Royal College of Obstetricians & Gynaecologists

Reducing and managing stigma experienced by providers of abortion care: a review of current practice

JUNE 2023

CONTENTS

Acknowledgements

This paper was developed by Dr Victoria Boydell in collaboration with the RCOG Making Abortion Safe Team including Emma Parnham, Merel Krediet, Suzanna Bright, Dr MaryJane Nweje and Nia Sheppard. We would like to thank Kate Austen (MSI Reproductive Choices UK), Rebecca Wilkins (International Planned Parenthood Federation), Dr Ulrika Rehnström Loi (HRP/WHO) Dr Caron Kim (HRP/WHO), Dr Ernest Nyamato (Ipas), Dr Theodmoir Sebazungu, Dr Sikiratu Kailani, Dr Jayne Kavanagh (University College London) and Professor Lesley Hoggart (The Open University) for their guidance and support in an advisory capacity.

About RCOG

The Royal College of Obstetricians and Gynaecologists is a professional association based in London, United Kingdom. Its members, including people with and without medical degrees, work in the field of obstetrics and gynaecology, that is, pregnancy, childbirth, and female sexual and reproductive health.

Royal College of Obstetricians & Gynaecologists

10–18 Union Street
London
SE1 1SZ, UK

Registered charity no. 213280

EXECUTIVE SUMMARY

This review was undertaken as part of the Royal College of Obstetricians and Gynaecologists' (RCOG) Making Abortion Safe programme, and is designed to support agencies' and organisations' strategic thinking about how best to support healthcare workers providing abortion care globally.

"Abortion stigma is a serious human resource issue and is associated with a range of individual and health system burdens, including stress, job dissatisfaction, burnout (emotional exhaustion), depersonalisation of clients and reduced feeling of personal accomplishment as a result of one's work, staff turnover and understaffed abortion facilities." (Janiak 2018)

Stigmatisation is a deeply contextual social process. The manifestations and magnitude of stigma change over time - increasing in some areas and decreasing in others. Healthcare professionals who provide abortion care often find they are discredited, harassed and discriminated against by their communities and colleagues because of their association with abortion. Abortion stigma is under-researched, and there has been limited evaluation of the interventions focused on reducing the burden of stigma faced by healthcare professionals or supporting healthcare professionals to deal with this burden.

The abortion-providing workforce deserves to feel safe and supported; stigma has a negative effect on their professional and personal lives. Organisations working with healthcare professionals have an obligation to reduce and manage the stigma experienced by these professionals.

To date, there has been limited research on interventions focused on reducing, or helping the abortion-providing workforce to manage, the burden of abortion stigma they so often face. Existing interventions have often not been systematically evaluated. Given these limitations, this guidance presents a combination of scientific research with practice-related evidence.

An exploratory scoping review was used to describe the existing literature on the stigma experienced by providers, and available interventions to reduce the stigma experienced by the abortion-providing workforce are described. The stigma reduction interventions outlined may be beneficial to those overseeing abortion care providers, and healthcare professionals themselves, in managing the stigma they experience.

The suggested interventions for stigma reducing efforts are underpinned by two principles: normalisation and reflective practices.

Stigma reduction

Interventions to support the individual

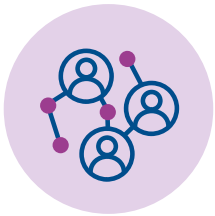
Mentoring

Incidence reporting

Reflective supervision

Provider Share Workshops

Wellness programmes



Peer groups/ informal networks

Legal safety and support

Interventions to create an enabling environment

Policy audit

Values clarification activities

Inclusion in healthcare student curricula and relevant postgraduate/ specialty training

Most interventions described are short-term strategies for coping with the effects of stigma experienced by the provider working at the level of the individual to promote reflective practice and do not target the external environments. On the other hand, several interventions that aim to create an enabling environment focus more on normalising abortion care and reducing the drivers of stigma rather than managing the impacts.

INTRODUCTION

The RCOG Centre for Women's Global Health Making Abortion Safe (MAS) programme has been working to address the stigma experienced by healthcare professionals who provide abortion care.

The MAS programme is a multi-country advocacy programme, delivered in partnership with healthcare professionals in Nigeria, Zimbabwe, Rwanda, Sierra Leone and Sudan, which aims to improve women's and girls' access to quality and safe abortion, post abortion care and post abortion contraception. The programme links healthcare professionals with quality educational, research, technical and advocacy resources to support local, regional and international efforts to improve the quality and accessibility of abortion care.

The MAS programme conducted a large-scale study into the experiences of stigma amongst 1,674 providers across 77 countries and conducted 41 in depth interviews with providers of abortion care in Rwanda, Sierra Leone, Nigeria and Zimbabwe. It is hoped that the findings from this work will highlight the issue to relevant organisations, professional bodies and policy makers so that as a community we can better support those most impacted by the stigma associated with their work in abortion care.

This review outlines a number of interventions that support organisational efforts to create an enabling environment for the health workforce to provide abortion services free from harassment and burnout.

Stigma is highly contextualised, and local understanding of the drivers and manifestations of stigma should inform adaptations and implementation of interventions to ensure they are locally relevant. The content has been developed to be relevant to a global audience, but local

adaptations may be needed depending on country circumstances, particularly legal contexts. The review includes options for

- Helping the abortion workforce manage their stigma experiences, including harassment and consequential burnout.
- Synthesising current understanding of practices that reduce and manage the stigma and discrimination faced by providers of abortion care.
- Supporting agencies' and organisations' strategic thinking about how best to support those providing abortion care.

This review does not constitute clinical or programmatic guidelines because of the dearth of current evidence; instead, it is a working paper that outlines promising interventions and recommendations for applying these interventions.

METHODOLOGY

To date, there is limited evidence on interventions focused on helping providers to manage the burdens of abortion stigma (Mosley et al., 2020). Many activities have not been systematically evaluated (Sorhaindo & Rehnstrom Loi 2022). Given these limitations, scientific research was combined with practice-related evidence.

An exploratory scoping review was used to describe the existing literature on the stigma experienced by providers, allowing various data sources to be used, including peer-reviewed, grey literature and expert opinion (Levac et al., 2010; Arksey & O'Malley 2005).

The scoping review methodology comprised three elements:

Review of Project Documentation

The authors reviewed the existing project documentation to understand the materials already developed for the RCOG global abortion care provider stigma study. This study was the first to aim to understand and map the perspectives held among abortion/post-abortion care (PAC) providers around the world regarding the manifestation of stigma they experience because of providing abortion care (including to understand the effect of feeling stigmatised on their personal and professional lives, and as a barrier to abortion care provision). The authors also reviewed other existing documentation developed during the Making Abortion Safe programme.

Literature Review

Second, peer-reviewed literature using appropriate search terms in MEDLINE was reviewed. This review explored stigma reduction (or burnout reduction/quality of life improvement) interventions for providers of the following stigmatised health services: HIV, mental health, and abortion. These areas were selected as notable stigmatised health services and contributed to our understanding of potential interventions into stigma reduction for the abortion-providing workforce. From 2692 abstracts, 41 papers were selected for data extraction. Following an abstract review, 18 were directly relevant to the subject matter, six were indirectly relevant (these provided recommendations for provider stigma reduction interventions), 11 were not relevant and five were inaccessible. A total of 18 papers was included.

Key Informant Interviews

One to one interviews using a topic guide were conducted with four key respondents with unique insights into the stigma faced by the abortion-providing workforce, including providers of abortion care themselves, and the types of interventions to address it from different geographical and legal contexts. The conversations were recorded using handwritten notes and were analysed to identify key themes. Relevant data on stigma and responses to it were extracted from 35 in-depth interviews with healthcare providers of abortion services in three of the countries participating in the Making Abortion Safe programme. A thematic analysis was performed on the data to identify the relevant patterns and themes.

When the scoping review had identified intervention areas, additional searches were conducted to examine interventions in other health sectors, such as mental health, for relevant findings.

Draft guidance was reviewed by representatives from an advisory group comprising Making Abortion Safe Champions, Ipas, International Planned Parenthood Federation (IPPF), MSI, and the World Health Organization (WHO) to ensure it resonated with their experiences in practice and their understanding of the existing evidence. The advisory group overviewed the scope, audience, objectives, structure and resources.

DEFINITIONS AND KEY CONCEPTS

What is abortion stigma? Definitions and key concepts underpinning our understanding of abortion stigma, as well as its impact on abortion care providers.

What is abortion stigma?

Stigma is understood as "an attribute that is deeply discrediting" (Goffman 1963). It labels people as "different" or "deviant", which causes lack of acceptance, loss of status and opportunities, and fuels inequalities. Fear of such status loss makes stigmatised persons less likely to talk openly about their experiences and perpetuates a sense of isolation (Harris et al., 2013). However, stigma is not static; it changes and evolves over time.

Negative attributes are ascribed to women seeking to terminate a pregnancy (Kumar et al., 2009) and this stigma extends beyond those seeking abortions to those who provide them (Norris et al., 2011; Mosley et al., 2020). It is not uncommon for this stigma to become embedded within healthcare institutions and the abortion-providing workforce. Performing stigmatised work can lead to personal and professional difficulties, limited disclosure to their community including close family and friends, lack of support from colleagues, isolation, stress and burnout, among other effects (Janiak et al., 2018; Martin et al., 2014).

Elements of abortion stigma experienced by providers

Abortion-related stigma is common for health professionals involved in the provision of abortion care and their experiences are multifaceted. Norris et al. (2011) explained how abortion stigma is driven by legal restrictions, the idea that abortion is 'dirty', and by the negative narratives surrounding abortion. There have been several attempts to define the stigma experiences of the abortion-providing workforce (Cockrill et al., 2013; Shellenberg et al., 2014), and the Abortion Providers Stigma Scale (APSS) (Martin et al., 2018) has been tested and validated in several settings. The APSS defines five dimensions of abortion stigma as it relates to providers:

- **Disclosure management** – the strategies and emotional reactions to disclosing abortion work to others (e.g., worrying about telling people about involvement in abortion work, avoiding telling people about their job).
- **Internalised states** – the positive and negative emotions associated with working in abortion care (e.g., pride and feeling good about the work, and guilt and shame).
- **Judgment** – feeling judged by other healthcare professionals, family and broader society.
- **Social isolation** – the level of isolation providers feel from their friends and family.
- **Discrimination** – experience of threats, harassment and violence.

These dimensions tend to focus on an individual's psychosocial experience of stigma over the structural drivers.

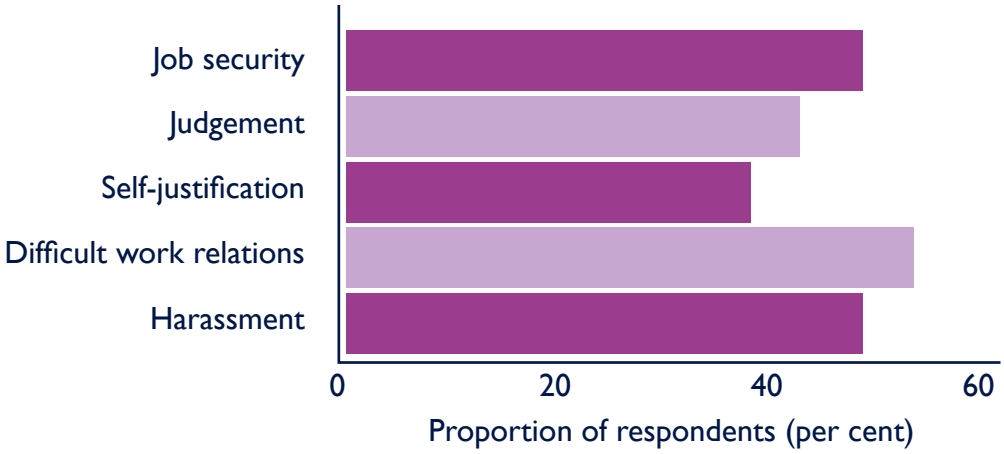
Incidence and manifestation of abortion-related stigma experienced by abortion care providers

Abortion-related stigma experienced by abortion care providers has been documented in many different settings, including Ireland (Dempsey et al., 2021), Uruguay (Cardenas et al., 2018), sub-Saharan Africa and Latin America (Mosley et al., 2020), Italy and Cataluña (De Zordo 2018), South Africa (Teffo 2017), the USA (Martin et al., 2018), Canada (Dressler et al., 2013), and Ghana (Aniteye et al., 2016). These studies have tended to be observational, exploring how abortion care providers experience abortion-related stigma, or intervention studies using the APSS to assess whether a specific activity has changed providers' experience of stigma.

In the United States, several national surveys of healthcare providers of abortion services have documented their experience, often with a focus on capturing the prevalence of violence and harassment (Jones & Jerman 2014; National Abortion Foundation 2019). These surveys have tended to reflect harassment and violence as a manifestation of abortion stigma.

More recently, Ipas and Safe2Choose (2020) undertook the International Survey of Abortion Providers and Companions to understand the experience of abortion care providers around the world, including experiences of stigma.

Figure 1: Experiences of stigma from abortion care providers



Responses were received from 339 companions and/or providers from six different regions. Disclosure management was a shared concern, with 50% of respondents stating that they found it hard to talk to others about their jobs or felt they had to hide it. Many respondents felt judged (43.8%) and felt they had to justify themselves (39.2%). More than half (54.9%) noted that other colleagues made their job more difficult and/or belittled their work. Half of the respondents (50%) had experienced harassment, intimidation, defamation, or attacks against their reputation.

In a larger online Abortion Provider Stigma Survey, the RCOG used items from the APSS (unpublished, RCOG 2023) to collect data from 1674 healthcare professionals working in abortion care from 77 countries. This global survey found stigma to exist universally for those working in abortion care across all levels of legality (unpublished, RCOG 2023). The greatest reported burden was in areas with increased legal restrictions. The survey also identified that

most providers held positive views about abortion, but this did not necessarily act as a 'protective' factor in experiencing stigma. In fact, a clear correlation was observed between experiencing higher levels of stigma and reporting feelings of professional burnout, with just under half of all respondents reporting that they felt exhausted or burnt out by their job at some time (unpublished, RCOG 2023).

Impact of stigma on professional and personal life

Working in abortion services can have a profound effect on providers' professional and personal lives. Providers described not disclosing the nature of their work to others when they leave abortion facilities to feel more 'normal', living with internal contradictions and missed opportunities for connection. Many providers felt that other health workers looked down on them for working in abortion and questioned their professional skills (Harris et al., 2011; 2013; Joffe 2009; Freedman 2010).

> **"Even in the workplace, it makes me an outsider, sometimes it makes me withdraw myself from my colleagues or they withdraw themselves from me. They push away from me as if I'm not part of them."**
> (Sierra Leone)

Abortion stigma is a significant predictor of lower compassion satisfaction, higher burnout (emotional exhaustion and depressed professional engagement) and higher compassion fatigue (Martin et al., 2014; Harris et al., 2011, 2013; Joffe 2009; Mosley et al., 2020). As Mosley et al. (2020) outline:

> **"Experiencing stigma can diminish professional quality of life and increase compassion fatigue, job dissatisfaction and 'burnout,' defined as a sense of emotional exhaustion, depersonalization of clients and reduced feeling of personal accomplishment as a result of one's work all of which threaten the abortion workforce and the accessibility of high-quality sexual and reproductive health care services."**

High levels of stigma were associated with decreased job satisfaction and increased burnout and compassion fatigue in the US (Martin et al., 2018) and in sub-Saharan Africa and Latin America (Mosley et al., 2020).

INTERVENTIONS

Organisations working with healthcare professionals have an obligation to reduce and manage the stigma experienced by these professionals. In this section, different interventions to reduce the stigma experienced by healthcare providers of abortion care are described. Such stigma reduction efforts should help healthcare professionals to manage the stigma they experience (Harris et al., 2011).

For those overseeing abortion care providers, these interventions can provide inspiration for approaches that could reduce stigmatising behaviours within healthcare facilities and support healthcare providers.

The interventions reflect two principles. The first principle underpinning stigma-reducing efforts is **normalisation**. Despite abortion being a common gynaecological procedure, the dominant and default views about abortion is that it is exceptional, inherently bad, negative or awful (Baird & Millar 2019). Normalisation moves the dominant view towards a positive attitude to abortion (Purcell et al., 2020). A more normalised view would present (1) abortion as a routine component of sexual and reproductive healthcare (Maxwell et al., 2020), (2) people who have abortions as empowered, competent decision-makers, and (3) clinicians who provide abortions as highly technically skilled healthcare professionals (Kavanagh 2022, personal communication). Normalising abortion as part of routine health care is essential to countering stigma, inequity and harassment for those seeking abortions and those providing them (Dyer 2017).

The second principle underpinning stigma-reducing efforts is **reflective practices** that can help health professionals to understand work situations and meet the challenges of their work (Schön 1963; Sommerville & Keeling 2004). Reflection is a powerful tool to enable learning from experiences; it helps health professionals to understand what they already know, and how their own personality and personal history contribute to situations, advance their understanding, make sense of new information and feedback, and guide future learning. Reflective practice is supported by reflective conversation about problems/issues, probing them, reframing them, and relating them to previous situations.

Overleaf, 10 stigma-reducing interventions are highlighted.

Stigma reduction

Interventions to support the individual

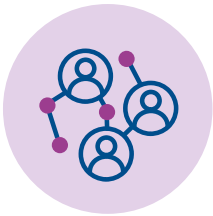
Mentoring

Incidence reporting

Reflective supervision

Provider Share Workshops

Wellness programmes



Peer groups/ informal networks

Legal safety and support

Interventions to create an enabling environment

Policy audit

Values clarification activities

Inclusion in healthcare student curricula and relevant postgraduate/ specialty training

Most interventions described are short-term strategies for coping with the effects of stigma experienced by the provider, working at the level of the individual to promote reflective practice. They do not target the external environments (Mosley et al. 2020, p.42), whereas the several interventions that aim to create an enabling environment focus more on normalising abortion care. The interventions shared here are aimed at those who are experiencing stigma, not those causing stigmatisation.

The interventions should be adapted to local circumstances to reflect the organisational or regional manifestation of abortion stigma that can be specific to the local context. For example, the stigma experienced by those providing abortions in hospitals that provide various services may be different to those working in clinics that only provide abortion care (Janiak et al., 2018). The method of abortion can also affect the stigma experienced, with surgical methods seen to be more stigmatised than medical abortion (Teffo et al., 2017; Dempsey et al., 2021). Similarly, the Ipas and Safe2Choose (2020) survey found that respondents working in countries where legislation indicates that abortion is legal upon request, under any circumstances, reported being less concerned with the hostile environment than those working in countries where abortion is legal only under specific grounds.

Mentoring

"Mentoring is regarded as involving a voluntary and mutually beneficial relationship in which one person is experienced and knowledgeable (mentor) who supports the maturation of a less-experienced person (mentee)."
(Siu & Sivan 2011)

There is no standard definition of mentorship, but it is characterised by an interactive, facilitated and structured process to promote clinical staff learning and development. It differs from conventional training because it occurs when a more skilled or experienced person is paired with a newly trained or less skilled person to develop specific abilities hence, fostering continuing professional development to support high-quality clinical care outcomes (WHO 2005). Mentoring focuses on reviewing clinical cases, assisting in case management, responding to questions, and providing feedback for practice improvement and supporting health workers' development and career paths. Though mentoring is associated with improving clinical skills and service delivery and provider performance, it does entail emotional support, particularly in responding to health worker stigma (Ipas 2014). Mentorship can either be formal (designed with specific phases over a set period) or informal (based on good rapport).

Such mentorship has been associated with various positive outcomes (Eby et al., 2008). Increased confidence and self-esteem, more knowledge, less stress and conflict, and job satisfaction are reported among mentored individuals compared with those not mentored (Ragins et al., 2000; Fagenson-Eland et al., 1997). Clinical mentoring has been used effectively in relation to abortion to expand access to services when laws have been liberalised (Schiavon & Sanhueza 2021).

The goal of mentoring is to ensure that newly trained providers are clinically competent and confident, provide services according to established standards of care, and document service delivery and adverse events appropriately (Ipas 2014). The mentoring process can occur between two people, peers or within a group and could take place during facility visits or through phone consultations. Mentoring can provide the opportunity to reflect and respond to experiences of stigma as part of professional and personal development.

Another form of mentorship is to match mentors who are abortion care clinicians or residents in reproductive health with medical students with an emerging interest in abortion care and reproductive health. In this way, mentors may provide advice on how to get into practice, and what life is like as a member of the abortion-providing workforce.

Case Study - Complex Family Planning Fellowship

The Complex Family Planning Fellowship aims to develop obstetrician-gynaecologist leaders in abortion and contraception through training in clinical care, research and education. Mentorship on research and clinical care is a foundational element to this fellowship program. To date, the Fellowship has produced over 400 obstetrician-gynaecologists and family physicians. This model is being replicated at the international level with a fellowship programme in Ethiopia and Rwanda (see societyfp.org/fellowship/).

In Nigeria, Making Abortion Safe (MAS) Champions have mentored medical students, particularly around leadership, advocacy and lobbying. These skills enable them to champion access to safe abortion throughout their careers, helping to destigmatise abortion and building positive associations with abortion care that will help to manage stigma they may face later in their careers. The trained medical students were officials of the Nigeria Medical Student Associations (NIMSA) in each university across the country. Training programmes conducted by Champions have been held in four geopolitical zones and students received mentoring to build their capacity in safe abortion care and cascade the training to their members. The President of the Society of Obstetrics & Gynaecology, Ipas and Marie Stopes International Nigeria pledged to support the medical students' activities. With guidance from their mentors, the trained medical students have conducted activities such as webinars, outreach programmes and conferences.

Useful resources

Turner KL, Huber A. Clinical mentoring and provider support for abortion-related care. Chapel Hill, NC: Ipas; 2014 [www.ipas.org/resource/clinical-mentoring-and-provider-support-for-abortion-related-care/].

Steinauer J, Turk J. Abortion training in the USA: prevalence, outcomes and challenges. In: Landy U, Darney P, Steinauer J, editors. Advancing women's health through medical education: a systems approach in family planning and abortion. Cambridge: Cambridge University Press; 2021. pp. 101–9.

Action points for health facility managers and professional associations:

- Set up mentoring schemes, particularly between abortion-providing healthcare workers, as a strategy to provide support, both clinical and emotional, between providers.
- Look at existing mentoring arrangements and protocols and ensure that experience of stigma is actively included as part of the guidance materials for mentors.
- Ensure mentors are trained to understand what stigma is and how to reflect and respond to it in their sessions with mentees.
- Mentor medical students and junior colleagues to build leadership and advocacy skills to help counteract and manage stigma throughout their careers.

Reflective supervision

Reflective supervision uses reflective practice to explore an individual's experiences of stigma, allowing them to discover solutions, concepts and perceptions on their own with support from the supervisor (Tomlin et al., 2014). Traditionally associated with infant and mental health, reflective supervision attends to the emotional content of the work and reactions to that content. Reflective supervision is designed to support and enhance the supervisee's reflective practice skills (Tomlin et al., 2014) and encourages high levels of reflection, introspection and self-awareness (Eaves et al., 2022). Reflective supervision is characterised by three components: reflection, collaboration, and consistency of the relationship. Ideally, there should be scheduled, uninterrupted and protected time for a supervisor to meet individually with each supervisee and for the team to meet on a regularly scheduled basis (Shahmoon-Shanok 2009). Reflective supervision may be carried out individually or within a group (Eaves et al., 2022).

> **"To overcome the stigma, … I think the best way of handling, it is by talking to that person and comfort that person. So far I think it's more of talking to that person trying to make him or her feel that even if there is this stigma… he will overcome."** (Rwanda)

When done well, reflective supervision increases the self-efficacy and coping skills of infant mental health professionals (Wallbank & Woods 2012; O'Rourke 2011). Three studies found a positive association between supervisory relationships that adhere to reflective supervisions guidelines with burnout and stress decreased (Frosch et al., 2018; Begic et al., 2019).

There is a strong emphasis on the supervisor's ability to listen and wait, allowing the supervisee to discover solutions, concepts and perceptions on their own without interruption. Supporting the social and emotional needs of staff entails listening to them attentively and empathetically, particularly when they feel overwhelmed, stressed or confused about their work (Mor Barak et al., 2009). Several attributes are consistently noted to support the development of an effective and trusting reflective supervisory relationship: confidentiality, availability, trust, emotional safety, sensitivity, attentiveness, protection of time to reflect, consistency, and dependability (Eaves et al., 2022). Such a relationship requires several hours of reflective supervision and emotional introspection to facilitate the exploration of difficult feelings.

Action points for health facility managers and professional associations:

- Review existing supervision arrangements and guidance to include activities that accommodate reflection.
- Supervisor training should include ways to encourage and support reflection around stigma experienced or witnessed, and resources to be able to support supervisees with these.
- Ensure supervisors and supervisees have protected and regular time for reflection work during normal working hours. This should be adapted to whether the supervision sessions are one-on-one, or group based.

Useful resources

Alliance for the Advancement of Infant Mental Health (AAIMH). Best practice guidelines for reflective supervision/consultation. Southgate, MI, USA: AAIMH; 2018 [www.allianceaimh.org/reflective-supervisionconsultation**].**

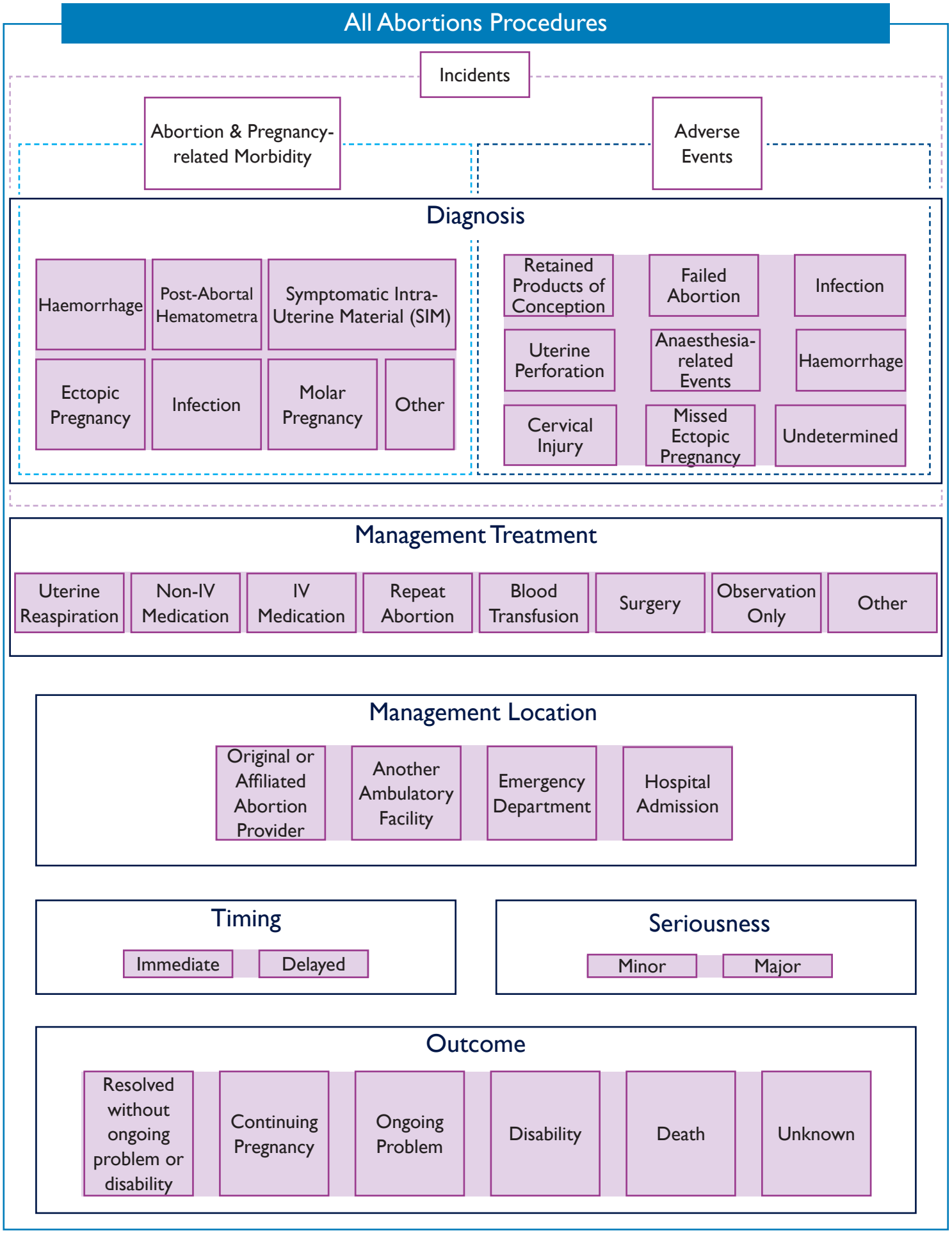
Alliance for the Advancement of Infant Mental Health (AAIMH). Guidelines for beginning and maintaining a reflective supervision/consultation relationship via distance technology reflective supervisory relationship. Southgate, MI, USA: AAIMH; 2020 [static1.squarespace.com/static/5884ec2a03596e667b2ec631/t/5ec58399b2ae022884fd28ae/1590002588308/Alliance_Virtual_RSC_2020_FINAL.pdf**].**

Incident reporting

Incident reporting is widely recognised as an important and effective strategy for improving patient safety and quality improvement in health care. An incident or adverse event (for example, a medical error, patient injury, or equipment failure) is an event that could potentially result in harm to a patient, caregiver, or other individuals. Such reporting helps to identify potential hazards and to develop interventions to mitigate the risks and reduce harms. Adverse incidents can be triggering for providers of abortion care, but can also provide an opportunity for reflective practice, such as writing a short reflective piece on their emotional response to these experiences. It is important to ensure a no-blame culture; if blame is associated with the incident reporting, it can become further stigmatising.

An incident reporting framework can be clinical but can also be adapted to include incidents of stigma and harassment against both clients and providers, and to give space for reflection. For example, the Procedural Abortion Incident Reporting & Surveillance (PAIRS) framework has been developed and tested with 20 000 patients for incidents resulting from procedural abortion care (Taylor et al., 2017). The PAIRS framework classifies incidents by diagnosis (confirmatory data, aetiology, risk factors), management (treatment type and location), timing (immediate or delayed), seriousness (minor or major) and outcome (see Figure 2 overleaf).

Figure 2: The PAIRS framework (Taylor et al., 2017)



Case Study - CLIP

In 2018, as part of a commitment to improving clinical quality and governance, MSI UK introduced weekly 'CLIP' meetings to discuss all live Complaints, Litigation, Incidents and Patient feedback. Each week, all UK centre managers and team leads, including safeguarding leads, attend these online meetings, and update on the status of every live point on the comprehensive agenda. The purpose of the CLIPS is to provide a contemporaneous organisational overview of all complaints, litigation, incidents and patient feedback to ensure the correct investigation and remedial action takes place. It also aims to identify, on a continual basis, all emerging themes, ensuring any material risks are identified for inclusion on the appropriate risk register for onward management and mitigation. This practice has proven to encourage transparency and a no-blame culture around all types of incidents.

Action points for health facility managers and professional associations:

- Review existing incidence reporting process to identify opportunities for reflection on potential experiences of stigma.
- Consider adding potential reflective exercises – whether a group conversation or written activities – to further expand on the experiences of stigma triggered by adverse events.

Useful resources

Taylor D, Upadhyay UD, Fjerstad M, Battistelli MF, Weitz TA, Paul ME. Standardizing the classification of abortion incidents: the Procedural Abortion Incident Reporting and Surveillance (PAIRS) Framework. *Contraception* 2017;96:1–13.

Provider Share Workshops

> **"When someone is getting a training about stigma and stigma management, and they become more comfortable, they know the information, they know what is happening and maybe the stigma may decrease or disappear."** (Rwanda)

The Provider Share Workshop (PSW) encourages providers of abortion care to share their lived experiences of stigma in a group setting. PSW was first designed in 2006 by a group of researchers at the University of Michigan (UoM) in response to a perceived need to break the silence typically surrounding abortion work. The team aimed to create a safe space for healthcare providers of abortion care to talk about their work with others. Following an initial pilot, the UoM team continued to develop the approach over several years, experimenting with formats and durations, and holding PSWs in several states in the USA and in parts of Latin America and Africa (Martin et al., 2014; Mosley et al., 2020).

The Provider Share Workshop uses a combination of storytelling and arts-based methods in a group process to foster reflection and communication and to create a sense of community among providers of abortion care. A workshop comprises 5 8 activity sessions, each one centred on a specific theme. The workshop begins by exploring motivations for providing abortion care: "what providing abortion care means to me" and "to my community", then explores the concept of stigma in depth. The theme of stigma is central in the subsequent activities, and the workshop goes on to encourage reflection and sharing of stigma as a dynamic phenomenon, which requires a 'stigmatiser'. Challenging activities include 'providers as stigmatisers' and 'managing complications', which explore how stigma can be perpetuated in providers' behaviours as well as by others, and the role that stigma plays in the clinical environment.

> **"At least, if you can come together with other trainers and trainees and those who offer services will share experiences and talk about how this stigma, can be, can be at least ameliorated."** (Nigeria)

The workshop also includes activities for participants to consider the subject of 'disclosure': who they can speak to about their work in abortion care; 'stigma mapping': how abortion stigma may appear to clients visiting their health facility; and 'paper prayers': a final activity imagining a world without abortion stigma.

Throughout a workshop it is typical for providers to share memorable stories from abortion work, to discuss abortion and identity, abortion politics, strategies for self-care, stigma, provider

burnout and abortion attitudes, and developing new measures for legal safety and support for legal advocacy (Martin et al., 2014; Mosley et al., 2020).

There have been three studies of the PSW approach (Harris et al., 2011; Debbink et al., 2016; Mosley et al., 2020). This is one of the few interventions that has been assessed in relation to its impact on abortion stigma (Martin et al., 2014). Participation in the workshop is associated with improvements in three domains of providers' stigma experience: internalised stigma, willingness to disclose abortion work, reduced internalised stigma and decreased perceived judgment from others in the USA over time (Martin et al., 2014; 2020). In sub-Saharan Africa, participation was associated with improvements in unfavourable attitudes, emotional exhaustion, depersonalisation and legal safety, with total abortion stigma decreasing among caregivers in both sub-Saharan Africa and Latin America (Mosley et al., 2020).

While the PSW is proven to be most effective as a two-day workshop, many of the activities in the Provider Share Workshop can be, and have been, used in shorter workshops to explore important themes.

The two-day Provider Share Workshop can be resource-intensive and can limit service provisions as providers participate in a series of workshops. Thus, organisations have modified the original curriculum to suit their needs and available budgets.

Case Study - PSW

"The Provider Share Workshop eases a lot of pain. Providers need this platform there so they can openly share without limitation." (Zimbabwe)

In Zimbabwe, the original PSW and activities have been adapted to the institutional context. As a result of the workshop, team members have told their loved ones about their work, tackled their own stigmatising behaviours, and formed informal peer-support groups.

In Ethiopia, the Ethiopia Society for Obstetricians and Gynecologists has adapted the PSW content to include sessions on legal literacy. In Uganda, PSW has been adapted for use with advocacy professionals working towards sexual and reproductive health and rights (SRHR) and abortion law reform. As a result of an initial pilot by MSI UG in 2019, PSW is now recommended for advocates as well as frontline providers.

In several countries, the methodology used to explore memorable complications in the PSW has been recommended as a practice to assist teams to reflect on complications or incidents in a holistic way, to explore the emotional as well as clinical aspects to incident management.

Action points for health facility managers and professional associations:

- Identify existing or potential facilitators to be trained in Provider Share Workshop Facilitators' training.
- Assess existing opportunities to reduce the resources required – this may vary by private or public sector.
- If resources are limited, consider developing a bespoke workshop.

Useful resources

Kayaconnect.org. Providers Share Workshop (PSW) facilitator training. Humanitarian Leadership Academy [kayaconnect.org/c/psw].

Debbink MLP, Hassinger JA, Martin LA, Maniere E, Youatt E, Harris LH. Experiences with the Providers Share Workshop method: abortion worker support and research in tandem. Qual Health Res 2016;26:1823–37

Mindfulness programmes

"Mindfulness is defined as a self-directed practice for relaxing the body and calming the mind through focusing on present-moment awareness. The emphasis of mindfulness is staying in the present moment, with a nonjudging, nonstriving attitude of acceptance. Mindfulness is cultivated through the practice of meditation." (Bazarko et al., 2013)

Mindfulness is a reflective practice that may be useful for individuals working in high stress working conditions (Grossman et al., 2004; Barzako et al., 2013). Employers can facilitate mindfulness and wellness interventions, but these usually target stress, burnout and compassion fatigue, not necessarily stigma directly. Though not found in relation to abortion stigma, mindfulness interventions were common in mental health. Across the board, despite small sample sizes and/or informal interventions, wellness programs seemed to have positive effects on provider wellbeing.

Mindfulness training can entail a course of meditative training where participants become more aware of their thoughts and feelings; such wellness retreats can be combined with social support activities held over a few consecutive days (Forstag & Cuff 2018). Another form of mindfulness training is through facilitated short sessions in the workplace over a few weeks (Riley et al., 2017; Van Kirk 2021; Forstag & Cuff 2018). One such programme is mindfulness-based stress reduction (MBSR), a structured group programme that employs mindfulness meditation over 8–10 weeks, with weekly sessions of 2.5 hours. Each session covers various exercises and topics. This can be combined with yoga practices, which have been associated with significant reduction in work-related stress and enhanced stress adaptation (Lin et al., 2015).

Mindfulness has been found to decrease work-related stress (Lin et al., 2015, pp. 236) and compassion fatigue (Brown et al., 2017, pp. 125). Wellness interventions were found to be cost-effective (Riley et al., 2017; Van Kirk 2021; Forstag & Cuff 2018).

Action points for health facility managers and professional associations:

- Employers should facilitate mindfulness as a coping mechanism as part of a larger programme to address stigma.
- Secure resources, including time and space, to support a mindfulness programme.
- Seek consultant expertise in mindfulness to design a programme suitable for your organisation and workspace.
- Ringfence time for staff to focus on mindfulness in their working hours.

Useful resources

Ackerman CE. *Mindfulness-based stress reduction: the ultimate MBSR guide*. Positive Psychology; 2017 [positivepsychology.com/mindfulness-based-stress-reduction-mbsr/].

Guy's and St. Thomas' NHS Foundation Trust. MBSR exercises. *Mindfulness-based stress reduction (MBSR)* [www.guysandstthomas.nhs.uk/health-information/mindfulness-based-stress-reduction-mbsr/mbsr-exercises].

Social support and perceived social support

"Because of the training that… we service providers receive, we now have a, discussion group and training group,…where my facility is located at least I have up to 5 to 6 providers, apart from the maternity, that also provide such services [abortion], so it has now made the thing [stigma] reduce remarkably." (Nigeria)

Respondents regularly reported seeking support from colleagues as a coping strategy. This was a documented coping strategy for those providing abortion in South Africa and in Uruguay (Teffo & Rispel 2020; Cardenas et al., 2018). Talking to colleagues with similar experiences can provide a safe space for the abortion-providing workforce to discuss and reflect on experiences of working in abortion care, including experiences with stigma. A strong team was seen as a source of emotional support with no fear of judgement (Teffo & Rispel 2020; Cardenas et al., 2018). Social support can emerge from both informal social circles of friends, families and colleagues, and from a more formal support systems provided by professionals and peers at work, clubs, or religious community (Hogan et al., 2002). There are two main strategies to build social support: (1) increasing a person's network size and (2) building social and communication skills helped generate social support (Waqas et al., 2020).

Table 1 outlines the types of groups that can be supported by agencies and organisations to encourage social support.

Table 1. Types of social support (Waqas et al.,2020, p15)

Type	Definition	Example
Professionally led support groups	Support groups that are headed or mediated by a mental health professional	Support groups of colleagues at workplaces receiving counselling services from a mental health professional. In some instances, the mental health professional may only act as a mediator with colleagues leading the direction of the groups.
Mutual support groups	Support groups at workplaces comprising peers	Peer-led support groups at workplaces without the involvement of a therapist. In some mutual support groups, peers are often paired to aid each other (e.g., in providing emotional, work-related and skill sharing support). It can also take the form of a mentor–mentee support group.
Social mobilisation interventions	Interventions aimed to use societal and personal influences to raise awareness or bring about behaviour change	Conduct motivational sessions for mental health promotion at healthcare workplaces. Change physical activity by building supportive relationships for behaviour change.
Support substitution interventions	Interventions aimed at compensating lack of one resource with another readily available. Substitution can be through adjustments of network size and through higher efficiency of personal ties.	Programmes focused at improving diversity at workplaces for international doctors immigrating from their home countries. Giving financial incentives and providing appreciation to healthcare workers.

Creating a sense of community and encouraging collegial relationships, peer support and collaboration have been found to contribute to resilience and compassion satisfaction (Waqas et al., 2020; Siegel et al., 2015). A meta-analysis of social support interventions on health workers (for example, those that promote human connectedness and stronger bonds between individuals) found (Waqas et al., 2020).

Providers feeling overwhelmed may benefit from using online platforms, which can provide consistent availability, accessibility and convenience (Wood et al., 2017). For example, at the beginning of the COVID-19 pandemic, the RCOG initiated the use of Slack for obstetrics and gynaecology leaders to share best practice and support resources. The RCOG has also established digital spaces using Facebook groups for SRHR Champions to support each other with advocacy to expand access to quality abortion care. There are various other platforms for those working in sexual and reproductive health to connect, including the WHO International Best Practice Network and INROADS. Wood et al. (2017) suggest that using a mobile app may have similar effectiveness as attending a seminar.

> **"If they put meetings with obstetricians and gynaecologists maybe we can sit and talk about it and feel like it's like an easy thing to do. For example, if I can sit with you, you told me that. You helped some people with safe abortion because you don't want to see the complications of unsafe one, and I can feel maybe why not me? He did it without any problem, so I feel like if they can just make some meetings or some trainings and talk about that'.** (Rwanda)

Case Study - Networks

In Latin America, the Abortion Provider Network is an example of a social support network that has been created to support healthcare providers of abortion care. The Abortion Provider Network meets once a year to share experiences and exchange technical assistance. Those who have been involved in the network report experiencing less stigma as they relate to others like themselves. In the USA, the National Abortion Federation (NAF) is the professional association of abortion-providing healthcare workers, which meets annually to support clinical capacity, professional development opportunities, and resources and facilities to keep staff and their patients well and safe.

Ipas Nigeria conducts a biannual Provider Network Meeting. Providers from all parts of the country meet at a venue where, ordinarily, many may not know or have the means to visit. The participants are mostly private providers of comprehensive abortion care. Participants at such meetings include officials from the government and regulatory authorities. Agendas include abortion updates, data presentation and social events to help providers unwind and rejuvenate and boost morale.

Action points for health facility managers and professional associations:

- Assess staff members' existing level of social support and assess the types of support they draw on.
- In cases where support already exists, explore ways to support existing relationships, encouraging social events, retreats or away-days.
- In cases where support does not exist, focus on activities to build support, such as team building activities, creating spaces and time for people to talk and share.

Useful resources

Wellcome Trust. Understanding what works for workplace mental health: putting science to work. London: Wellcome Trust; 2020 [wellcome.org/reports/understanding-what-works-workplace-mental-health**].**

Legal safety and support

"We need the support from the state government. If the government can legalise the work, to improve, it will even be with joy to carry out the work." (Nigeria)

Abortion-related stigma is manifest through national abortion laws and through the inconsistencies and ambiguity of legal frameworks that leave the law open to interpretation and confusion (Payne et al., 2013; Aniteye et al., 2016). Testimonials and expert consultations described a sense of legal jeopardy, which affected providers' experiences of stigma and professional quality of life. Most (49.7%) consider their main challenges to be rooted in discriminatory legislation and legal restrictions (Ipas & Safe2Choose 2020).

Legal restrictions affect the experience of providers of abortion care, such as the fear of being harassed, entrapped, or of law enforcement (Mosley et al., 2020). Feelings of legal jeopardy stemming from abortion restrictions are associated with provider burnout and stigma (Mosley et al., 2020). An improved perception of legal safety was associated with a decrease in emotional exhaustion and depersonalisation (Mosley et al., 2020).

Planned Parenthood Global has nurtured legal networks, working with providers of safe abortion care in Latin America since 2006 and in East Africa since 2010, to minimise the legal risks and ensure the legal protection of the rights and safety of providers (Casas et al., 2019). This includes preventing the harassment and arrest of members of the abortion-providing workforce; managing legal risk to reduce the incidence of arrest and police harassment, and to reduce the personal risk of legal issues for the provider, clinic staff, and clients. It also includes serving as the provider's advocate and influencing public policy, including advocating for laws and regulations (Casas et al., 2019). The legal networks have been effective in reducing police harassment, offering providers the support to stand up to intimidation and, in a few cases of prosecution, providers have access to competent legal counsel (Casas et al., 2019).

"If we can have a law that can guide us, because what brings the stigma more is, you are doing work which… the law can come after you. If we have a law that can guide service providers like myself… that will help reduce all the stigma." (Sierra Leone)

Case Study - Ipas Nigeria

IPPF developed the 'Ensuring staff protection guidelines' for its network of member associations. These guidelines were developed in response to concerns around safety, threats from police and law enforcement, and stigma and harassment, particularly in countries with restrictive abortion laws, social stigma and organised opposition. The guidelines provide recommended actions and protocols to prepare for, minimise the risk of, and effectively manage security, legal and harassment risks and incidents. Having such robust, organisational procedures, and knowing they are in place, can help staff to feel more secure, confident and supported.

In Nigeria, private healthcare workers who offer abortion services were being harassed and extorted by the police. Because of this fear of harassment, private abortion care providers were not properly documenting abortion care services in their facilities. In collaboration with Ipas Nigeria, the private healthcare workers were trained on quality comprehensive abortion care and, specifically, on recording service documentation in a way that will not legally implicate them. Ipas Nigeria also created a network of the 'Bar, the Bench and the Police'. Providers regularly meet with the police, lawyers and government/ regulatory authorities, and this has reduced the incidence of police harassment and improved the quality of service documentation.

Action points for health facility managers and professional associations:

- Assess the potential risks of harassment from law enforcement and perceived legal needs of providers of abortion care and the organisations they work with.
- Identify legal partners that could help to improve individual and institutional legal literacy and responses.
- Develop clear standard operating procedures to mitigate risks and provide support for staff for different legal circumstances.

Useful resources

Casas X, Kimathi-Osiemo M, Redwine D, Tebbets C, Plafker K. Preventing state harassment of abortion providers: the work of the legal support network in Latin America and East Africa. Health Hum Rights 2019;21:181–8.

Policy audit

Often, internal procedures and guidelines can perpetuate discrimination, including abortion stigma (Sorhaindo & Rehnstrom Loi 2022). Such barriers can lead to further stigmatisation (WHO 2022). To address this potential driver of stigma, policy audits can be conducted to compare various institutional policies against best practices and ensure they are consistent with organisational principles. This can include clinical, administrative, financial, performance, staffing and human resources policies, as well as leadership and decision-making policies. If relevant, it can also apply to programme, research, and project management. This may be more relevant to providers working in the public sector or integrated within a wider range of healthcare services.

This draws on the long-established practice of gender audits. These assess an organisational capacity to examine its policies and activities from a gender perspective. They identify strengths and weaknesses in promoting gender equality performed by governmental agencies and departments, educational institutions and nongovernmental bodies (NGOs) (ILO 2012). A gender audit requires preparation, analysis of the gender within an organisation and then gender action planning and follow-up (InterAction 2010).

Policy audits tend to follow a similar structure:

1. reviewing the existing policies and determining if and how they are implemented;
2. examining whether the policies align with the principles of reducing stigma and
3. whether such principles have been mainstreamed and are effective; then
4. developing recommendations for improvements.

Case Study - Policies

IPPF has undertaken extensive work with its member associations to address internal stigma by establishing strong policies and procedures that articulate institutional commitment to abortion and integrate abortion care within their integrated package of sexual and reproductive health (SRH) services. These policies and practices, including holding regular values clarification activities, ensure that all members of the organisation, from the Board down, are aligned with institutional values on abortion. By implementing these policies, staff and health workers are enabled to provide nonstigmatising abortion care within a supportive environment.

Action points for health facility managers and professional associations:

- Put strong policies and procedures in place that express a commitment to abortion care.
- Assess the organisation's readiness for a policy audit on abortion and abortion stigma.
- Review and adapt existing policy audit methodologies
- Allocate sufficient resources to not only undertake the audit, but to follow up on it as well.

Useful resources

International Labour Office (ILO). A manual for gender audit facilitators. The ILO Participatory Gender Audit Methodology. 2nd ed. Geneva: ILO; 2012.

InterAction. The Gender Audit Handbook. Washington, DC, USA: InterAction; 2010.

Inclusion in the nursing, midwifery, medical and allied health professional curricula

Medical students in the UK and the USA demonstrate a limited understanding of abortion and feel unprepared to provide abortion counselling (Horan et al., 2022; Cessford & Norman 2011; Brown et al., 2022). An important step towards the normalisation of abortion care within mainstream medicine is its inclusion in undergraduate and postgraduate medical and allied healthcare professional curricula. Normalising abortion through education of healthcare professionals can help tackle the negative image of abortion. It should start in medical, nursing and midwifery schools and extend into continuing professional development. This includes securing adequate teaching time on abortion within the medical and allied health professional core curricula. Online training can also be effective at building skills and supporting continuing professional development.

Organisations also have a role to play in ensuring their staff are adequately trained on abortion care. Many NGOs provide their own abortion training, and also often train public providers. However, reliance on the private sector for abortion training means that efforts to normalise abortion are unsustainable and require donor funding to continue.

> **"Frequent training, frequent education, updated information. Every day, week, or month they need to be updating health workers, health workers need to be appraised because when we are appraised, we feel relieved, so you know you are on the right track."**
> (Sierra Leone)

As well as including abortion training in core curricula, other incentives can encourage medical and health professional students to engage in abortion training. These can include developing a specific fellowship for post-residency and supporting attendance at conferences and congresses for greater exposure and understanding of the profession.

Case Study - Barriers

In the UK, teaching on abortion varies across institutions, with a focus on legal and ethical aspects of abortion over the clinical. Research from the USA and in the UK (Rennison et al., 2022) found four main barriers: (1) lack of curriculum time; (2) limited clinical learning opportunities; (3) the idea that abortion is a 'sensitive' topic; and (4) few teachers with the relevant expertise, and the will and the time to teach. In response, Doctors for Choice UK (DfCUK) have designed an eight-step plan for addressing these barriers to comprehensive abortion education for healthcare students in the UK.

1 is to identify one or more healthcare providers with relevant clinical and teaching expertise and the desire to improve teaching at their local institution. Ideally, they would work with some enthusiastic pro-choice students who also recognise the importance of being taught about abortion and want to help make improvements. The staff champion could also be a pro-choice lecturer with knowledge of the curriculum and some influence over curriculum design and content, but they would ultimately need to work with a local clinician to design and implement the vital clinical aspects of the teaching once adequate teaching time is secured.

2 staff and student champions work together to find out what is currently taught on abortion. For example, how many hours are spent on teaching? In which years? Who teaches it? What are the learning outcomes? What is the content? Is learning assessed? How much teaching is dedicated to the ethical and legal aspects of abortion and how much is clinically focused? Are there any clinical placements? DfCUK has drafted a survey to gather this information, which can be accessed here: doctorsforchoiceuk.com/curriculum-champion

3 involves finding out what students think about their teaching. This can be done informally by the student champions via student networks, and/or more formally via a survey, focus group or interviews.

4 involves identifying suitable time in the curriculum for abortion teaching. Students can be very helpful here, identifying gaps or repetition in the curriculum and times when abortion teaching would work well.

5 is to secure adequate curriculum time for teaching by engaging curriculum leads in discussions about the importance of abortion teaching. This might include presenting findings about the institution's current teaching, emphasising that students want comprehensive teaching on abortion, citing national curriculum guidance and, very importantly, outlining a solution.

6 involves producing effective learning materials. Clear, well-structured lesson plans and learning outcomes with engaging, inclusive content is important for the success and sustainability of the teaching. There is no point in reinventing the wheel – existing, excellent, open-access educational resources can be adapted from Doctors for Choice UK, the RCOG's Making Abortion Safe programme, and from the US-based Innovating Education in Reproductive Health.

Case Study - Barriers

7 the staff champion leads the delivery of the new teaching sessions. Over time, they can involve various colleagues (including junior clinicians), which is important for sustainability of the teaching. Encouraging those new to abortion teaching to observe experienced teachers and mentoring them until they are confident in good practice helps to allay any fears they might have about abortion being too sensitive a topic to teach.

8 involves evaluating the teaching, formally and informally, and responding to student and facilitator feedback. This should ensure that teaching continually improves, and will help embed it into the core curriculum.

Action points for health facility managers and professional associations:

- Organisations should ensure training plans are in place to give providers the necessary skills in the absence of abortion within national training curricula.
- Staff should have access to online training courses to continue professional development (see Useful Resources).
- Review Doctors for Choice UK's eight-step plan for addressing barriers to comprehensive abortion education for healthcare students. doctorsforchoiceuk.com/curriculum-champion

Useful resources

The RCOG's national undergraduate curriculum provides guidance for medical schools on abortion teaching, including legal, ethical and clinical dimensions..

World Health Organization (WHO). Family planning and comprehensive abortion care toolkit for the primary health care workforce: volume 2. Geneva: WHO; 2022 [www.who.int/publications/i/item/9789240063907].

Landy U, Darney P, Steinauer J, editors. Advancing women's health through medical education: a systems approach in family planning and abortion. Cambridge: Cambridge University Press; 2021.

Horan C, Zadeh PG, Rennison C, Hoggart L, Kavanagh J. A qualitative analysis of medical students' attitudes to abortion education in UK medical schools. BMJ Sex Reprod Health 2022;48:205–9.

Royal College of Obstetricians and Gynaecologists (RCOG). Making abortion safe [elearning.rcog.org.uk/catalog?pagename=Making-Abortion-Safe].

How to Use Abortion Pill [elearning.howtouseabortionpill.org/].

Values clarification activities

> **"Yes, because the first stigma is being done by our fellow colleagues, the ones that we are working with, so I think if there is a mobilisation or a training among our colleagues, I think it can help them change their mind."**
> (Rwanda)

Many healthcare professionals who provide abortions encounter hostility from others, particularly those working in women's health (Maxwell et al., 2020; Freedman 2010; Aniteye et al., 2016). Activities focused on clarifying values to encourage healthcare providers, policymakers and other participants to identify and examine personal beliefs, attitudes and behaviours related to abortion, and in turn, reducing stigmatising attitudes, can contribute to stigma-reducing efforts (Turner et al., 2018).

Values clarification has its roots in both education and in psychology, whereby a person seeks to identify the underlying values that guide one's interests, choices, actions, and consequences of those values in different contexts. By better understanding one's personal belief systems and behaviour patterns, a person is better placed to critically reflect on and change them (Turner & Chapman Page 2008).

There are two approaches to values clarification. The first model implements *Abortion attitude transformation: a values clarification toolkit for global audiences* (Turner & Chapman Page 2008) in full over a two-day period. The values clarification and attitudes transformation (VCAT) intervention toolkit comprises 14 activities that engage participants with accurate abortion information, scenarios, critical self-reflection, empathy-evoking experiences and dialogue on abortion beliefs, values and professional ethics and responsibilities. Through these activities, the participant passes through the three stages of values clarification: making an informed value choice, affirming that choice, and acting on the chosen value (Turner et al., 2018). Through VCAT, it is anticipated that participants will move from active obstruction to tolerance, through to acceptance and then provision or support. Some may also move towards advocating for high-quality, comprehensive abortion care.

Working with trained facilitators, VCAT interventions lead stakeholders through an emotionally safe process to examine their personal values, attitudes and actions related to abortion, and to engage in critical reflection and evaluation of personally relevant abortion information and situations. This is in addition to them fully comprehending the harmful consequences of stigmatising abortion and restricting service delivery and access to care (Turner et al., 2018). Through this process, VCAT addresses some of the root causes of stigma-related barriers to abortion service delivery, access and quality (Turner et al., 2018). Using the VCAT toolkit has seen significant increases in knowledge, and improvements in attitudes and behaviours toward abortion care (Turner et al., 2018).

The second approach to values clarification is to use specific activities or elements of the VCAT toolkit and embed them in other training opportunities, such as clinical training, refresher training and induction training. This provides a short introduction to values clarification embedded in continuing activities and is less resource intensive.

Action points for health facility managers and professional associations:

- Review existing VCAT materials and curricula that are best suited to the needs of the organisation.
- Ensure adequate resources to support VCAT activities, including securing time for staff participants.
- Recommend participation in VCAT training for wider staff in facilities (including management), commissioners/ministry staff and healthcare students.

Useful resources

Turner KL, Chapman Page K. Abortion attitude transformation: a values clarification toolkit for global audiences. Chapel Hill, NC, USAA: Ipas; 2008 [www.ipas.org/resource/abortion-stigma-ends-here-a-toolkit-for-understanding-and-action/**].**

MSI Reproductive Choices. VCAT facilitator training [rise.articulate.com/share/G-4WDaeI-UCfJHmtVc9Iq7s7VZdtdFHi#/**].**

Evaluation

Several measures have been developed to assess whether such interventions have been successful (or not) in reducing stigma experienced by providers of abortion care. These measures can be used in conjunction with one another.

Abortion Providers Stigma Scale (APSS)

The Abortion Providers Stigma Scale (APSS) measures perceptions of stigma among the abortion-providing workforce, and its impact on workers' professional and personal lives. The Abortion Providers Stigma Scale (APSS) has been validated in different sites in the USA, and was more recently adapted to African and Latin American settings. It has performed well across settings with some changing to wording (Dempsey et al., 2021; Mosley et al., 2020). Using this validated and standardised measure allows stigma-reducing efforts to be compared.

ProQol

The Professional Quality of Life Scale (ProQOL) is a 30-item questionnaire designed to measure compassion fatigue, work satisfaction and burnout in helping professionals. The ProQOL measures three aspects of professional quality of life:

- Compassion satisfaction (pleasure derived from being able to work well)
- Burnout (exhaustion, frustration, anger and depression related to work)
- Secondary traumatic stress (feeling fear in relation to work-related primary or secondary trauma)

The ProQOL is the most used measure of the positive and negative effects of working with people who have experienced extremely stressful events (Stamm 2010). This is the industry-standard way of assessing professional quality of life and is important for comparing the experience of abortion care providers with other sectors.

Resiliency measures

A series of measures has been developed to measure a person's ability to bounce back or recover from stress. One of the most used measures is the Connor–Davidson Resilience Scale (CD-RISC). The Connor–Davidson Resilience Scale measures the ability to:

- adapt to change
- deal with what comes along
- cope with stress
- stay focused and think clearly
- not get discouraged in the face of failure
- handle unpleasant feelings such as anger, pain or sadness.

In conjunction with the APSS and ProQol, this measure can be useful to see how efforts and interventions affect people's ability to cope and respond to working conditions.

Evidence Gaps

This paper highlights key evidence gaps. Other than the Provider Share Workshop, most other approaches currently have only anecdotal evidence of their effectiveness. Much more work is needed to rigorously assess these (and other methods) to help providers cope with stigma. Additionally, experiences of abortion-related stigma are common for healthcare professionals involved in the provision of abortion care. This has implications on their professional lives by decreasing professional quality of life, and increasing compassion fatigue, job dissatisfaction and burnout. Many of the activities undertaken to reduce stigma have not been systematically evaluated (Sorhaindo & Rehnstrom Loi 2022). This limits the available evidence on the best interventions to support providers, help them to cope with abortion stigma (Mosley et al., 2020), and address the structural drivers behind stigma (Sorhaindo & Rehnstrom Loi 2022). Therefore, there is a large research gap on assessing these relevant interventions using standard evaluation tools that requires further attention for future research and practice.

Call to Action

Based on the research and consultation, this document calls for key actions to support organisational efforts to create an enabling environment for the health workforce to provide abortion services and reduce harassment and burnout:

- Healthcare organisations should all work to break the silences surrounding abortion, to make it safe for people to speak openly about their experiences.
- Healthcare organisations should support the normalisation of abortion, highlighting that abortion is a routine and unexceptional, essential medical service.
- Most examples of stigma-reducing efforts are applied in isolation, and there may be value in implementing several efforts across services to target different drivers and experiences of stigma in tandem.
- Efforts to reduce stigma must involve affected communities, and interventions should be locally targeted and heavily contextualised.
- Much more work is needed to rigorously assess these and other interventions to manage the drivers of stigma and support providers to cope with stigma. This is a critical area of exploration, further study and funding.
- Successful stigma-reduction strategies operate on several levels — most interventions focus on working with health providers, but attention must also focus on working with structural drivers of stigma.

References

Ackerman CE. *Mindfulness-based stress reduction: the ultimate MBSR guide.* Positive Psychology; 2017 [positivepsychology.com/mindfulness-based-stress-reduction-mbsr/].

Alliance for the Advancement of Infant Mental Health (AAIMH). *Best practice guidelines for reflective supervision/consultation.* Southgate, MI, USA: AAIMH; 2018 [www.allianceaimh.org/reflective-supervisionconsultation].

Alliance for the Advancement of Infant Mental Health (AAIMH). *Guidelines for beginning and maintaining a reflective supervision/consultation relationship via distance technology reflective supervisory relationship.* Southgate, MI, USA: AAIMH; 2020 [static1.squarespace.com/static/5884ec2a03596e667b2ec631/t/5ec58399b2ae022884fd28ae/1590002588308/Alliance_Virtual_RSC_2020_FINAL.pdf].

American College of Obstetricians and Gynecologists. ACOG Committee opinion no. 612: Abortion training and education. *Obstet Gynecol* 2014;124:1055–9.

Aniteye P, O'Brien B, Mayhew SH. Stigmatized by association: challenges for abortion service providers in Ghana. *BMC Health Serv Res* 2016;16:486.

Arksey H, O'Malley L. Scoping studies: towards a methodological framework. *Int J Soc Res Methodol* 2005;819–32.

Baird B, Millar E. More than stigma: interrogating counter narratives of abortion. *Sexualities* 2019;22:1110–26.

Bazarko D, Cate RA, Azocar F, Kreitzer MJ. The impact of an innovative mindfulness-based stress reduction program on the health and well-being of nurses employed in a corporate setting. *J Workplace Behav Health* 2013;28:107–33.

Begic, S, Weaver, J & McDonald, Th. (2019). Risk and protective factors for secondary traumatic stress and burnout among home visitors. Journal of Human Behavior in the Social Environment. 29. 137-159. 10.1080/10911359.2018.1496051.

Brown JLC, Ong J, Mathers JM, Decker JT. Compassion fatigue and mindfulness: comparing mental health professionals and MSW student interns. *J Evid Inf Soc Work* 2017;14:119–30.

Brown L, Swiezy S, McKinzie A, Komanapalli S, Bernard C. Evaluation of family planning and abortion education in preclinical curriculum at a large midwestern medical school. *Heliyon* 2022;8:1–7.

Cardenas R, Labandera A, Baum SE, Chiribae F, Leus I, Avondet S, et al. "It's something that marks you": abortion stigma after decriminalization in Uruguay. *Reprod Health* 2018;15:150.

Casas X, Kimathi-Osiemo M, Redwine D, Tebbets C, Plafker K. Preventing state harassment of abortion providers: the work of the legal support network in Latin America and East Africa. *Health Hum Rights* 2019; 21:181–8.

Cessford TA, Norman W. Making a case for abortion curriculum reform: a knowledge-assessment survey of undergraduate medical students. *J Obstet Gynaecol Can* 2011;33:38–45.

Cockrill, K., Upadhyay, U.D., Turan, J. and Greene Foster, D. (2013), The Stigma of Having an Abortion: Development of a Scale and Characteristics of Women Experiencing Abortion Stigma. Perspect Sex Repro H, 45: 79-88. https://doi.org/10.1363/4507913

De Zordo S. From women's 'irresponsibility' to foetal 'patienthood': Obstetricians-gynaecologists' perspectives on abortion and its stigmatisation in Italy and Cataluña. *Glob Public Health* 2018;13:711–23

Debbink MLP, Hassinger JA, Martin LA, Maniere E, Youatt E, Harris LH. Experiences with the Providers Share Workshop method: abortion worker support and research in tandem. *Qual Health Res* 2016;26:1823–37.

Dempsey B, Favier M, Mullally A, Higgins MF (2021) Exploring providers' experience of stigma following the introduction of more liberal abortion care in the Republic of Ireland. *Contraception* 2021:104:414–9.

Dressler J, Maughn N, Soon JA, Norman WV. The perspective of rural physicians providing abortion in Canada: qualitative findings of the BC Abortion Providers Survey (BCAPS). *PLoS One* 2013;8:e67070.

Dyer C. Decriminalisation of abortion. *BMJ* 2017;356:j1485.

Eaves T, Robinson JL, Brown E, Britner P. Professional quality of life in home visitors: core components of the reflective supervisory relationship and IMH-E® Endorsement ® engagement. *Inf Ment Health* 2022;43:242–55.

Eby LT, Allen TD, Evans SC, Ng T, Dubois D. Does mentoring matter? A multidisciplinary meta-analysis comparing mentored and non-mentored individuals. *J Vocat Behav* 2008;72:254–67.

Fagenson-Eland EA, Marks MA, Amendola KL. Perceptions of mentoring relationships. *J Vocat Behav* 1997;51:29–42.

Forstag & Cuff 2018. A Design Thinking, Systems Approach to Well-Being Within Education and Practice. Washington (DC): National Academies Press (US)

Freedman LR. *Willing and unable: Doctors' constraints in abortion car*e. Nashville, TN, USA: Vanderbilt Press; 2010.

Frosch CA, Varwani Z, Mitchell J, Caraccioli C, Willoughby M. Impact of reflective supervision on early childhood interventionists' perceptions of self-efficacy, job satisfaction, and job stress. Infant Ment Health J. 2018 Jul;39(4):385-395.

Goffman E. *Stigma: notes on the management of spoiled identity.* Englewood Cliffs, NJ, USA: Prentice-Hall; 1963.

Grossman P, Niemann L, Schmidt S, Walach H. Mindfulness-based stress reduction and health benefits: a meta-analysis. *J Psychosomat Res* 2004;57:35–43.

Guy's and St. Thomas' NHS Foundation Trust. MBSR exercises. Mindfulness-based stress reduction (MBSR) [www.guysandstthomas.nhs.uk/health-information/mindfulness-based-stress-reduction-mbsr/mbsr-exercises].

Harris LH, Debbink M, Martin L, Hassinger J. Dynamics of stigma in abortion work: findings from a pilot study of the Providers Share Workshop. *Soc Sci Med* 2011;73:1062–70.

Harris LH, Martin LA, Debbink M, Hassinger J. Physicians, abortion provision and the legitimacy paradox. *Contraception* 2013;87:11–6

Hogan BE, Linden W, Najarian B. Social support interventions: do they work? *Clin Psychol Rev* 2002;22;383–442.

Horan C, Zadeh PG, Rennison C, Hoggart L, Kavanagh J. A qualitative analysis of medical students' attitudes to abortion education in UK medical schools. BMJ Sex Reprod Health 2022;48:205–9.

How to Use Abortion Pill [elearning.howtouseabortionpill.org/].

International Labour Office (ILO). *A manual for gender audit facilitators. The ILO Participatory Gender Audit Methodology.* 2nd ed. Geneva: ILO; 2012.

InterAction. *The Gender Audit Handbook.* Washington, DC, USA: InterAction; 2010.

Ipas. *Literature review on clinical mentoring and programmatic support.* Chapel Hill, NC, USA: Ipas; 2014.

Ipas, Safe2Choose 2020.
Ipas & Safe2Choose. International Survey of Abortion Providers and Companions; 2020. Available from: https://ipaslac.org/documents/IpasCAM-2021-ResumenING.pdf

Janiak E, Freeman S, Maurer R, Berkman LF, Goldberg AB, Bartz D. Relationship of job role and clinic type to perceived stigma and occupational stress among abortion workers, *Contraception* 2018;98:517–21.

Jones RK, Jerman J. Abortion incidence and service availability in the United States, 2011. *Perspectives on Sexual and Reproductive Health.* 2014; 46(1):3–14.

Joffe, C. 2009. Dispatches from the abortion wars: The costs of fanaticism to doctors, patients, and the rest of us. Boston, MA: Beacon Press.

Kumar A, Hessini L, Mitchell EM. Conceptualising abortion stigma. *Cult Health Sex* 2009;11:625–39.

Landy U, Darney P, Steinauer J, editors. *Advancing women's health through medical education: a systems approach in family planning and abortion.* Cambridge: Cambridge University Press; 2021.

Levac D, Colquhoun H, O'Brien KK. Scoping studies: advancing the methodology. *Implement Sci* 2010;5:69.

Lin S, Huang C, Shiu S, Yeh S. Effects of yoga on stress, stress adaption, and heart rate variability among mental health professionals – a randomized controlled trial. *Worldviews Evid Based Nurs* 2015;12:236–45.

Martin LA, Debbink M, Hassinger J, Youatt E, Harris LH. Abortion providers, stigma and professional quality of life. *Contraception* 2014;90:581–7.

Martin LA, Hassinger JA, Seewald M, Harris LH. Evaluation of abortion stigma in the workforce: development of the revised Abortion Providers Stigma Scale. *Womens Health Issues* 2018;28:59–67.

Maxwell KJ, Hoggart L, Bloomer E, Rowlands S, Purcell C. Normalising abortion: what role can health professionals play? *BMJ Sex Reprod Health* 2020;47:32–6.

Mor Barak MEM, Travis DJ, Pyun H, Xie B. The impact of supervision on worker outcomes: a meta- analysis. *Soc Serv Rev* 2009;83:3–32.

Mosley EA, Martin L, Seewald M, Hassinger J, Blanchard K, Baum SE, et al. Addressing abortion provider stigma: a pilot implementation of the Providers Share Workshop in sub-Saharan Africa and Latin America. *Int Perspect Sex Reprod Health* 2020;46:35–50.

MSI Reproductive Choices. VCAT facilitator training [rise.articulate.com/share/G-4WDaeI-UCfJHmtVc9Iq7s7VZdtdFHi#/].

National Abortion Foundation. 2019 Violence and Disruption Studies. 2019. Available from: https://prochoice.org/wp-content/uploads/NAF-2019-Violence-and-Disruption-Stats-Final.pdf.

Norris A, Bessett D, Steinberg JR, Kavanaugh ML, De Zordo S, Becker D. Abortion stigma: a reconceptualization of constituents, causes, and consequences. *Womens Health Issues* 2011;21 3 Suppl:S49–54.

O'Rourke P. The significance of reflective supervision for infant mental health work. *Inf Ment Health* J 2011;32:165–73.

Payne CM, Debbink MP, Steele EA, Buck CT, Martin LA, Hassinger JA, et al. Why women are dying from unsafe abortion: narratives of Ghanaian abortion providers. *Afric J Reprod Health* 2013;17:118–28.

Purcell C, Maxwell K, Bloomer F, Rowlands S, Hoggart L. Toward normalising abortion: findings from a qualitative secondary analysis study. *Cult Health Sex* 2020;22:1349–64.

Ragins BR, Cotton CJ, Miller JS. Marginal mentoring: the effects of type of mentor, quality of relationship, and program design on work and career attitudes. *Acad Manag J* 2000;43:1177–94.

Rennison C, Woodhead EJ, Horan C, Lohr PA, Kavanagh J. Abortion education in UK medical schools: a survey of medical educators. BMJ Sex Reprod Health. 4 Apr 2022. https://doi.org/10.1136/bmjsrh-2021-201387.

Riley KE, Park CL, Wilson A, Sabo A, Antoni MH, Braun TD, et al. Improving physical and mental health in frontline mental health care providers: yoga-based stress management versus cognitive behavioral stress management. *J Workplace Behav Health* 2017;32:26–48.

Royal College of Obstetricians and Gynaecologists (RCOG). Making abortion safe [elearning.rcog.org.uk/catalog?pagename=Making-Abortion-Safe].

Schiavon R, Sanhueza P. Abortion training and integration of legal services in the public health system of Mexico City. In: Landy U, Darney P, Steinauer J, editors. *Advancing women's health through medical education: a systems approach in family planning and abortion.* Cambridge: Cambridge University Press; 2021. pp. 321–30.

Schön D. *The reflective practitioner.* New York: Basic Books; 1983.

Shahmoon-Shanok R. Introduction: what is reflective supervision? In: Heller SS, Gilkerson L, editors. *A practical guide to reflective supervision.* Washington, DC: Zero to Three Press; 2009. pp. 7–23.

Shellenberg KM, Hessini L, Levandowski BA. Developing a scale to measure stigmatizing attitudes and beliefs about women who have abortions: results from Ghana and Zambia. Women Health. 2014; 54 (7):599–616.

Siegel J, Yassi A, Rau A, Buxton JA, Wouters E, Engelbrecht MC, et al. Workplace interventions to reduce HIV and TB stigma among health care workers – where do we go from here? *Glob Public Health* 2015;10;995–1007.

Siu GP, Sivan A. Mentoring experiences of psychiatric nurses: from acquaintance to affirmation. *Nurs Educ Today* 2011;31:797–802.

Sommerville D, Keeling J. A practical approach to promote reflective practice within nursing. *Nurs Times* 2004;100:42–5.

Sorhaindo A, Rehnstrom Loi U. Interventions to reduce the stigma related to contraception and abortion: a scoping review. *BMJ Open* 2022;12:e063870.

Stamm BH. *The ProQOL manual.* Derwood, MD, USA: Sidran Press; 2005.

Taylor D, Upadhyay UD, Fjerstad M, Battistelli MF, Weitz TA, Paul ME. Standardizing the classification of abortion incidents: the Procedural Abortion Incident Reporting and Surveillance (PAIRS) framework. *Contraception* 2017;96:1–13.

Taylor S. Social support: A Review. In: Friedman M, ed. *The Handbook of Health Psychology.* New York: Oxford University Press; 2011:189–214.

Teffo ME, Rispel LC. *'I am all alone': factors influencing the provision of termination of pregnancy services in two South African provinces.* Global health action. 2017;10(1):1347369.

Teffo ME, Rispel LC. Resilience or detachment? Coping strategies among termination of pregnancy health care providers in two South African provinces. *Cult Health Sex* 2020;22:336–51.

Tomlin AM, Weatherston DJ, Pavkov T. Critical components of reflective supervision: responses from expert supervisors in the field. *Inf Ment Health J* 2014;35:70–80.

Turner KL, Chapman Page K. Abortion attitude transformation: a values clarification toolkit for global audiences. Chapel Hill, NC, USAA: Ipas; 2008 [www.ipas.org/resource/abortion-stigma-ends-here-a-toolkit-for-understanding-and-action/].

Turner KL, Pearson E, George A, Andersen KL. Values clarification workshops to improve abortion knowledge, attitudes and intentions: a pre-post assessment in 12 countries. *Reprod Health* 2018;15:40.

Van Kirk ML. Employee Wellness Pilot Program. *Workplace Health Saf* 2021;69:192–7.

Wallbank S, Woods G. A healthier health visiting workforce: findings from the restorative supervision programme. *Community Pract* 2012;85:20–3.

Waqas A, Akhtar A, Afzaal T, Meraj H, Naveed S. *Social support interventions for young healthcare professionals: In-sight analyses based on a mixed-methods systematic review and meta-analysis.* London: Wellcome; 2020.

Wellcome Trust. *Understanding what works for workplace mental health: putting science to work.* London: Wellcome Trust; 2020 [wellcome.org/reports/understanding-what-works-workplace-mental-health].

Wood A, Prins A, Bush NE, Hsia JF, Bourn LE, Earley MD, et al. Reduction of burnout in mental health care providers using the provider resilience mobile application. *Commun Ment Health J* 2017;53:425–59.

World Health Organization (WHO). *WHO recommendations for clinical mentoring to support scale-up of HIV care, antiretroviral therapy and prevention in resource-constrained settings.* Geneva: WHO; 2005.

World Health Organization (WHO). *Abortion care guideline.* Geneva: WHO; 2022.

World Health Organization (WHO). *Family planning and comprehensive abortion care toolkit for the primary health care workforce: volume 2.* Geneva: WHO; 2022 [www.who.int/publications/i/item/9789240063907].

Registered charity no. 213280

Royal College of Obstetricians & Gynaecologists