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‘Making abortion safe’: abortion and post-abortion care providers’ experiences of stigma in Rwanda, Zimbabwe, Sierra Leone and Nigeria

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ABSTRACT

Background Social stigma and the marginalisation of abortion care within medical settings can negatively affect abortion providers. While some research has evaluated stigma interventions in legally restrictive settings, little work has explored the experiences of healthcare professionals (HCPs) providing abortion and post-abortion care (PAC) outside the USA. This study, part of the Royal College of Obstetricians and Gynaecologists’ ‘Making Abortion Safe’ programme, aimed to understand providers’ experiences of abortion stigma in four African countries with restrictive legislation.

Methods In-depth interviews with 44 abortion and PAC providers were conducted in Nigeria, Rwanda, Sierra Leone and Zimbabwe.

Results Four themes emerged: personal and professional effects of stigma, multiple manifestations of stigma, driving forces of stigma, and positivity and resilience. Stigma affects providers' professional identity, community belonging and relationships. Restrictive legal frameworks are the main driver of abortion stigma, operating at multiple levels that reinforce each other. The legal status of abortion labels it as ‘dirty work’, conflicting with healthcare principles. Judgmental attitudes from other HCPs negatively impact providers’ well-being and care quality. However, providers showed resilience through professional and personal commitment, and the belief in ‘doing the right thing’ helped them resist stigma.

Conclusions Legal changes are crucial for increasing access and reducing stigma among the workforce. In these countries, providers face challenges in offering legal healthcare. Organisational interventions are needed to address stigmatising values and create positive workplaces. Ongoing support is essential for HCPs to remain resilient against abortion stigma, helping to normalise abortion care and those who provide it.

WHAT IS ALREADY KNOWN ABOUT THIS TOPIC

⇒ The legal status of abortion, social stigma and the marginalisation of abortion care within medical settings can profoundly affect the experiences of abortion providers. Abortion stigma is a serious human resource issue and is associated with a range of individual and health system burdens.

WHAT THIS STUDY ADDS

⇒ This study shows how restrictive legal frameworks are the main driver of abortion stigma, affecting societal and workplace contexts and negatively impacting abortion and post-abortion care providers’ lives and the quality of care. Providers' positivity and commitment to abortion work help them resist and reject stigma.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE, OR POLICY

⇒ Legal changes are crucial for increasing access and reducing stigma among the workforce. Organisational interventions are also needed to address stigmatising values and create positive workplaces, especially in countries with restrictive abortion laws.

BACKGROUND

Research, primarily in the USA, has shown that social stigma, and the marginalisation of abortion care within medical settings,

can negatively affect the experiences of abortion providers.[1–3] This threatens the accessibility of services and quality of care.[4] While there has been some work to evaluate interventions addressing stigma in legally restrictive settings (Africa and Latin America),[2] little work has explored the experiences of healthcare professionals (HCPs) working to deliver abortion care and post-abortion care (PAC) outside of the USA. PAC is a set of medical services provided to women who have experienced an abortion (or miscarriage) and is especially important in countries with restrictive legal frameworks, such as those discussed in this article.

This research was conducted as part of a two-phase mixed-methods study to investigate different aspects of abortion providers' experience of abortion-related stigma within the Royal College of Obstetricians and Gynaecologists (RCOG) 'Making Abortion Safe' (MAS) programme. Phase 1 consisted of a global, online, cross-sectional survey of abortion care providers. Phase 2 consisted of in-depth interviews among selected abortion and PAC providers conducted in four focus countries: Nigeria, Rwanda, Sierra Leone and Zimbabwe. This article reports on Phase 2, which sought to understand manifestations of abortion stigma, including its personal and professional effects, and to explore what may help providers resist abortion stigma.

METHODS

Local researchers conducted a total of 44 interviews (lasting on average 38 minutes) conducted across the selected countries – Nigeria (n=10), Sierra Leone (n=15), Rwanda (n=10) and Zimbabwe (n=9) – between December 2021 and June 2023. Participants were purposively selected and included nurses, doctors and midwives who had from 1 to 23 years of service across private, public, non-governmental organisation (NGO) and faith-based hospitals and clinics; gender was evenly split; and slightly more providers worked in PAC than abortion care. The eligibility criteria for participants were straightforward: aged 18 years or older and working as trained providers of safe abortion care and/or PAC within the legal framework of one of the target countries. Additionally, participants needed to understand English or the national language and have access to a mobile phone or computer for a virtual or online interview (due to COVID-19 restrictions). Written consent was obtained following presentation of the study information sheet through an online platform. Ethical approval for the global study was obtained through the Open University (HREC/3994/Hoggart) and through each national ethics board. In-depth interviews were conducted by a local researcher using a semi-structured topic guide. The topic guide was drafted by the study principal investigators (LB and LH) and adapted by in-country MAS Champions. The principal investigators also facilitated workshops with the researchers to ensure consistency across the four countries.

Interviews were recorded, transcribed and anonymised, and stored securely by national co-investigators. Anonymised transcripts were uploaded for analysis using MAXQDA 2020 using a coding frame based on the themes in the topic guide and other codes identified in the data using an inductive approach. The data were then coded collaboratively by two co-investigators (EP and SB). Coding was verified by the other team members.

PATIENT AND PUBLIC INVOLVEMENT

This was a study on the experiences of HCPs involved in abortion or PAC. It was considered to not be appropriate or possible to involve patients or the public in the design, or conduct, or reporting, or dissemination plans of our research.

RESULTS

We developed four themes from the data relating to stigma: multiple manifestations of stigma; driving forces of stigma; consequences of stigma; and positivity and resilience. We explore these overlapping and interconnected themes in more detail later. In this article we report on similarities across all four countries rather than exploring in detail the complexities of differential experiences in different contexts. This is in order to highlight what are likely to be common themes across countries with similar restrictive legal frameworks.

Multiple manifestations of stigma

This theme analyses how abortion stigma manifests, including participants' descriptions of how they are treated and feel they are perceived by others, where they experience stigma (eg, the community or workplace) and who stigmatises them. We also explored differential stigma, including whether providing abortions at later durations of pregnancy effects internalised stigma; and whether HCPs providing abortion experience stigma differently to those providing only PAC.

Participants from all four countries described being stigmatised by members of their community, family, colleagues and fellow healthcare workers. This stigma manifested in different ways within communities and also families. Some participants described how association with certain facilities or organisations identified them as working in abortion care and one explained how she felt her NGO uniform made her a target. [NB. In the quotes that follow, participant details are given in square brackets, where the letter references the country, the number is a unique identifier and the final letter identifies gender.]

> Some people as soon as they see you with the […] uniform, they point at you because they have the mentality that [name of NGO] only does abortions. And they will be pointing at you that your only job is to abort pregnancies. [S14F]

Many felt that on the whole, society did not accept their work.

> Then of course the community, because it's not socially acceptable and morally…to them it's actually a sin for you to be able to be doing things like that. So you'll find a community as a whole will have a problem with you, and in what you do. [Z5F]

Reports around financial incentives associated with providing abortion were referred to by participants who said that some colleagues believed they were mostly motivated by money or being paid extra to provide abortion or PAC, or sometimes referred to their salaries as 'blood money'.

Such labelling also impacted on participants' relationships with their families and kin networks, as some described how family members refused to accept financial support from them

> …one of my family members, when she was told that I work at a particular place, she told me she didn't want my money because it's blood money. [S6F]

Participants were also on the receiving end of stigmatising behaviour in their workplaces, speaking about directly experiencing or indirectly witnessing stigmatising behaviour from colleagues and fellow healthcare workers. This included being told by other HCPs '*you are killing babies*' [R7F] and noting '*…as soon as they say you are working for that NGO, they will start looking at you as if you are a murderer*' [S6F]. A small number of participants suggested that they experience more stigma inside health facilities because they are known as abortion providers as compared to within the community where they are more careful not to disclose their profession.

It was not uncommon for participants to maintain that other health professionals did not view them as 'good' doctors because they provided abortion.

> When you perform an abortion, your colleagues think that you are not good. You are not a good doctor. You are just committing a killing of someone. [R5F]

However, not all participants described experiences of stigma from within the workplace, and several referenced a sense of unity among colleagues. More generally, reflecting on their role, a number of participants said that they did not feel they were treated any differently to other HCPs because of their provision of abortion and/or PAC. Some said that they were viewed positively because they '*do a good job*' [S11F], '*providing essential and safe services*' [N7M].

This was not the only way in which stigma was experienced unevenly. The main factors described by participants that influenced the extent to which they experienced stigma were whether participants provided abortion or PAC only, and the pregnancy duration at which an abortion is provided.

Some participants described how abortion providers are thought of as 'killers' whereas providers of PAC are seen as 'lifesaving'.

> …the person that provides the abortion services, is actually the one that is most likely to be discriminated against, is the one that is being discriminated against most of the time, but the post-abortion […] that one is seen as saving the person's life, there is not so much stigmatisation there. [N8M]

Many participants, mostly from Rwanda and Nigeria, described their concerns about providing abortion and PAC with increasing pregnancy duration. This was both in relation to worries about an increase in stigmatising behaviours from others and expressing their own increased feelings of ambivalence.

> …the more the months pile up, the more unacceptable it becomes, that is actually what I feel. [N8M]

There was also a strong indication that participants had concerns about the viability of the fetus when providing abortion in the second and third trimesters. Many spoke about the challenges associated with seeing activity on an ultrasound scan, and the visibility of fetal parts compared with non-recognisable pregnancy remains, such as 'blood', in the first-trimester abortions.

Driving forces of stigma: legal, social and cultural

The legal status of abortion was identified as a structural driver of abortion stigma in all study countries but more strongly in Nigeria, Sierra Leone and Rwanda. Providers from Sierra Leone talked about how the legal status of abortion, being completely prohibited, underpinned cultural attitudes.

> Just because abortion is illegal in our country… I think that's it, just because it's a crime, it's a stigma to our culture and our religion, that's why people are looking at it that way. [S5M]

The consequences of the legal framework as a cause of stigma were oulined by a provider in Nigeria.

> OK, the stigma is there, because in Nigeria the law it is not passed, so all of us are doing it we are doing it under just like, because the police too, they are on one side, if they know your clinic is doing it, they will be coming and arresting you. [N2F]

An overwhelming number of participants across all four countries described how they felt that religion and culture were drivers of abortion stigma and many recalled that their religiosity, faith or moral values were called into question because they provided abortion and/or PAC.

> They see it as a sin, they see it as a sin among community members, and a dirty work, they see it as a sin, we face judgement. [N1F]

This was the case for both Christian and Muslim participants. Several providers conjoined religious and cultural drivers, or spoke of both as equally driving stigma; others felt that religion was the most important driver. Abortion care was frequently described as being viewed as a sin, or as killing, leading to its stigmatisation.

> It's, uh, it's both, even culture. So they say that maybe you can't abort because of the religions means that you commit a sin. And even the culture they say that you kill someone. So I think it's like both mainly. [R5F]

Some participants described questioning their own role because of their religiosity.

> At times, I feel like I'm in the community to save lives, but because of these two services that I provide even my conscience sometimes judges me that I'm not doing the correct thing before man and God even religiously as a Muslim person. [S1M]

Consequences of stigma

Many participants across the four countries described great personal and professional costs to their work, which were frequently associated with the deeply entrenched stigma they experience because of their work as abortion or PAC providers.

Some described their work as leading to negative feelings about themselves. Sometimes these feelings were attributed to the work itself, but more often it was a response to the stigma directed towards them. Participants described their work leading to social exclusion, isolation and a negative response from their communities as '*nobody wants to associate with anyone that is doing this work*' [S7F]. Feeling guilty, an emotion associated with stigma, about their role in abortion and PAC was expressed in all four countries.

> I don't feel fine. People look at me funny…some people have negative things to say about me because of the service that I provide…I often hear these things and I don't feel good about it. [S3F]

Some participants reflected on how their work had an impact on their mental health including trauma and emotional exhaustion. In one case, striving for secrecy included the participant's husband.

> Psychologically, there is this trauma there. You don't feel free to walk among others proudly and say 'Oh, I'm doing this and this'. You have to hide it. Even as I'm having this interview now, I have to close my door because my husband does not know that I'm doing this particular work. [S7F]

Other participants explained that their work in abortion and PAC had led to arguments with family and friends.

> I have a friend from college, and any time we meet, she tells me to change my job to avoid going to hell and at one point at a public market she told me the same thing and I got annoyed and we had a spat. [S6F]

Many participants spoke about professional consequences of abortion stigma that ranged from facing '*disapproval among my colleagues, and disrespect*' [N1F] to loss of income, and harassment and violence. Some participants described how the lack of support from colleagues manifested in obstructive behaviour in the clinic.

> And then when an abortion client comes in, a pregnant client comes in, registering them sometimes they will say I will not collect the money, because to them sometimes they think that they don't want to touch that money, they don't have anything to do with this client. [N3M]

Participants also spoke of the repercussions of being stigmatised by community members. These included patients not wanting to receive care from them, and the loss of income from patients avoiding their clinic for other reproductive healthcare because of the stigma associated with abortion.

> I have a private clinic, there are people who cannot come to my clinic because I offer abortion because they think I cannot help. So those are like socially speaking, financially speaking, and morally, so these are some consequences I would be facing. [R4M]

Stigma was also seen by many participants as negatively impacting the quality of care given to patients, though this was primarily through the attitudes and behaviour of other HCPs at facilities. However, some participants also described how their own stigmatisation impacted on the care they offered.

> If someone judges you and stigmatises you, by the next you will not feel OK to help the client and you will also stop to help the client because we are a human being and we don't like the people who judge us. [R2F]

This participant is expressing the view that the quality of the service could be affected if the providers are not 'comfortable', and that providers are less inclined to help patients if they feel judged and stigmatised.

Feeling positive, resisting and rejecting stigma

Despite experiencing the discrimination and stigma we have discussed so far, many participants described feeling positive about their work. They talked of '*helping people*' [N10F] and feeling proud of their work.

> I feel good about the work I do, because people get relief from the work I do. They get better health and productive life from my work. [N10F]

This framing of their work – as helping people – can be characterised as resisting abortion stigma. Several providers described how their belief that they were

doing the right thing, or could justify their reasons, helped them to cope with the stigmatisation. Others described focusing on the needs of the patient above their own feelings or the views of their colleagues.

> You just remind them that what I'm doing is for the benefit of the client not for me, or neither for you. [Z8F]

A number also spoke of rejecting the views of others and explicitly said they did not care '*what the next person thinks*' [N6M]. A minority of participants, from Nigeria and Sierra Leone, did not express any negative consequence as a result of abortion stigma, citing supportive management, and purposively discounting the views of others.

> I am not bothered, I choose to be a doctor, I didn't ask permission from anybody to do that, it is a decision I took. I have always been interested in it, I took pains to find out information on it, and I have been on it, all these years, so I have no regrets actually, it doesn't really matter to me, what the next person thinks. [N6M]

DISCUSSION

This research, echoing other studies,[4 5] has shown how stigma can impact on multiple dimensions of abortion providers' lives, including their professional identity, community belonging, and relationships with family and friends. Stigma experiences were identified within the workplace, within communities and networks of family and friends, thus traversing personal and professional spheres. It has been argued[6] that the legal status of abortion drives the stigma surrounding the provision of abortion, and the labelling of this as 'dirty work' in conflict with the principles that should underpin working in healthcare. Our findings lead to the identification of restrictive legal frameworks as the main driver of abortion stigma that goes on to work at intermediate levels which intersect and reinforce one another, as shown in other research.[7 8]

Abortion stigma has been identified as a serious human resource issue associated with a range of individual and health system burdens, including stress, job dissatisfaction, burnout, depersonalisation of and negative attitudes towards patients who have abortions, and reduced feelings of personal accomplishment.[2–4] Our research shows how experiencing judgemental attitudes associated with stigma can negatively affect quality of care. We have also shown how these participants associated stigma within their work environment as being often generated by other HCPs (not directly engaged in abortion care) or administrative staff.

We have also shown resilience. This study adds weight to the findings of a recent global review[9] in identifying the the importance of professional and personal commitment and the belief that they are 'doing the right thing' in helping providers resist and reject stigma. When this was problematic, as with providing abortion in the second and third trimester, their work was more morally fraught, challenging their own beliefs. Overall, however, their preference to focus on the positives can be seen as an intentional move to resist stigmatisation by reframing their work to focus on addressing the burden of unsafe abortion and facilitating reproductive rights.

CONCLUSIONS

Progress towards reducing deaths related to unsafe abortion cannot be achieved without addressing barriers that occur throughout all levels of the abortion care ecosystem.[10] Change at a legal level is clearly important not only for increasing access to services but also for ensuring the workforce feel less stigmatised and safer in their practice. However, it is important to emphasise that in many countries, including the four referred to in this article, providers operating within a restrictive law are experiencing difficulties undertaking perfectly legal healthcare. Interventions are thus needed at other levels. At the organisational level it is vital to address stigmatising values and attitudes to create positive workplaces and communities. Additionally, the workforce needs ongoing support to stay resilient against the risk of abortion stigma. Supportive interventions would help healthcare practitioners resist abortion stigma and further normalise abortion care and those who provide it.

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Patient consent for publication Not applicable.

Ethics approval This study involves human participants. Ethical approval for the global study was obtained through the Open

University (HREC/3994/Hoggart) and through each national ethics board. Participants gave informed consent to participate in the study before taking part.

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