ABORTION STIGMA AND QUALITY OF CARE:
A Proposed Framework for Analysis and Integration

Informed by an online forum of members of the International Network for the Reduction of Abortion Discrimination and Stigma (inroads) addressing Abortion Stigma and Quality of Care.

HOW ARE ABORTION STIGMA AND QUALITY OF CARE RELATED?

Abortion stigma is a social process of devaluing people who have had abortions or are associated with them. Stigma is a barrier to quality abortion care. Stigma may reduce individuals' and communities' access to abortion, impede health worker's ability to provide comprehensive and people-centered care and lead to discrimination. Stigma is experienced most acutely by people who are already marginalized in society — due to age, social-economic status, race/ethnicity, religion or other factors. In those contexts, providers, advocates, researchers, technical and policy practitioners, can directly address the stigma that creates barriers to, and compromises the quality of, abortion care.

From literature around stigma in other health fields, we know that negative attitudes of health care workers influence client-perceptions, judgment, interpersonal behavior and decision-making, which may cause stress, postponement of care, negative experiences with care, and lack of appropriate follow-up.[1,2] Individual patients may experience self-stigma, anticipated or perceived stigma linked to fear of rejection, social isolation and status loss that influences their interactions with the health care system. Thus the internalization of stigma affects quality of care: "Measures such as exit interviews and user preference surveys that simply ask people about their views of health service entitlements can legitimate deeply unjust social distributions in sexual and reproductive health. One of the most effective forms of marginalization is the enlisting of people themselves in accepting, even believing they are entitled to no more than what they receive, however inadequate to their needs (Cornwall and Gaventa, 2001, Pap, Gogoi and Campbell 2013)."[3] Stigma in laws, policies, and their implementation can lead to discrimination and inequity.[4]

1. Phelan, S. M., Burgess, D. J., Yeazel, M. W., Hellerstedt, W. L., Griffen, J. M., & van Ryn, M. (2015). Impact of weight bias and stigma on quality of care and outcoems for patients with obesity. *Obesity Reviews, 16(4),* 319–326.
2. Kelly, J. F., Wakeman, S. E., & Saitz, R. (2015). Stop talking 'dirty': Clinicians, language, and quality of care for the leading cause of preventable death in the United States. *The American Journal of Medicina, 128(1),* 8–9.
3. Erdman, J. (2015) Community-led Human Rights Accountability in Sexual and Reproductive Health: A Critical Analysis. [unpublished]
4. Cooper, S., Ssebunnya, J., Kigozi, F., Lund, C., Flisher, A., & The Mhapp Research Programme Consortium. (2010). Viewing Uganda's mental health system through a human rights lens. *International Review of Psychiatry, 22(6),* 578–88.

QUALITY OF CARE: A PROCESS FOR MAKING STRATEGIC CHOICES IN HEALTH SYSTEMS

To start the process of integrating an abortion stigma lens into a quality of care framework, we chose the World Health Organization's framework[1] to structure our conversation:

Dimensions of quality health care

1. **effective**, delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need;
2. **efficient**, delivering health care in a manner which maximizes resource use and avoids waste;
3. **accessible**, delivering health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need;
4. **quality acceptable/patient-centered**, delivering health care which takes into account the preferences and aspirations of individual service users and the cultures of their communities;
5. **equitable**, delivering health care which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status;
6. **safe**, delivering health care which minimizes risks and harm to service users.

We also take special note of the WHO's emphasis on the inclusion of stakeholders and service users in the creation of quality standards and measures.

1. World Health Organization (2006) *Quality of Care: a process for making strategic choices in health systems.*

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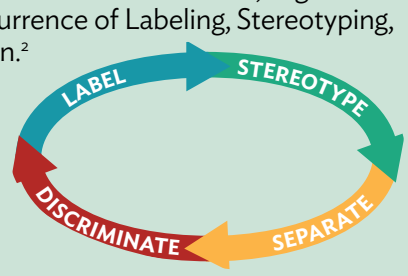
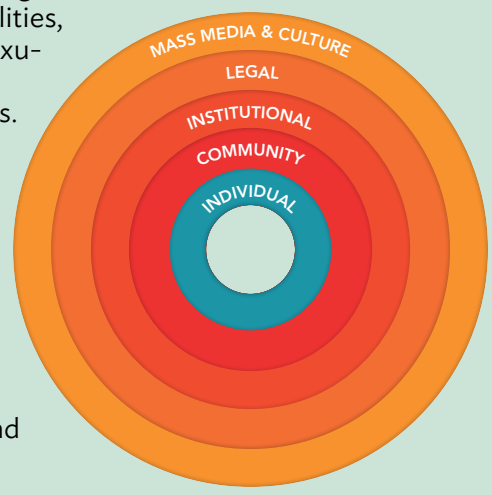
WHAT IS ABORTION STIGMA? HOW DOES IT MANIFEST?

Stigma is both a social construct and a fundamental cause of population health inequalities.[1] Across health fields, stigma manifests itself in the co-occurrence of Labeling, Stereotyping, Separation and Discrimination.[2]



The drivers of abortion stigma are complex and embedded in societal norms and gender constructs that seek to control female sexuality, link female sexuality solely to procreation, and limit women's roles to that of mothers and nurturers. Because sexuality, gender, and abortion intersect and interact in the abortion care environment, complex stigma can manifest at these five levels, impeding quality abortion care in a number of ways.[3]

Within a single geographical region or culture abortion stigma can also vary, becoming more limiting and rigid when compounded by other stigmas and socio-economic inequalities, disability, gender and sexuality discrimination, and geographic access issues. In addition to negative feelings and social isolation, abortion stigma exists and manifests itself at multiple levels compromising quality and leading to negative experiences, unsafe practices, ill-health, reproductive morbidity and mortality.



Manifestations of abortion stigma in the health system

An absence of or negative representation in television drama creating a stereotype of a typical abortion service-seeker • Laws that label certain reasons for or stages of abortions as bad or illegal • A hospital practice of withholding pain management support during abortion • A community custom of reporting providers and marginalized abortion seekers to legal authorities • An abortion provider being denied support for managing a complication by colleagues unwilling to assist in abortion • A healthcare worker lecturing a clinic patient when she discloses her choice to have an abortion.

1. Hatzenbuehler, M. L., Phelan, J. C., & Link, B. G. (2013). Stigma as a fundamental cause of population health inequalities. *American Journal of Public Health, 103(5),* 813–21.
2. Link, B. G., & Phelan, J. C. (2001). Conceptualizing Stigma. *Annual Review of Sociology, 27,* 363–385
3. Hessini, L. (2014). A learning agenda for abortion stigma: recommendations from the Bellagio Expert Group Meeting. *Women & Health, 54(7),* 617–621.

INTEGRATING APPROACHES

During an ongoing, guided discussion, inroads members reported few examples of quality of care frameworks used explicitly in health care facilities or standalone clinics that provide abortion care. However, examples from other fields such as HIV and AIDS, mental illness and quality of care more generally defined were discussed. In the absence of a larger body of evidence or practice around abortion stigma, we discussed what stands in the way of quality services in order to build up a model of what stigma-free, quality services could look like and achieve.

A DRAFT FRAMEWORK FOR QUALITY, STIGMA-FREE ABORTION CARE

In July and August, 2015, inroads members gathered for a 2 week long asynchronous online discussion forum about Quality of Care and Stigma-free Abortion Services. 26 active participants representing 16 different member countries reviewed five issues of quality of care in the context of abortion stigma. Participants represented NGOs and community-based organizations, independent providers and activists, academic and research institutes, and locally based networks. Based on themes that emerged during this discussion, we drafted the following framework, applying a stigma lens to the WHO framework for quality care: [1]

	Stigma-related barriers to quality abortion care	What stigma-free services look like
Dimension of quality: **EFFECTIVENESS**	• Laws and policies prohibit or restrict provision of effective abortion technologies. • Laws or policies restrict who can provide abortion care. • Women don't have information or skills to access abortion care. • High level officials don't understand or have information about abortion care and create inadequate access or provisions for care.	• Standards and guidelines about abortion care are created with end-users in mind and are regularly updated and communicated to staff. • All WHO-recommended abortion technologies are offered in the health facility. • Staff are trained about how to describe abortion methods available in their clinic and local context and trained in how to channel patients to services. • Where abortion is restricted, health facility staff are trained in a harm-reduction approach. • The facility has identified reputable sources and delivery mechanisms for abortion technologies.
Dimension of quality: **EFFICIENCY**	• Abortion care is separated within a health system leading to duplication of resources. • Providers are restricted from using existing medicine delivery systems. • People seeking abortion or post-abortion care are made to wait until all others are seen. • People who seek abortion are made to explain themselves at multiple points of care, or at multiple visits. • People who seek abortion care are charged different costs (procedure, differing pain management, etc.).	• Abortion care is integrated into existing services and clinic spaces. • Healthcare providers in a variety of settings and specialties have up-to-date information about where abortion technologies are available. • Abortion care flow models are developed to ensure that the service-user meets the fewest number of staff necessary. • If a service requires more than one visit to the facility, every effort is made to provide consistency in staffing. • Protocols should reflect state of the art knowledge on the necessary degree and level of contact patients need to have with providers to prevent additional, unnecessary visits or other artifacts of inefficient care. • There are community-based, online, or mobile sources of aftercare and follow-up.
Dimension of quality: **ACCESSIBILITY**	• Services are not designed with end-users in mind, i.e. not available where and when all women, and young women most need them. • Few facilities or providers lead to burdensome, expensive, or prohibitive travel. • Providers are shamed in the community for offering abortion care, leading them to abandon their practice or take them underground. • Clinics that offer abortion are labeled as abortion providers and targeted by law enforcement with insufficient understanding of the law around abortion.	• All services — from the design to implementation to the evaluation of care — are created with the end-users at the table. • Abortion providers are held to same standards of quality and care as other healthcare providers and not subjected to additional scrutiny. • Abortion providers and clinics who provide abortion have community outreach and education that focus on the importance of abortion in the spectrum of Sexual and Reproductive health. • Abortion providers and clinics get familiar with the legal setting of abortion in their region and, if possible, develop a relationship with law enforcement focused on the protection of themselves and their patients as citizens and rights holders.
Dimension of quality: **ACCEPTABILITY/USER-CENTEREDNESS**	• Providers or other facility staff have implicit or explicit negative attitudes about abortion and those who seek abortion. • The public doesn't know where abortions are accessible, affordable and client-centered. • People choose to seek abortion in secrecy. • Post-abortion contraception is pushed on patients equating needing an abortion with a failure and something to prevent, not simply one option or choice.	• Training for all providers and staff includes content about non-judgmental and non-directive care, service user/patients' rights, the principles of informed consent, kindness and empathy, women's self-use of misoprostol. • The facility has implemented a Code of Conduct to ensure stigma-free care. • The facility has built relationships with community partners with accurate information about services and costs. • Methods for people to stay connected with the facility after an abortion experience are offered (e.g., volunteering, serving as peer-educators, participating in an accompaniment model). • A full suite of post-abortion contraception is offered but not required or incentivized. • Services are provided in a manner that ensures privacy and confidentiality. • Women who have self-induced are treated with respect and dignity and not forced to undergo unnecessary medical procedures.
Dimension of quality: **EQUITY**	• Young people and marginalized groups are denied abortion care or services are not offered with their needs in mind. People without financial resources cannot access abortion care. • People who have accessed abortion outside of the health facility are treated poorly. • People who may need multiple abortions are denied access. • People who don't use contraception or choose less effective forms of contraception are discriminated against. • Appropriate abortion or pain management technologies are withheld.	• The facility has a policy that specifies respectful and equal care for all service-users, regardless of age, economic status, HIV-status, sexual orientation, gender identity, or other key characteristics. • Facility staff use non-judgmental, non-directive language and approaches to choice or contraceptive counseling. • Facility staff are trained in a harm-reduction approach, and are trained in respectful and compassionate care for following-up after an abortion outside of the health system. • Pain management is offered without undue or additional financial burden.
Dimension of quality: **SAFETY**	• Training in abortion care is not routine or integrated. • Providers are hesitant to report on or directly address adverse events. • No forum for abortion providers to discuss or directly address adverse events.	• Abortion-specific training, both pre-service and in-service, is available for all providers and staff, including clinical and technical skills, for all available abortion technologies, as well as women's self-use of misoprostol. • All available abortion methods are offered. • Facility has a clear and transparent system for adverse event reporting and learning from error all supported within a culture of safety.

1. Unless otherwise noted "facility" refers to a facility where abortion services are provided and "providers" refers to healthcare providers who do or may provide abortion services.

WHAT WE CAN DO NOW:

Our goal is to come to agreement on a set of ideas for what quality looks like across global settings. It's now up to all of us to answer the question "What would creating a facility that has quality, stigma-free care take to achieve?" Which indications of quality could you start with, what barriers would you face? Through taking these concepts of quality and stigma-free abortion services into our individual contexts we can turn these definitions into promising practices, we can start measuring change, we can increase quality and decrease stigma.

Keep us posted on your progress!

A. Learn more about this effort or abortion stigma: www.endabortionstigma.org/makinginroads

B. Use or test this draft framework document at your next Quality of Care meeting or in your own practice.

C. Keep us posted on your progress or your current stigma and quality of care work : info@endabortionstigma.org or www.facebook.com/inroadsGlobe

D. Join inroads to continue this dedicated conversation and other inquiries into abortion stigma and discrimination: www.endabortionstigma.org/join

Thanks to all of our members who participated in the discussion and the eight reviewers of this framework; for further information about the production of the document and additional resources visit www.endabortionstigma.org