discourse analysis, field observations, and narrative analysis.[1]

Study characteristics

The settings for included articles represented a diversity of geographic setting, with a majority of studies in Africa and North America (Figure 2). Several studies included multi-country analyses. Countries included:

- **Africa:** Burkina Faso (2), Ethiopia (2), Ghana (4), Kenya (2), Malawi (1), Nigeria (2), South Africa (3), Uganda (1), Zambia (1)

- **Asia:** Bangladesh (1), China (1), India (1), Iran (1), Nepal (1), Pakistan (1) Philippines (1)

- **Europe:** United Kingdom (3)

- **Latin America and the Caribbean:** Bolivia (1), Mexico (2), Northeast Caribbean, including Anguilla, Antigua, St. Kitts, St. Martin, and Sint Maarten (1), Peru (2)

- **North America:** Canada (1), United States (13)

Figure 2: Geographic Distribution of Studies

Africa

North America

Asia

Latin America and the Caribbean

Europe

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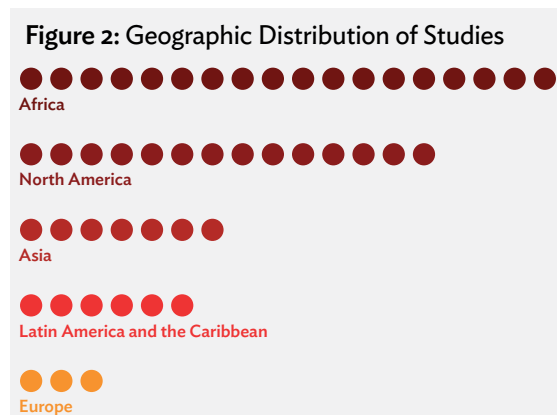
1 With in-depth interviews and focus groups, researchers examined the transcripts for themes. Researchers also observed doctors and health workers, taking notes on observations and analyzing those notes. Discourse analyses included analyses of statements and themes about abortion in the news media, religious and folk teachings, etc. Narrative analysis is a specific approach using text (laws, articles, media, etc.) as the unit of analysis to identify meaning. For a more detailed discussion of abortion stigma measurement methods, see Cockrill, et al. 2013.

To ensure understanding of how stigma manifests across multiple levels, studies were coded as to which level of the ecological model the primary themes corresponded. Most studies identified themes that addressed multiple levels. The individual, institutional, community and legal levels were fairly evenly represented across the included studies. Fewer studies identified themes at the mass media level (Figure 3).

The included studies focused on a variety of populations. Stigma attaches not only to women seeking abortions, but to the individuals and systems of care that provide abortion.

Overall, the study populations can be classified into three main groups:

Figure 3: Distribution of Themes Across the Ecological Model

- Women who have personal experience with abortion (had an abortion, turned away from an abortion, sought post-abortion care): 17 studies

- Professionals involved with providing abortion: 12 studies

- General community members: 11 studies
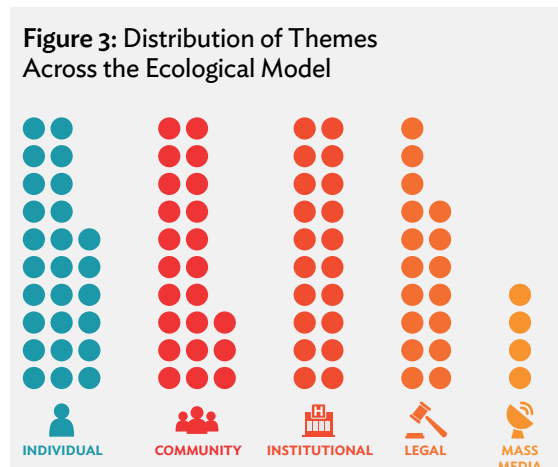
Synthesis

In order to fully understand how abortion manifests across the multiple levels of the ecological model, we first present findings by each level: individual, community, institutional, legal and mass media. Then, we explore how stigma at some levels may impact the manifestations of stigma at other levels. Finally, we explore the intersections of abortion stigma with other stigmatized characteristics — specifically HIV status and young women's sexuality.

Individual

Secrecy and isolation. Among women who have abortions, experiences of secrecy and isolation was common throughout different cultural contexts. In a variety of

countries throughout Africa, Asia and Latin America (Peru, Mexico, Pakistan, Nigeria, Kenya, Ghana, and Ethiopia), researchers found that women deliberately keep their decision-making and abortion experiences secret from peers, family members and partners for fear of damage to reputations. Secretiveness is one strategy that women use to avoid the social consequences of having peers and community members know about their abortions. (Izugbara, Otsola, & Ezeh, 2009; Kebede, Hilden, & Middelthon, 2012; Tagoe-Darko, 2013)

> "Those who do it know why they do it but those who don't support it would say many bad things about them. So women do it secretly."
> — Rural older woman, Kenya

Other researchers also found that abortion stigma affects women's disclosure of their experiences with abortion in the developed world, as well. In the United States and the United Kingdom, women also reported keeping their abortion experiences secret out of fear of social judgment. (Astbury-Ward, 2015; Cockrill & Nack, 2013; Weitz & Cockrill, 2010) Such secrecy and social isolation can further distance women from needed social and emotional support and can exacerbate feelings of guilt and shame. This can also lead to the paradox that something as common as abortion is seen as rare and deviant (Kumar et al., 2009).

Providers also carefully manage how to and when to disclose that they provide abortions (Freedman, Landy, Darney, & Steinauer, 2010; Harris, Martin, Debbink, & Hassinger, 2013). In the United States, fear of violence and threats to professional-peer relationships drive physicians to hide or minimize their work as abortion providers. Harris and colleagues posit that this leads to a "legitimacy paradox":

> "The legitimacy paradox cycle works in this way: when abortion-providing physicians do not disclose their work in everyday encounters, their silence creates an impression that performing abortion work is unusual, non-standard, or non-normative (or at the very least their non-disclosure allows people to believe that nobody they know provides abortion care). Abortion work comes to be seen as deviant or not the kind of work that a neighbor, friend or colleague would do. The social stereotype that legitimate, mainstream doctors don't do abortions is perpetuated. This stereotype contributes to the marginalization of abortion providers, both inside and outside of medicine, and to targeting of abortion providers for harassment and restrictive

legislation. Providers reasonably come to fear stigmatization and harassment, which brings ongoing reluctance to disclose abortion work. Therefore, the cycle continues."

Guilt and shame. Some studies across a diversity of region and culture found that women report feeling guilt and shame for having abortions, which was frequently articulated in the context of religion. (Chiappetta-Swanson, 2005; Gipson, Hirz, & Avila, 2011; Hosseini-Chavoshi, Abbasi-Shavazi, Glazebrook, & McDonald, 2012; Palomino et al., 2011; Shellenberg et al., 2011; Sorhaindo et al., 2014) In many countries, religious forces hold political and cultural power, and shape the discourse that shapes how people understand abortion. In some studies, participants who report feelings of guilt and shame rarely tied those feelings to experiences of enacted stigma or discrimination. Rather, feelings of guilt were tied to beliefs that abortion is a sin (or that others would judge them as having sinned in the eyes of God). (Palomino et al., 2011; Shellenberg et al., 2011)

Some women who have internalized negative stereotypes about women who have abortions stigmatize other women by conjuring images of others as irresponsible, callous or promiscuous in order to distance themselves from feelings of guilt or shame. By judging other women having abortions, they created distance in order to view their own experience positively. (Nickerson, Manski, & Dennis, 2014)

> "If you're talking about the habitual person who uses abortion as a method of birth control, that's one thing. If you're talking about a person in a one-time situation, like mine, never had an abortion again." — United States, 33-year-old woman

Guilt and shame, however, are not correlated with regret. While some women express feelings of shame, they still remain firm that an abortion was the best course of action. (Orner, de Bruyn, & Cooper, 2011; Shellenberg et al., 2011)

Community

Centrality of motherhood. Community social norms around motherhood and the role of women, about the focus on and value of the fetus, about women's sexuality all impact the stigma attached to women who have abortions and the caregivers providing abortion. Where community norms center on the role that women are, first and foremost, mothers, the stigma surrounding abortion may be rooted in

the shame of deviating from that role. The importance of motherhood arose as an important factor driving abortion stigma in Mexico, Peru, Burkina Faso, Bangladesh and Nepal. (Hill & Kirkwood, 2009; Payne et al., 2013; Shellenberg et al., 2011; Sorhaindo et al., 2014; Tagoe-Darko, 2013)

Female sexuality. Social and community norms around women's sexuality are at the heart of the stigma surrounding abortion. In many settings, there is a strong stigma attached to sexual activity outside of marriage. In such cases, the fear of pregnancy serving as proof of sanctioned sexual activity may overwhelm the barriers to and stigma of accessing an abortion: abortion may be bad, but ill-timed pregnancy is worse. (Dahlback, Maimbolwa, Kasonka, Bergstrom, & Ransjo-Arvidson, 2007; Hill & Kirkwood, 2009; Kebede et al., 2012; Omo-Aghoja et al., 2009; Rossier, 2007; Shellenberg et al., 2011) However, in other settings, no matter how stigmatized extramarital sex and unwanted pregnancy, abortion is seen as the more serious transgression. (Gipson et al., 2011)

> "Even if people will talk about you as not having a husband, as a pinaangkan (one who has a child without a husband), it doesn't matter as long as you don't abort... Even if I don't have a husband, that's a baby already in your womb. If you have an abortion, you are already eaten by worms even if you are still alive." — Philippines, 23-year-old woman

Community attitudes towards women who have abortions: labelling and stereotyping. Violations of norms around the role of women as mothers and around socially-sanctioned sexuality lead to the labeling and stereotyping of women who have abortions. Social pressures have created a number of negative labels to apply to women who have abortions: being associated with sex work, being loose or selfish, and deserving future misfortune. (Bhandari, Mo Hom, Rashid, & Theobald, 2008; Gipson et al., 2011; Levandowski et al., 2012; Palomino et al., 2011; Shellenberg et al., 2011)

> "[People think that] only women with loose character [baraali-yera hideki aaimaai] have abortion. So, people do not consider it good." — Nepal, 30-year-old woman

Perceived consequences of abortion. In some studies, respondents framed any subsequent misfortune as perceived negative outcomes attributed to having an abortion. In Iran, misfortune after abortion is seen as punishment for the sin of abortion, and is attributed to having had an abortion. (Hosseini-Chavoshi et al.,

2012) In Mexico, Pakistan, Malawi and Nepal, abortion was viewed as a threat to future fertility. (Bhandari et al., 2008; Levandowski et al., 2012; Shellenberg et al., 2011)

> "If a woman goes for abortion, she won't see the face of [give birth to] a son in next seven births." — Nepal, 45-year-old woman

The shame and stigma of abortion is seen as contagious in Zambia, Pakistan and Malawi. In Malawi, some believe that men will die if they have sex with a woman who has had an abortion. (Levandowski et al., 2012) In Pakistan, some believe that a woman who has an abortion is can make those around her sick. (Shellenberg et al., 2011).

> "If a woman opts for abortion, people try to avoid her because they believe she is possessed and that can affect children and other women. They do not visit that woman's home for some time. They do not even want to pass by her house and they consider that they will get weak or sick if they talk about that woman." — Pakistan, female focus group participant

Community-enacted consequences of abortion. Perceived consequences of abortion can be linked to very real consequences. In many places, women may be shunned for seeking or having abortions, further perpetuating women's secrecy and isolation. In Ghana, young women might be thrown out of their homes. (Tagoe-Darko, 2013) In one small Caribbean island, providers note that "If their church finds out they have had an abortion, they'll be expelled from the church." (Gipson et al., 2011). Two examples from Mexico and the United States mirror each other:

> "I actually lost her, a best friend, over this situation because she is so against abortion. Without even realizing how strongly she felt about the situation, she actually turned her back on me and was like, "I have no respect for you because you're trying to do this." — United States (Cockrill & Nack, 2013)

> "A friend of ours,... She turned on us when... she was new at the club when this had just happened, at that time she learned that almost all of us had done so [had an abortion]. She said that we were bad, bitches, that we did not value life, that we didn't even know what we were losing and she was very, very religious. She then said God would punish us." — Mexico (Sorhaindo et al., 2014)

Community attitudes towards abortion providers: labeling and stereotyping. As we've seen with women, abortion providers are also labeled and stereotyped. In Ghana and Kenya, some see abortion providers as motivated by money and greed. (Izugbara et al., 2009; L. Martin, Debbink, Hassinger, & Harris, 2011; Payne et al., 2013)

Institutional

Barriers to providing abortions. Before addressing how stigma impacts the way abortion services are provided, it's important to note the multitude of barriers that have been put into place to delink abortion care from regular health care. In the United States, for example, there are system-level institutional policies and prohibitions on offering abortion care. Even individuals within those systems who support access to abortion may be relieved to avoid abortion provision. "The chief of my department told me, 'I think everybody's just very relieved that we don't have to worry about this ourselves.' ... And she's somebody who's actually a supporter, but she was relieved as the chief not to have to deal with ... who was going to do [abortions], who wasn't going to do them, and whether the department had to be all in agreement about providing the service." (Freedman et al., 2010) In Ethiopia, midwifery students report that religiously-based stigma surrounding abortion is a barrier to even becoming abortion providers. (Holcombe, Berhe, & Cherie, 2015) Lack of access to training is also a very real barrier for individuals who may wish to become providers, as well as those who already provider abortion care. For example, in Canada, a real lack of institutional support for nurses who manage pregnancy termination for fetal abnormality includes a lack of standardized procedures and training. (Chiappetta-Swanson, 2005)

Abortion stigma and quality of care. Abortion stigma can be linked to poor quality care both through institutional barriers such as training and obstructionist polies and procedures, as well as through individual stigmatizing attitudes and beliefs on the part of health-care professionals. Following are a few examples:

- "There was little support for abortion among the medical staff. The nurses shouted roughly at her and added she was not the type who assisted people killing innocent children" — Ghana, 20-year-old woman (Chiappetta-Swanson, 2005)

- In Ghana, nurse views on abortion are a significant barrier for providers in offering high quality care. Some nurses refuse to set up the surgical cart and instruments. (Payne et al., 2013)

- In Malawi, patients seeking post-abortion care may be "looked at as having done a bad thing and may be neglected." — Malawi, Nurse-midwife (Levandowski et al., 2012)

- In South Africa, studies find inconsistent quality of care. One woman reported a surprising "lack of care received immediately post-abortion, expecting to be washed and her pain attended to, not '*chased out of the room because other people must come in*'" while others reported preferring their abortion provider for continuing family planning care because of high quality experiences. (Orner, De Bruyn, Harries, & Cooper, 2010)

- In Bangladesh, provider judgments about their clients' characteristics shaped the quality of service that they provided. (Bhandari et al., 2008)

- Health care professionals in settings where institutional policies are ambiguous can also serve as gatekeepers to care, either stigmatizing and discriminating against women, or ensuring access in a complicated policy environment. (Gipson et al., 2011; Orner et al., 2011; Payne et al., 2013; Pheterson & Azize, 2005)

Legal

Legal abortion. Decriminalization and ensuring legal access to abortion is primary strategy of advocates for non-stigmatized abortion access. However, legal abortion is not sufficient to ensure non-stigmatized care, and law reform can lead to an increase in stigmatizing rhetoric and activism. (Becker & Diaz-Olavarrieta, 2012) In some settings, where abortion is both criminalized and heavily stigmatized socially, providers and advocates may not actually support efforts for decriminalization. Consider the complicated environment of the Northeast Caribbean, where some islands have more liberal abortion laws, and others have a more legally restricted context (Pheterson & Azize, 2005):

- In Saint Maarten, abortion is illegal but tolerated: "Everyone knows it is done. It's an institutionalized toleration system. Safe abortions are available, also by gynecologists at the hospital ... The Health Department here is totally aware of the situation but they don't acknowledge it. They like to keep the situation illegal because then they could catch you. If anything goes wrong, they could prosecute ... it's a taboo situation ... But no, I'm not for legalization, that would

mean more controls, more delays. The system works fine the way it is."
(General practice physician)

- In Anquilla, where the law had been liberalized shortly before this research
  was conducted, stigma was still a significant factor: "The change in law was not
  intended to open up abortion for women here. It was recognized that there are
  certain circumstances that may be dangerous for the mother ... The culture of
  Anguilla would not permit abortion on demand. This is a Christian society. Laws
  from Great Britain are not our laws." (Attorney General)

- St. Martin is governed by French law and abortion is available in the hospital
  system. However, women seek abortion on neighboring islands or illegally with
  private practitioners in order to avoid the hospital and risk public exposure.

Meanwhile, South Africa boasts one of the most liberal abortion laws in the world.
However, in practice, researchers have observed a proliferation of unlicensed pro-
viders advertising and openly practicing. Additionally, physicians in the public sector
are mandated to provide services. Many seek conscientious objection avenues to
avoid providing abortion. (Harries, Gerdts, Momberg, & Greene Foster, 2015) And
in the United States, an analysis of legal rulings demonstrates enacted stigma in the
laws that separate abortion services from mainstream medicine. (Abrams, 2013)

Ambiguous legal environments. Environments where the laws and policies around
abortion are unclear or ambiguous, providing abortion care can be a source of great
stress and risk. Consider the case of Ghana, where the law first states that abortion
is illegal, but then goes on to lay out a number of exceptions such that in practice, it
is a liberal legal framework. However, that ambiguity has physicians worried about
fines and imprisonment for providing abortion that could be argued to fall outside
of those criteria. (Payne et al., 2013)

> "The ambiguity of the law is both a manifestation of abortion stig-
> ma, and a method by which such stigma is perpetuated. The legal
> code begins with a clear prohibition; it is only after that prohibition
> is crisply demarcated that the "extenuating circumstances" under
> which abortion is permitted can be listed." (L. Martin et al., 2011)

Restricted abortion settings. Where abortion is criminalized or restricted, the
manifestations of stigma and discrimination may be conspicuous. Women only

have clandestine avenues available to them, and the safety of those avenues is variable depending on the context and their access to quality information and drugs In some settings, such as Burkina Faso, while there are providers willing to offer care, they only offer services to people that they can personally vouch for: "Se´cou did not have the right connections, i.e. someone trusted by the male nurse who would guarantee Se´cou's silence afterwards, so the nurse did not admit that he performed abortions." (Rossier, 2007) In such settings, women with means "'go to private clinics and have it done by the doctors and you won't even hear about it' while 'the girls and women who die from bad abortion are those who don't have money to go to proper doctors.'" (Izugbara et al., 2009) It is not enough to simply liberalize laws. It is also critical shift the cultural context in which abortion provided and sought.

Mass media and culture

We identified few studies which examined themes of abortion stigma at the level of mass media. This may be due to databases that were consulted during the search phase. We expect that this section will continue to be updated in the coming years, with recent contributions in late 2015 and upcoming research underway. The four studies that were identified both employed discourse and narrative analysis methods to examine themes of abortion in the media. In Uganda, two discourse frames emerged: the sanctity of life (a religious frame) and the fetal right to life (co-opting a human rights frame). Both discourses are in service to restricting access to abortion, and have consequences for how women who access abortion are portrayed. (Larsson et al., 2014)

In Burkina Faso, themes around a public health frame (saving women's lives) and a rights-based frame (women's rights) were analyzed. Informants concluded that institutional and legal actors in Burkina Faso are resistant to a rights-based frame, though there was disagreement: "The issue of rights is actually a hindrance because many ...as soon as you mention a woman's rights they become completely closed up and they don't want to have anything to do with it. But when you present it in terms of a public health issue, it's far more difficult for officials to ignore it." (Storeng & Ouattara, 2014). Both of these studies assessed the way abortion is portrayed in the news media.

In the United States and in the United Kingdom, researchers found narrative themes that emphasized abortion as a risk, as unsafe. In the UK, an analysis of Scottish and British newspapers found that abortion was consistently framed as negative: risky, unsafe, and immoral. The voices of women themselves were mar-

ginalized, creating a discourse that marked abortion as deviant and abortion stigma as inevitable. (Purcell, Hilton, & McDaid, 2014) In the US, researchers analyzed all representations of pregnancy decision-making and abortion in American film and television from 1916 through January 2013. They found that abortion was fictionally linked to mortality at a much higher rate than in reality, contributing to a social understanding that abortion is risky and dangerous. (Sisson & Kimport, 2014) The way abortion is characterized in the popular media, both the entertainment media and the news media, can influence the way abortion is understood.

Stigma at one level may impact how stigma manifests on other levels

The discussion in this report so far has centered on how stigma manifests at each of the five levels of the ecological model. Now, let's turn to some examples of the complex interplay between levels.

The law/policy environment and institutional settings. For example, in some Caribbean islands, providers offer abortion extra-legally. As we saw in the case of Sint Maarten, physicians actually fear that new laws "legalizing" abortion will actually restrict their provision more than the status quo. At the same time, regardless of the nature of a country's abortion laws, the impact of provider-level stigmatizing attitudes can be very powerful. Physicians hold a great deal of privilege and power, and can determine who can have an abortion and when/why. "I try to discourage women from having an abortion unless they have heavy social reasons. If a woman has six or seven or eight children, okay, but if she has only two or three then I don't do the abortion." (Pheterson & Azize, 2005) Consider also Burkina Faso, where there are very few indications for legal abortion: "Due to the difficult procedures involved in obtaining abortions for legal indications, individual doctors often arbitrate over women's access to 'therapeutic' abortion, often without consulting the legal system or medical colleagues. This is in order to avoid being accused of colluding with women, who are often suspected of lying about sexual assault to justify their abortion requests." (Storeng & Ouattara, 2014). Legal ambiguity can also have an impact on the quality of care provided in an institutional setting. In Ghana, for example, some private practices don't maintain any records. (Payne et al., 2013). Finally, the legal and policy environment directly impacts how doctors characterize their work – with each other, with administrators and with the general public. In Bolivia, doctors' discourse about the care they were providing was highly attuned to

their audience, and they expressed compliance and adherence to law and policies even as their practice conflicted with established rules (Rance, 2005). Opaque and ambiguous legal and policy environments can have both a chilling effect on providers and health systems while also offering some opportunities for those providers to resist stigma and create avenues of access.

Institutional, community and individual: What is a safe abortion? Researchers observed a paradox that where abortion is legal and there have been concerted efforts to increase availability within health systems, women are still seeking abortion outside of those legal avenues of care. This can be related how it is provided institutionally, including the quality of care or lack thereof, perceptions of confidentiality. When combined with stigmatizing community norms about abortion, pregnancy, and sexuality, the question arises: What does "safe" really mean? Upon examination, it appears that "safe" can mean different things, depending on the social and cultural context of abortion. In Kenya, great efforts have been underway to train providers and to educate women about accessible abortion services. However, the social stigma of abortion is still pervasive. A public health framework for safety may seem unambiguous: evidence-based methods with trained providers in a health facility. Women, on the other hand, value privacy, cost, in some cases, the ability to maintain secrecy, and in other cases, services that are vouched for through social networks. This may lead women to seek care in settings that public health practitioners would deem unsafe. (Izugbara, Egesa, & Okelo, 2015). This theme is echoed in the United States, where women express a preference for abortion clinics over their own provider. Again, women value privacy, cost and an ability to control their image in their assessments of safe or appropriate services. (Weitz & Cockrill, 2010).

Researchers in the United States also found that some abortion clinic processes can reinforce a community narrative that abortion is unsafe and lonely. When women experience clinical processes and interactions that are mandated by the realities of anti-abortion hostility, women can have negative individual experiences and the social myth that an abortion clinic is dangerous can be reinforced. (Kimport, Cockrill, & Weitz, 2012; Kimport, Preskill, Cockrill, & Weitz, 2012) As providers, policymakers and programmers seek to increase women's access to safe abortion, whether within a health-care setting, or by increasing access to medications through other channels, an understanding of how women conceptualize safety and danger and how that is influenced by abortion stigma is critical.

Intersections: the compounding effect of multiple stigmas

The impact of stigma can be exacerbated among those who are marginalized due to other stigmatized identities. Two recurring themes emerged in the literature: Young women and HIV positive women.

Youth and abortion stigma. In many cultural settings, sexual activity among young unmarried women is highly penalized. For example, in China, sexual activity under the age of 16 is illegal regardless of consent: "By the threat of punishment of men to deter sexual intercourse, these laws have also increased teenage girls' vulnerability to unsafe abortions or having babies at a young age." This explicit law and cultural norm leads to girls hiding pregnancies and abortions to protect their partners. Laws that criminalize sexual activity among young people and that mandate parent consent create silence, shame, and increased access to poor quality and frequently expensive services instead of high quality, publicly available care in Hong Kong. (Hung, 2010) In India, the social stigma surrounding young people's sexuality is so pervasive that the fear of disclosing unplanned parenthood leads to delays in seeking abortion services. (Sowmini, 2013) And in Zambia, the "double stigma" of social unacceptability is manifested by a young, unmarried woman's pregnancy and abortion, which may even be coerced by her parents (Dahlback et al., 2007). The stigma of abortion that is rooted in community norms around women's sexual agency is compounded for young people, who may have fewer resources at their disposal and even more barriers stopping them from accessing care.

HIV stigma and abortion stigma. A series of studies in South Africa explored the impact of stigma among HIV-positive women who were pregnant and considering abortion. "The HIV-positive women in this study represent a triple-bind situation. They experience social disapproval if they become pregnant after knowing their HIV-positive status; they are often impeded in attempts to prevent pregnancy by uncooperative partners or experience difficulties in using contraception; they feel even stronger social and internalised disapproval when they consider or have an abortion." (Orner et al., 2010)

Some women perceive that abortion is even more taboo than HIV. Study participants in both Kenya and South Africa observed that more women disclose HIV status than experience with abortion. "In this country, HIV-infected people speak openly about their status and even attract sympathy and support. Abortion is the worst thing you can do as a woman. If you admit to it openly or if it is found out,

you will lose every respect you have. People will call you bad names" (Izugbara et al., 2015; Orner et al., 2011). However to make sense of the differential experience of stigma, it is important to consider two factors: 1) There is a growing body of research and interventions to address HIV stigma in these regions, and 2) many people who are HIV positive treat their HIV status as a part of their ongoing identity, whereas many women see abortion as one discrete experience.

Counter-narratives of abortion: Themes of resistance, resilience, and opportunity for change

Research also points to the ways that women and providers manage abortion stigma and the ways that resistance and resilience work to mitigate stigma at various levels. There are also opportunities or levers for possible change that are manifest in this body of literature.

Abortion is a positive and powerful experience. In Kenya, some female participants identified their experiences with abortion as empowering, sometimes soothing, and frequently relieving. Ma Grace, an elder woman in rural Kenya, shared that "'such a woman would say 'now I am okay'. She can continue with her activities… She feels better and will not worry again" (Izugbara et al., 2009). In Mexico, some of the youngest women participating in the study articulated a pride in their ability to decide and have an abortion. "For these women, having successfully resolved a serious problem on their own was empowering. Further, they felt that deciding not to become a mother under these circumstances was an example of prioritizing their personal health and wellbeing" (Sorhaindo et al., 2014).

Perceptions about abortion can change. All of the women interviewed in Mexico (Sorhaindo et al., 2014) reported that they had changed their perception of abortion once they had a personal experience with unwanted pregnancy. Whereas prior to having an abortion, many participants believed that abortion should only be allowed under particular circumstances, and that women who have abortions were irresponsible. After having an abortion, they believed this perspective is damaging to women. Working with women who have had abortions to shift their perceptions and framing is a possible lever for shifting stigmatizing norms.

Provider resistance to stigma. Nurses who work in hospitals offering abortions for genetic abnormalities found a freedom to develop their own systems and strategies.

They developed formal and informal routines to ease the burden of their work – to mitigate the stigma associated with their roles (Chiappetta-Swanson, 2005). The nurses also focused their energy and found dignity and satisfaction in helping their patients, applying a caring framework as a coping strategy to mitigate stigma, as well as to find power and dignity in their work. Abortion providers in the United States echoed this: by focusing on a strong belief in the "goodness" of their work and by forming a supportive, in-group work culture, and providers were able to resist stigma (O'Donnell, Weitz, & Freedman, 2011).

Positive responses to disclosure. In the U.K., some study participants found positive responses when they disclosed their experience terminating a pregnancy due to fetal abnormality that they didn't expect (France, Hunt, Ziebland, & Wyke, 2013). In Burkina Faso, deliberate sharing and disclosing of abortion with social networks is a stigma management strategy in a legally ambiguous and culturally censuring environment (Rossier, 2007). Participants in a pilot of the Provider Share Workshop, an intervention aimed at reducing the stigma experienced by abortion providers, found that "disclosure can also be a reflection of pride and resistance to the construction of abortion work as immoral" (Harris, Debbink, Martin, & Hassinger, 2011).

Discussion

This synthesis examines the individual, social, institutional, legal, and media-based manifestations of abortion stigma identified in the past decade's qualitative research findings. Abortion stigma is socially constructed, culturally and socially embedded and is influenced by social and cultural mores. The manifestations of stigma are impacted by the legal context, however a liberal law and policy environment does not necessarily lead to a reduction of stigma. Without cultural norm transformation, stigma continues to manifest in different ways.

Stigma has been attributed to social and cultural norms related to gender, sexuality and motherhood. Consequences include perceived negative experiences attributed to abortions (e.g., contagion, future fertility problems), as well as enacted experiences such as community isolation and shunning. Stigma creates barriers to provide safe and high quality abortion services, and creates the conditions for ambiguous and opaque law and policy environments.

The impact of abortion stigma is made more complex by its intersections with other marginalized and stigmatized characteristics. We understand that the impact of stig-

ma is often driven by a difference in power. This is exemplified by the compounded social impact of sexual activity and abortion stigma on young and unmarried women. Furthermore, an existing body of literature on sexuality, race and gender discrimination suggest that social marginalization of people experiencing discrimination in general society correlates with adverse health outcomes. The stigma of abortion among people otherwise marginalized may be compounded, leading to further shame, isolation, complications associated with unsafe abortion, and mortality.

This body of literature suggests that women and providers employ strategies to mitigate stigma, including looking for avenues of support among close friends and colleagues, as well as reframing the experience of abortion as a positive and empowering experience. This is reflected in the very few published evaluations (to date) documenting stigma reduction as a result of an intervention (Littman, Zarcadoolas, & Jacobs, 2009; L. A. Martin, Debbink, Hassinger, Youatt, & Harris, 2014).

Consistent with literature around HIV-related stigma and the stigma of mental illness, these findings suggest that efforts to combat stigma will require more than targeted interventions to abortion providers and to women who have abortions. Efforts to dismantle stigma must address the social construction of stigma at all levels of the ecological model. Inroads members around the globe are taking note and taking action. The inroads Partnership Fund has issued a series of grants to pilot strategies at multiple levels, as well as to further understand the barriers to care. Grantees will be disseminating findings in the latter half of 2016. Additionally, research evaluating impact of interventions to reduce abortion stigma are underway in several contexts:

- Service delivery settings

- Community

- Individual women

- Individual providers

There is still more to do to develop and refine strategies to reduce abortion stigma and discrimination and even more work to measure the impact of these strategies. We envision this qualitative synthesis to be a living document, where we update inroads members about current understanding of how stigma manifests, what interventions are underway to mitigate and reduce stigma, and what results have been

shown to WORK to reduce stigma. You can get involved and stay informed!

- If you aren't already a member of inroads, you can learn more and join inroads at www.endabortionstigma.org

- If you are a member of inroads and are implementing or evaluating interventions that you want to let other members know about or that you think should be added to the inroads compendium of stigma resources and tools, you can let us know at info@endabortionstigma.org

- If you've published a resource, tool or study and want to make sure members know about it, you can share it on the inroads Collaboration Workspace

- Participate in online discussions and in-person gatherings convened by inroads.

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Table 1: Included Qualitative Studies

Citation	Region: Country	Method	Population	Ecological Level
Abrams, P. (2013). Abortion Stigma: The Legacy of Casey. Women's Rts. L. Rep., 35, 299.	North America: USA	Narrative analysis	Content of legal decision	Legal
Astbury-Ward, E. (2015). Abortion 'on the NHS': the National Health Service and abortion stigma. J Fam Plann Reprod Health Care, 0(1-2).	Europe: UK	Semi-structured interview	Women who have had abortions	Individual, Community
Bhandari, A., Mo Hom, N., Rashid, S., & Theobald, S. (2008). Experiences of abortion in Nepal and menstrual regulation in Bangladesh: a gender analysis. Gender & Development, 16(2), 257-272. doi:10.1080/13552070802120434	Asia: Nepal, Bangladesh	Multi-modal (survey + IDIs, FGDs, informal interviews, process obs)	Women of reproductive age Providers Community members	Individual, Community, Legal
Chiappetta-Swanson, C. (2005). Dignity and Dirty Work: Nurses' Experiences in Managing Genetic Termination for Fetal Anomaly. Qualitative Sociology, 28(1), 93-116.	North America: Canada	In-depth interviews	Providers (nurses)	Individual; Institutional
Cockrill, K., & Nack, A. (2013). "I'm Not That Type of Person": Managing the Stigma of Having an Abortion. Deviant Behavior, 34(12), 973-990. doi:10.1080/01639625.2013.800423	North America: USA	Two studies featuring "one-on-one, confidential, in-depth interviews"	Women who have had abortions	Individual
Dahlback, E., Maimbolwa, M., Kasonka, L., Bergstrom, S., & Ransjo-Arvidson, A. B. (2007). Unsafe induced abortions among adolescent girls in Lusaka. Health Care Women Int, 28(7), 654-676. doi:10.1080/07399330701462223	Africa: Zambia	Semi-structured interview	Adolescent girls	Community, Legal
France, E. F., Hunt, K., Ziebland, S., & Wyke, S. (2013). What parents say about disclosing the end of their pregnancy due to fetal abnormality. Midwifery, 29(1), 24-32. doi:10.1016/j.midw.2011.10.006	Europe: UK	Interviews	Women who have had abortions Male partners	Individual, Community
Freedman, L., Landy, U., Darney, P., & Steinauer, J. (2010). Obstacles to the integration of abortion into obstetrics and gynecology practice. Perspectives on sexual and reproductive health, 42(3), 146-151.	North America: USA	In-depth interviews	Providers Health professionals	Institutional
Gipson, J. D., Hirz, A. E., & Avila, J. L. (2011). Perceptions and Practices of Illegal Abortion among Urban Young Adults in the Philippines: A Qualitative Study. Studies in Family Planning, 42(4), 261-272.	Asia: Philippines	Focus group discussions, in-depth interviews	Women, adolescents who have had abortions Male partners	Community Legal
Harries, J., Gerdts, C., Momberg, M., & Greene Foster, D. (2015). An exploratory study of what happens to women who are denied abortions in Cape Town, South Africa. Reprod Health, 12, 21. doi:10.1186/s12978-015-0014-y	Africa: South Africa	In-depth interviews	Women who were turned away from abortion services	Individual, Institutional, Legal
Harris, L. H., Debbink, M., Martin, L., & Hassinger, J. (2011). Dynamics of stigma in abortion work: Findings from a pilot study of the Providers Share Workshop. Social Science & Medicine, 73, 1062-1070.	North America: USA	Focus groups; semi structured interviews	Providers	Individual

Citation	Region: Country	Method	Population	Ecological Level
Harris, L. H., Martin, L., Debbink, M., & Hassinger, J. (2013). Physicians, abortion provision and the legitimacy paradox. Contraception, 87(1), 11-16. doi:10.1016/j.contraception.2012.08.031	North America: USA	Interviews	Providers	Individual
Hill, Z. E. T.-A., Charlotte, & Kirkwood, B. (2009). The Context of Informal Abortions in Rural Ghan. JOURNAL OF WOMEN'S HEALTH, 18(12), 2017-2022.	Africa: Ghana	Focus group discussions, narratives	Women of reproductive age Providers Community members	Individual, Community
Holcombe, S. J., Berhe, A., & Cherie, A. (2015). Personal beliefs and professional responsibilities: Ethiopian midwives attitudes toward providing abortion services after legal reform. Studies in Family Planning, 46(1), 73-95.	Africa: Ethiopia	Multi-modal (survey + interviews)	Midwifery students	Individual, Community, Institutional, Legal
Hosseini-Chavoshi, M., Abbasi-Shavazi, M. J., Glazebrook, D., & McDonald, P. (2012). Social and psychological consequences of abortion in Iran. International Journal of Gynecology & Obstetrics, 118, S172-S177.	Middle East: Iran	In-depth interviews	Women who have had abortions	Individual, Community
Hung, S. L. (2010). Access to safe and legal abortion for teenage women from deprived backgrounds in Hong Kong. Reproductive Health Matters, 18(36), 102-110.	Asia: Hong Kong	In-depth interviews	Women who have had abortions	Individual, Community, Institutional
Izugbara, C. O., Egesa, C., & Okelo, R. (2015). 'High profile health facilities can add to your trouble': Women, stigma and un/safe abortion in Kenya. Soc Sci Med, 141, 9-18. doi:10.1016/j.socscimed.2015.07.019	Africa: Kenya	Qualitative interviews	Women who have had abortions; complications from unsafe abortions	Community; Institutional; Legal
Izugbara, C. O., Otsola, K. J., & Ezeh, A. C. (2009). Men, women, and abortion in central Kenya: a study of lay narratives. Med Anthropol, 28(4), 397-425. doi:10.1080/01459740903304009	Africa: Kenya	Focus group discussions	Community members	Individual, Community, Legal
Kebede, M. T., Hilden, P. K., & Middelthon, A. L. (2012). The tale of the hearts: deciding on abortion in Ethiopia. Cult Health Sex, 14(4), 393-405. doi:10.1080/13691058.2011.649495	Africa: Ethiopia	Mixed methods: interviews, focus group discussion, discourse analysis	Women who have had abortions; complications from unsafe abortions	Individual, Community
Kimport, K., Cockrill, K., & Weitz, T. A. (2012). Analyzing the impacts of abortion clinic structures and processes: a qualitative analysis of women's negative experiences of abortion clinics. Contraception, 85, 204-210. doi:10.1016/j.contraception.2011.05.020	North America: USA	Semi-structured interview	Women who have had abortions	Individual, Community, Institutional
Kimport, K., Preskill, F., Cockrill, K., & Weitz, T. A. (2012). Women's perspectives on ultrasound viewing in the abortion care context. Womens Health Issues, 22(6), e513-517. doi:10.1016/j.whi.2012.09.001	North America: USA	In-depth interviews	Women who have had abortions	Individual, Institutional
Larsson, S., Eliasson, M., Allvin, M., Glingberg, M., Faxelid, E., Atuyambe, L., & Fritzell, S. (2014). The discourses on induced abortion in Ugandan daily newspapers: a discourse analysis. International Journal of Gynecology & Obstetrics, 125(1), 89-92.	Africa: Uganda	Discourse analysis	Articles about abortion from daily newspapers	Community; Mass media & Culture

Citation	Region: Country	Method	Population	Ecological Level
Levandowski, B. A., Kalilani-Phiri, L., Kachale, F., Awah, P., Kangaude, G., & Mhango, C. (2012). Investigating social consequences of unwanted pregnancy and unsafe abortion in Malawi: The role of stigma. International Journal of Gynecology & Obstetrics, 118, S167-S171.	Africa: Malawi	Multi-modal: Data from WHO Strategic Approach to Strengthening Sexual and Reproductive Health Policies and Programs in Malawi; in-depth interviews	Policymakers, gov't empoyees, educators, healthcare providers, religious leaders, NGO members, community members	Community, Institutional, Legal
Martin, L., Debbink, M., Hassinger, J., & Harris, L. H. (2011). Abortion-possible and impossible: Stigma and the narratives of Ghanaian doctors who provide abortions. Reflections: Narratives of Professional Helping, 17(3).	Africa: Ghana	Secondary report from Ghanaian narrative study: Ghana doctors	Health care professionals	Community, Legal
Nickerson, A., Manski, R., & Dennis, A. (2014). A qualitative investigation of low-income abortion clients' attitudes toward public funding for abortion. Women Health, 54(7), 672-686. doi:10.1080/03630242.2014.919984	North America: USA	In-depth interviews	Women who have had abortions	Institutional, Legal
O'Donnell, J., Weitz, T. A., & Freedman, L. R. (2011). Resistance and vulnerability to stigmatization in abortion work. Social Science & Medicine, 73(9), 1357-1364.	North America: USA	In-depth interviews	Health care professionals	Individual, Institutional
Omo-Aghoja, L., Omo-Aghoja, V., Okonofua, F., Aghedo, O., Umuerl, C., Otayohwo, R., . . . Esume, C. (2009). PERCEPTIONS AND ATTITUDES OF A RURAL COMMUNITY TO ABORTION IN THE NIGER-DELTA REGION OF NIGERIA. Nigerian Joumal of Clinical Practice, 12(4), 443-449.	Africa: Nigeria	Focus group discussions, in-depth interviews	Community members	Community
Orner, P., de Bruyn, M., & Cooper, D. (2011). 'It hurts, but I don't have a choice, I'm not working and I'm sick': decisions and experiences regarding abortion of women living with HIV in Cape Town, South Africa. Cult Health Sex, 13(7), 781-795. doi:10.1080/13691058.2011.577907	Africa: South Africa	In depth, semi structured interviews	HIV positive women	Individual; Institutional
Orner, P., De Bruyn, M., Harries, J., & Cooper, D. (2010). Qualitative exploration of HIV-positive pregnant women's decision-making regarding abortion in Cape Town, South Africa. Journal of Social Aspects of HIV/AIDS, 7(2), 43-51.	Africa: South Africa	In-depth interviews	HIV positive women	Individual, Community, Institutional, Legal
Palomino, N., Padilla, M. R., Talledo, B. D., Mazuelos, C. G., Carda, J., & Bayer, A. M. (2011). The social constructions of unwanted pregnancy and abortion in Lima, Peru. Glob Public Health, 6 Suppl 1, S73-89. doi:10.1080/17441692.2011.590813	LAC: Peru	In-depth interviews; focus groups	Community members	Individual, Community, Legal
Payne, C. M., Debbink, M., Steele, E. A., Buck, C. T., Martin, L., Hassinger, J., & Harris, L. H. (2013). Why women are dying from unsafe abortion: Narratives of Ghanaian abortion providers. African Journal of Reproductive Health, 17(2), 118-128.	Africa: Ghana	Interviews	Health care professionals	Individual, Institutional, Legal
Pheterson, G., & Azize, Y. (2005). Abortion Practice in the Northeast Caribbean: "Just write down stomach pain". Reproductive Health Matters, 13(26), 44-53. doi:10.1016/s0968-8080(05)26201-8	LAC: NE Caribbean	In-depth interviews	Providers, health care professionals	Community, Institutional, Legal

Citation	Region: Country	Method	Population	Ecological Level
Purcell, C., Hilton, S., & McDaid, L. (2014). The stigmatisation of abortion: a qualitative analysis of print media in Great Britain in 2010. Cult Health Sex, 16(9), 1141-1155. doi:10.1080/13691058.2014.937463	Europe: UK	Narrative analysis	Articles about abortion from daily newspapers	Mass media & culture
Rance, S. (2005). Abortion discourse in Bolivian hospital contexts: Doctors' repertoire conflicts and the Saving Women device. Sociology of health & illness, 27(2), 188-214.	LAC: Bolivia	Field observations, recordings, and transcripts	Fieldwork following two providers	Community, Institutional, Legal
Rossier, C. (2007). Abortion: An Open Secret? Abortion and Social Network Involvement in Burkina Faso. Reproductive Health Matters, 15(30), 230-238. doi:10.1016/s0968-8080(07)30313-3	Africa: Burkina Faso	Semi-structured interview	Community members	Individual, Community, Legal
Shellenberg, K. M., Moore, A. M., Bankole, A., Juarez, F., Omideyi, A. K., Palomino, N., . . . Tsui, A. O. (2011). Social stigma and disclosure about induced abortion: results from an exploratory study. Glob Public Health, 6 Suppl 1, S111-125. doi:10.1080/17441692.2011.594072	Mexico; Nigeria; Pakistan; Peru; US	Focus groups; semi structured interviews	Community members	Individual, Community, Legal
Sisson, G., & Kimport, K. (2014). Telling stories about abortion: abortion-related plots in American film and television, 1916-2013. Contraception, 89, 413-418. doi:http://dx.doi.org/10.1016/j.contraception.2013.12.015	North America: USA	Narrative analysis	American film and television	Mass media & culture
Sorhaindo, A. M., Juárez-Ramírez, C., Olavarrieta, C. D., Aldaz, E., Mejía Piñeros, M. C., & Garcia, S. (2014). Qualitative evidence on abortion stigma from Mexico City and five states in Mexico. Women & health, 54(7), 622-640.	LAC: Mexico	Focus group discussions; in-depth interviews	Community members	Community
Sowmini, C. (2013). Delay in termination of pregnancy among unmarried adolescents and young women attending a tertiary hospital abortion clinic in Trivandrum, Kerala, India. Reproductive Health Matters, 21(41), 243-250.	Asia: India	In-depth interviews	Women who have had abortions	Individual, Institutional
Storeng, K. T., & Ouattara, F. (2014). The politics of unsafe abortion in Burkina Faso: the interface of local norms and global public health practice. Glob Public Health, 9(8), 946-959. doi:10.1080/17441692.2014.937828	Africa: Burkina Faso	Mixed methods: discourse analysis; in depth interviews	Health care professionals; daily newspapers	Community, Institutional, Legal, Mass media & culture
Tagoe-Darko, E. (2013). "Fear, Shame and Embarrassment": The Stigma Factor in Post Abortion Care at Komfo Anokye Teaching Hospital, Kumasi, Ghana. Asian Social Science, 9(10), p134.	Africa: Ghana	Focus group discussions, narratives, and observations	Women who have had abortions	Individual, Community, Institutional
Weitz, T. A., & Cockrill, K. (2010). Abortion clinic patients' opinions about obtaining abortions from general women's health care providers. Patient Educ Couns, 81(3), 409-414. doi:10.1016/j.pec.2010.09.003	North America: USA	Semi-structured interview	Women who have had abortions	Individual, Institutional

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