

ADDRESSING ABORTION STIGMA THROUGH SERVICE DELIVERY

A White Paper

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INTRODUCTION

The purpose of this paper is to provide a context and background for our work to address abortion stigma through service delivery. Abortion stigma is a major barrier to adequate reproductive health care for women and a primary challenge for service delivery providers to address. Stigma contributes to legal restrictions on abortion that are accompanied by criminal penalties directed at women and abortion providers. In addition to the legal barriers, stigma shames and silences women who seek abortion services, marginalizes abortion providers, and contributes to myths and misperceptions about abortion in communities.

Abortion stigma appears in many parts of the world, though it manifests differently according to law, culture, and religion. It is within these stigmatizing environments that organizations, communities, and individuals are engaged in innovative service-delivery programs to bring safe abortion services to women. Dedicated people, sometimes in incredibly difficult circumstances, conduct these programs. This paper aims to highlight what we currently know about how clinical and community-based interventions do or could address abortion stigma at various levels both directly and indirectly and how a select group of service delivery providers understand stigma in their work.

So what is abortion stigma? In this paper we draw on the following definition:

Abortion stigma can be defined as a shared understanding that abortion is morally wrong and/or socially unacceptable. The stigma of abortion manifests within multiple levels, including media, law and policy, institutions, communities, relationships, and individuals.

Abortion stigma is experienced through a) negative attitudes, affect, and behaviors related to abortion and b) inferior status experienced by women who seek abortions or who have abortions, abortion providers, and others involved in abortion care.

Abortion stigma leads to the social, medical, and legal marginalization of abortion care around the world and is a barrier to access to high quality, safe abortion care.

The first part of this paper discusses the definition of abortion stigma and reviews the existing literature around abortion stigma and interventions that address stigma. We also include social stigma literature from other fields such as HIV and mental health in order to develop a deeper understanding of measurement and programs that have contributed to reducing stigma. The second part of the paper presents the opinions, experiences, and programs of reproductive health care service-delivery organizations. The themes in this section emerged from key informant interviews with directors and staff of organizations that provide reproductive health care services in sub-Saharan Africa and Latin America.

The final section provides recommendations for increasing and expanding programs to address abortion stigma.

We envision this paper as a document that can and should change over time. We list a set of open-ended questions at the end of each section and ask that readers communicate with us and with one another to improve our collective knowledge on how to dismantle abortion stigma.

A METAPHOR TO GUIDE THIS PAPER

Social scientists often struggle to describe complex problems with multiple manifestations. Perhaps no story better summarizes this challenge than that of the Blind Men and the Elephant (The Blind Men and the Elephant). In the Jain version of the story, six blind men come upon an elephant, each from a different angle. Each man goes on to describe the elephant from his point of view. A man holding the tusk reports that the elephant is a spear. One grips the trunk and describes a tree. Another holds the ear and calls it a hand fan. And so on...

The purpose of the story is to convey that sometimes when we encounter a difficult problem, we are only able to see what is directly in front of us. In some versions of this story, the men begin to communicate with one another and in these discussions are able to fully understand the complex organism in front of them.

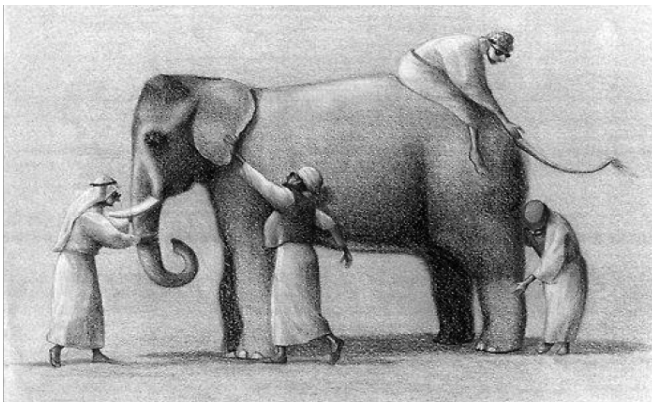


Figure 1: The Blind Men and the Elephant
(<http://eatsleepdraw.com/post/107356094>)

We share this story to advocate for the latter approach. Whether you encounter abortion stigma among women or their partners, service delivery providers, advocates, or social scientists, your perspective and wisdom contribute to the full picture. Hopefully, by communicating across our various experiences and positions we engage in addressing the full problem rather than a few of its parts.

METHODOLOGY

Part 1

ABORTION STIGMA LITERATURE

This paper benefits from our authors' ongoing research related to abortion stigma. During the writing of this paper, one of our authors was involved in a systematic review of abortion stigma in the published literature. The study followed an existing protocol for reviewing observational studies (Moher, Liberati, Tetzlaff, & Altman, 2009). Briefly, the authors searched databases such as GenderWatch, JStor, LexusNexus, Popline, PsychInfo, and PubMed for English-language articles including the following: "pregnancy termination", "abortion", "pregnancy Loss", "voluntary interruption of pregnancy", "menstrual regulation", "stigma", "discrimination", "prejudice", "stereotype", "taboo". The review included only articles that (1) were published after January 1, 1967 and before February 1, 2013 and (2) were published in a peer-reviewed journal. Once relevant articles were selected, the reviewers read the full text and extracted the objectives, methods, and main findings from each article.

LITERATURE ON STIGMA SCALES AND MEASUREMENT

To identify existing stigma measures, we used Google Scholar and PubMed to search for stigma measures. We used search terms such as "stigma," "stigma measure," "stigma scale," and "measuring stigma." The literature on measurement is vast, so we narrowed by first identifying systematic reviews of measures. This search yielded six articles reviewing 54 measures of stigma related to HIV/AIDS, obesity, intellectual disability and mental illness. Though we could not find a review of the literature related to measuring homophobia and sexual stigma, we conducted a search for papers and reviewed 19 articles.

Recognizing that not all stigma would be measured by scales, indexes, or surveys, we also sought articles that used systematic strategies for documenting structural forms of stigma such as in law, policy, and the media. We used search terms such as "structural stigma," "stigma and

media," "stigma and law", and "homophobia and media." These searches yielded five relevant articles.

We also drew on our relationships with colleagues who are studying abortion stigma around the world and we have included two newly developed abortion stigma measurement scales.

LITERATURE ON STIGMA INTERVENTIONS

To frame our initial search, we sought systematic reviews and meta-analyses of interventions to identify which strategies appear to consistently reduce stigma in a variety of settings across a variety of stigmas. To explore interventions designed to reduce stigma and prejudice, we used Google Scholar, PubMed, and the Cochrane Library to conduct a search for combinations of the following terms: "systematic reviews," "meta-analysis," "intervention," "stigma," and "prejudice." Our search produced 13 papers reviewing hundreds of interventions addressing stigma related to drug use, HIV/AIDS, mental illness, and sexual prejudice (stigma around minority sexual orientation).

We then expanded our search to identify peer-reviewed articles of interventions to reduce stigma around drug abuse and sex work and found five additional articles outlining specific interventions. The combined articles presented data about the following types of interventions: counseling, education, contact, protest, social marketing, and media.

Structural interventions were not reviewed in any of the articles we found, so we went back to the literature and searched for articles using the terms "structural," "stigma" and "intervention." Through this search we found seven additional articles for review.

Part 2

INTERVIEWS WITH SERVICE DELIVERY PROVIDERS

To document the experiences and programs of service delivery organizations as they relate to abortion stigma, we conducted 12 interviews with key informants from five

service-delivery organizations between February and August of 2013.

Organizations were invited to participate if their programs, or a portion of their programs, were committed to reproductive health care service delivery in sub-Saharan Africa and/or Latin America. Three of the institutions were international non-profit organizations with headquarters in the United States or United Kingdom. All of these organizations work with in-country affiliates or partners who provide reproductive health care services, including access to safe and legal abortion. Two additional organizations were nationally-based NGOs that provided services and support to women seeking abortion care in Latin America.

Interviews were conducted in two phases. First, at each organization, one senior staff member who had a leadership role in program implementation was invited to participate. If interested, a research team member explained the study and scheduled a telephone interview at a time that was convenient to the participant. The second-phase interviews were conducted with additional staff members that were recommended by the first-phase participants. These interviews included monitoring and evaluation staff or in-country directors and coordinators. In this paper, there are currently more perspectives from Latin America-focused programs due to logistics of interviewing, however we continue to interview key informants, from both regions to expand the breadth of knowledge from service-delivery organizations.

For all interviews, two research team members were present on the call, one to conduct the interview and one to take notes. The same semi-structured interview guide was used in all interviews in order to ensure similar topics were discussed. Open-ended questions asked participants to define abortion stigma and provide their organization's definition if one existed. They were asked to describe how their organization staff and target populations experienced and managed abortion stigma. Then participants identified programs that directly and indirectly impacted abortion stigma and any evaluation tools used to measure

the outcomes. Lastly, they were asked what improvements or additional programs they would implement if money was no object. The study protocol was approved by the Institutional Review Board of the University of California, San Francisco. All participants provided electronic written informed consent for their participation.

PART I: ABORTION STIGMA DEFINITION, LITERATURE AND MEASUREMENT

SECTION I. DEFINING STIGMA

The most influential figure in defining stigma is sociologist Erving Goffman who describes stigma as an “attribute that is deeply discrediting” and that “reduces an individual from a whole and usual person to a tainted, discounted one.” (Goffman, 1963, p. 3) Goffman presented three types of stigma that could affect individuals: blemishes of character, deformations of the body, and group identity (1963). Stigmas can vary from one another by several dimensions (Jones et al., 1984).

DIMENSIONS OF STIGMA

Visibility: The degree to which the stigma is readily apparent or known to others.

Course: The degree to which the stigma endures with time. Whether it is episodic or continuing.

Salience: The degree to which the stigma is a core part of a person’s identity.

Aesthetic: The degree to which the stigma marks personal appearance.

Peril: The degree to which the stigmatized person is seen as a threat to others.

Cause/Responsibility: Whether the stigma was acquired through birth, accident or personal decisions.

Adapted from Jones et. al, 1984

Another highly influential contribution to understanding stigma is Link and Phelan’s conceptualization of stigma as a social process. Their paper was developed to respond to the assertion that definitions of stigma are often “vaguely defined” and “individually focused.” The authors enhance Goffman’s original

definition by describing stigma as a social process in which individuals are (1) labeled as different, (2) stereotyped or associated with negative attributes, (3) conceived of as an “other” - a different and subordinate social group - and then (4) subjected to status loss and discrimination. Link and Phelan situate this social process within a context of social, economic, and political power which perpetuates stigma to maintain the status quo (Link & Phelan, 2001).

Closely related to stigma, there is a large body of literature focusing on prejudice. Gordon Allport, a psychologist and contemporary of Goffman, offered a rigorous conceptualization of prejudice in his book *The Nature of Human Prejudice* (Allport, 1954). Allport defines prejudice as “antipathy based on a faulty and inflexible generalization” (Allport, 1954, p.9). Historically, the stigma literature has focused more on the experience of the “marked” or stigmatized individual while the literature on prejudice has focused more on the attitudes of the non-stigmatized, or the people in the majority group. In more recent years these two distinct literatures appear to be converging under a more ecological and holistic understanding of stigma, which is concerned with both the stigmatized and the stigmatizer (Phelan, Link, & Dovidio, 2008). Contemporary social scientists will find that the literature on prejudice (including conceptualizations and reviews of measures and interventions) is highly related to that of stigma. We have drawn on some of this literature in our summaries below.

Though the literature on stigma and prejudice originates in the fields of sociology and psychology, the public health community is increasingly drawing on these frameworks. Stigma has been found to be a major barrier to health care and can often have negative consequences for the health and well-being of the stigmatized (Ellison, 2003; Major & Gramzow, 1999b). For this reason, many public health programs, service delivery organizations, and public health advocates are working to address stigma directly to yield better health outcomes for marginalized populations.

SECTION II: DEFINING ABORTION STIGMA

Women have been having abortions for thousands of years, and today it is one of most common and safe medical procedures (Finer & Zolna, 2011; Luker, 1984). Worldwide, over 40 million women have abortions every year (Sedgh, Henshaw, Singh, Ahman, & Shah, 2007). Despite the prevalence, abortion carries a social stigma that can affect anyone associated with it, including patients, their partners, providers, advocates, and researchers (Norris et al., 2011).

In 2009, Kumar, Hessini, and Mitchell offered a conceptualization of abortion stigma as “a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally,

as inferior to ideals of womanhood” (Kumar, Hessini, & Mitchell, 2009, p. 628) They specify that in having an abortion, women violate social norms: sex is solely for procreation, the inevitability of motherhood, and women as nurturers. The authors detail the varied levels of stigma, using the ecological health model (Bronfenbrenner, 1979):

mass media and communications, law and policy, institutions, communities, and individuals. These levels are summarized below.

Mass Media and Communications

Representations of abortion in mass media can shape public opinion. Often abortion is framed as a controversial and taboo topic. The controversy surrounding abortion and lack of media representation of abortion adds to a perception that abortion is an abnormal and rare experience for women. Mass media can also perpetuate stereotypes of who have abortions as selfish, irresponsible, immoral, young, and childless.

Law and Policy

In many parts of the world, abortion is regulated differently than other forms of health care. In some countries, criminal laws threaten to punish abortion providers or women having abortions. Global health care policies can also create

discriminatory practices such as the Mexico City Policy or Global Gag Rule which prevented global health care organizations receiving USAID funding from providing or talking about abortion services.

Institutions

Institutional stigma refers to sets of practices employed by institutions (often healthcare related) or by institutional actors (such as health care providers) that have the effect of marginalizing abortion or people who are involved in abortion care. This may lead to poor quality health care.

Communities

Community-level stigma describes the social norms, prejudicial attitudes, and negative behaviors toward abortion that exist in communities.

Individuals

Individual-level stigma refers to the experience of stigma by individuals.

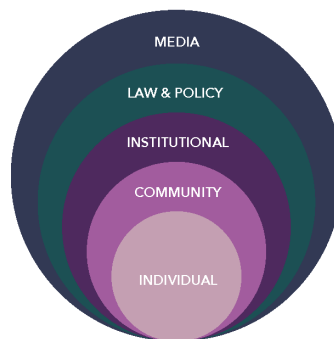
Individual-Level Abortion Stigma

Currently abortion stigma literature that specifically explores abortion stigma has mainly focused on the experiences of individuals who are marked by

abortion; namely women who have abortions and abortion providers. Individual-level stigma is usually conceptualized as having three main manifestations: internalized stigma, felt (or perceived) stigma, and enacted stigma (Herek, 2009). Internalized stigma comprises negative feeling toward oneself, such as shame and guilt, related to seeking an abortion or having had an abortion. Felt stigma describes perceptions of negative attitudes and concerns about stigmatizing behavior from others. Enacted stigma is actual discriminatory behaviors or negative interactions related to abortion experience.

In addition to these manifestations, the literature on individual stigma is concerned with stigma management. The behaviors that individuals use to manage stigma are related to how the stigma manifests and the dimensions of the stigma itself. For example, if the stigma is visible to others,

LEVELS OF ABORTION STIGMA



an individual must manage the stigma in every in-person interaction (Crocker, Major, & Steele, 1998). If the stigma is invisible to others, the stigmatized individual may want to keep others from finding out and therefore pass as “normal” in in-person interactions.



Figure 3: Four manifestations of individual level stigma, Cockrill and Nack, 2013

In their paper on the stigma of having an abortion, Cockrill and Nack explored the three manifestations of individual-level stigma and the stigma management behaviors that women employed to manage their sense of self, maintain their good reputation, or manage their reputation once it had been tarnished (Cockrill & Nack, 2013). Cockrill and Nack argued that while stigma management may help women to avoid negative enactments of stigma, certain behaviors such as secrecy and selective disclosure can paradoxically contribute to stigma by contributing to social silence and individual isolation (Cockrill & Nack, 2013). Major et al. found that individual-level stigma contributes to difficulty coping following an abortion (Major & Gramzow, 1999a).

Abortion-providing clinicians and pharmacists, individuals who work in abortion facilities, and abortion advocates can also be negatively affected by stigma (C. Joffe, 1995; Norris, et al., 2011; O'Donnell, Weitz, & Freedman, 2011). Abortion providers have been described as “dirty workers” in the social psychological literature because of the stigma attached to their work. Dirty work refers to professions that are stigmatized because of their association with physical dirtiness (grime, contamination),

social dirtiness (interaction with stigmatized individuals), or moral dirtiness (having to do with sin, duplicity or deception) (C. E. Joffe, 1986). Because of their dirty worker status, abortion providers typically experience felt and enacted stigma. Research on providers reveals that providers experience isolation from mainstream medicine, stress related to anticipating anti-abortion activity, fears about disclosing their work, and increased risk for burnout (Harris, Debbink, Martin, & Hassinger, 2011; O'Donnell, et al., 2011). Stigma management among abortion providers involves both internal and external strategies that are typical of dirty workers including reframing or transforming the meaning of the work, refocusing or stressing the elements of work that evoke pride, and seeking greater integration into the full spectrum reproductive health care (Harris, et al., 2011; O'Donnell, et al., 2011).

SECTION III. MEASURING STIGMA

A first step to understanding abortion stigma involves measurement. Measuring the stigma of abortion can help to provide a baseline understanding of how it manifests, its prevalence and how it differs across contexts. Stigma measurement is also vital to designing, implementing, and evaluating interventions.

Abortion stigma can be measured at multiple levels and can involve a variety of tools and methods. Most common are scales and indexes, which are administered to individuals. These tools can help us to understand individual experiences of stigma as well as attitudes and behaviors toward the stigmatized among community members and health care providers.

Social scientists have also employed systematic methodologies to explore stigma in laws and policies, using qualitative coding strategies to examine the production of stigma in public records (P. W. Corrigan, Watson, Heyrman, et al., 2005). Stigma can be measured in media and framing discourses by evaluating how media impacts the target audience's behavior, attitudes, and emotions and whether the messages penetrate into the culture of the target audience (P. W. Corrigan & Shapiro, 2010). The production

of stigma in media can also be measured through language analysis (P. W. Corrigan, Watson, Gracia, et al., 2005). There are no standard protocols for exactly how to measure stigma at different levels.

A. *Stigma Scale*

A measurement scale is a collection of items that are combined to form a total score, and intended to reveal theoretical variables that are “not readily observable by direct means”(DeVellis, 1991, p. 8). Most measures of stigma and prejudice are specific to certain stigmas (such as HIV/AIDS, obesity, sexual orientation). To develop a scale, researchers typically begin with qualitative data from interviews or focus groups to help them understand and conceptualize the latent variable they are trying to measure. The data is analyzed and the findings used to develop a conceptual model of stigma. From this model, researchers develop a set of items (questions with multiple choice answers) relating to the model. Scales generally begin with many items to capture the broadest range of attitudes and experiences. After collecting data on a sufficiently large sample, the researchers typically conduct a factor analysis to explore which items are the most reliable and valid for measuring stigma.

Individual-level stigma scales are usually designed to measure internalized, enacted, and felt stigma as well as stigma management behaviors of the stigmatized. Community-level stigma scales typically measure the attitudes, beliefs, and behaviors of the non-stigmatized. Similarly, institutional-level scales aim to measure the attitudes and behaviors of workers who come in contact with stigmatized individuals. Though not technically a stigma measure, social norms scales measure attitudes and behaviors, but also measure beliefs about what behaviors are approved (injunctive norms) and beliefs about what others actually do (descriptive norms).

Our review of the literature on stigma measurement of various stigmatized groups suggests that measures of the attitudes of community members or health care workers toward the stigmatized group are more

common than measures of individual-level stigma. For example, one review of HIV stigma measurement articles found that two-thirds measured the attitudes, beliefs, and behaviors of the uninfected and only one-third measured the stigma experienced by HIV-infected individuals (Earnshaw & Chaudoir, 2009).

Type of Scale	Concepts Measured	Examples of subscales
Individual Level Stigma	• Internalized stigma • Felt stigma • Enacted stigma • Stigma management	• Isolation • Disclosure concerns • Negative self-image • Concern about public attitudes • Shame • Self-blame • Neglect
Community Level Stigma	• Prejudice • Discrimination • Interpersonal distancing • Stereotypes • Behavioral intentions	• Blame and judgment • Social rejection • Sympathy • Fear of contagion • Willingness to socialize with • Perception of rights • Moral issues
Community Norms	• Injunctive norms • Descriptive norms • Behaviors • Attitudes	• What others do • What they think others do • What they do • What they think people should do
Institutional Stigma	• Discrimination • Prejudice • Stigma management	• Willingness to treat • Fear of contagion • Estimation of risk • Work disclosure

The perspectives of HIV-uninfected people have been studied for longer and in more geographic locations than the perspectives of the HIV-infected (Earnshaw & Chaudoir, 2009). Measures focusing on HIV-infected people’s perspectives have been developed in fewer geographical locations than measures for HIV-uninfected people’s perspectives. Our review of the measures exploring sexual stigma (the stigma of minority sexual orientation) suggests the research in this field is slightly more balanced. Of the nineteen scales we found, ten measured heterosexual attitudes towards gay and lesbian individuals, and nine scales measured internalized homophobia among gay and lesbian individuals. The early scales focused on the former, and scales developed in the last decade focus on measuring the latter (Bouton et al., 1987; Currie, Cunningham, & Findlay, 2004; Earnshaw & Chaudoir, 2009; Ernulf & Innala, 1987; Hansen, 1982; Hudson & Ricketts, 1980; Larsen, Reed, & Hoffman, 1980; Lingardi, Baiocco, & Nardelli, 2012; Mayfield,

2001; Price, 1982; Raja & Stokes, 1998; Ross & Rosser, 1996; Shidlo, 1994; Szymanski & Chung, 2001; Theodore et al., 2013; Van de Ven, Bornholt, & Bailey, 1996; Van de Ven et al., 1998; Wagner, Brondolo, & Rabkin, 1997; Wright Jr, Adams, & Bernat, 1999).

Measures of abortion stigma are a relatively recent phenomenon in the field of stigma measurement. Cockrill et al.'s ILASS scale is the first published scale to measure the stigma of having an abortion. The ILASS scale and "Stigmatizing Attitudes, Beliefs and Actions Scale" (SABAS) scales are described below.

- ***The Individual Level Abortion Stigma Scale (ILASS)***

To investigate how women experience abortion stigma, Cockrill et al. created the ILASS scale to measure individual-level abortion stigma in the US (Cockrill, Upadhyay, Turan, & Foster, 2013). They found that among women who have abortions, abortion stigma manifests as worries about judgment, isolation, self-judgment, and perceptions of community condemnation. Developing a valid and reliable scale allowed the research team to explore demographic differences in the experience of stigma. They found that Catholic and Protestant women experience higher levels of stigma than non-religious women, and that generally, women with stronger religious beliefs experienced higher levels of self-judgment and anticipated greater community condemnation related to their abortion than somewhat religious women. Cockrill and colleagues also found differences in experiences of abortion stigma across race, age, education, and motherhood status. The scale was tested in English and Spanish.

Cockrill, K. (2013). The Individual Level Abortion Stigma Scale. *ANSIRH*

- ***The Stigmatizing Attitudes, Beliefs and Actions Scale (SABAS):***

Shellenberg et al. have developed the SABAS to measure community-level stigma, based on study populations in Ghana and Zambia (Shellenberg & Hessini). This measure captures negative stereotypes about people associated with abortion, discrimination and exclusion of women who have had abortions, and fear of contagion as a result of coming

into contact with someone who has had an abortion. The researchers plan to use the scale to measure community attitudes in a variety of contexts and to evaluate community-level stigma interventions. This scale has not been tested outside of Ghana and Zambia.

Ipas. (2013). The Stigmatizing Attitudes, beliefs and Actions Scale.

B. Measuring Stigma in Media, Law and Policy

Measuring stigma in structures such as the media, law, and policy, requires a different set of methodologies than measuring stigma at the individual level or other levels. A summary of these methodologies and articles that use them are described below.

Probability sampling: In this case, every newspaper in the United States that met certain criteria (such as a certain circulation threshold) had the same random chance of its articles being included in the study.

Theory-based coding: Coding refers to a process in which data are categorized in order to enable analysis. In the Corrigan et al. article, they analyze legislation based on codes derived from a particular theory.

Qualitative content coding: There are several different approaches to this type of analysis. In the articles above, the authors reviewed relevant laws, created codes to reflect themes in the documents, coded the documents, and interpreted their data.

Focus groups: Corrigan et al. brought together groups of mental health advocates to have a facilitated discussion of the trends they saw regarding the treatment of mental illness in the media. They analyzed the transcripts from the group discussion in order to make sure the codes they developed were in line with what the mental health professionals observed.

Categorical analysis: This type of analysis involves separating data into clear categories to analyze each separate category as a group. Cook separated global abortion laws into three distinct categories for purposes of interpretation and analysis. She created these categories and defined their parameters.

Narrative analysis: This type of analysis uses text as the unit of analysis as a way to discern meaning. Abrams examined the text of United States Supreme Court cases to search for manifestations of abortion stigma.

Table 2: Measuring stigma in structures

	Article	Methodology	Results	Authors
Law & Policy	Newspaper stories as measures of structural stigma	Probability sampling and theory-based coding	Snapshot of negative attitudes towards people with mental illness portrayed in media that contribute to stigma and positive messages that may counter stigma	(P. W. Corrigan, Watson, Gracia, et al., 2005)
	The Discursive Production of Abortion Stigma in the Texas Ultrasound Viewing Law	Qualitative content coding	Law contributes to abortion stigma by rendering women as passive and abortion providers as predatory	(Weitz & Kimport, 2013)
	Structural stigma in state legislation	Qualitative content coding and focus groups	Legislation related to mental illness fit three categories related to stigma: laws that expand or take away liberties, laws that expand or decrease protection against discrimination, and laws that expand or take away privacy protections	P.W. Corrigan, Watson, Heyrman, et al., 2005
	Abortion laws and policies: challenges and opportunities	Categorical and narrative analysis	Three categories of criminalizing abortion laws: basic laws, developed laws, and advanced laws, that contribute to abortion stigma at different levels	Cook, 1989
	The Scarlet Letter: The Supreme Court and the Language of Abortion Stigma	Narrative analysis	Language of Supreme Court cases contributes to abortion stigma	Abrams, 2012

SECTION IV. INTERVENTIONS THAT ADDRESS STIGMA

We organized our findings from our literature review of stigma interventions using categories developed by Brown, Macintyre, and Trujillo (2003). First we present a set of interpersonal and intrapersonal interventions. These interventions are mostly aimed at improving the experiences of the stigmatized or addressing the negative attitudes and behaviors of the non-stigmatized. These interventions fall into four themes: counseling approaches, information-based education, skills-building education, and contact with affected groups.

We then present a set of interventions aimed at addressing the structural levels of stigma: institutions, laws and policies, and the media. There is no doubt that not all interventions will fit nicely into these categorical boxes. However, these categories help us to organize this paper so that we can explore the greatest amount of interventional approaches.

In our review of the literature related to abortion stigma we found that there was only one published study exploring an intervention. Yet, we know that publications will not present the full picture of interventions, practices, or programs. Throughout the review of interventions, we provide several abortion-related examples based on our knowledge of the field.

We recognize that many of these “stigma-reducing” interventions and practices are employed for other health-related goals. For example, health education is useful for improving all kinds of health behaviors. Counseling can meet mental health and emotional needs that are unrelated to abortion. We did not conduct an exhaustive review of each practice as it has been applied in the field of reproductive health. Instead we conducted a survey of practices that have been used to address abortion stigma.

A. Interpersonal and Intrapersonal Interventions

Counseling and Peer Support

Counseling programs can provide healthcare information, emotional support, and empowerment to people who experience stigma. For example, the research on internalized stigma and counseling appears promising. HIV/AIDS counseling programs have been shown to reduce anxiety around HIV testing (Brown, et al., 2003). Therapeutic models of counseling, such as Acceptance and Commitment Therapy, have been found to help internalized stigma, including shame and negative self-evaluations among substance abusers and gay men (Livingston, Milne, Fang, & Amari, 2012; Luoma, Kohlenberg, Hayes, Bunting, & Rye, 2008).

Many clinics will provide information and emotional support for women at the time of abortion. However, other points of counseling may occur in seeking an abortion through a

referral service or after an abortion. Post-abortion counseling and peer support services may include talk lines, facilitated support groups, peer support groups, or online communities (Baker, 2003; Foster, 2013). Since women have varying reactions to having an abortion, a one-size-fits-all solution may not work. Having an abortion has not been shown to be associated with negative mental health, but social stigma can be source of poor coping or emotional difficulty following an abortion (Kimport, 2012; Major et al., 2008; Major & Gramzow, 1999b). In a study of US women, Kimport et al. found that women calling post-abortion talklines for emotional support following an abortion describe three main reasons: conflict between head and heart over the abortion, relationship troubles, or stigma (Kimport, 2012). Additionally, women seeking post-abortion support may also present with intersecting struggles around domestic violence, sexual orientation, and mental illness (Madsen, 2013).

There have been no formal evaluations of therapeutic counseling practices for women having abortions and whether these practices reduce the negative effects of abortion stigma. However, Upadhyay et al. reviewed emotional care practices around other stigmatized issues and identified several best practices that might be supportive for women who are seeking abortions. They categorized the practices into four categories: establishing a supportive client-provider relationship, assisting with decision-making, offering supplemental sources of support, and directly addressing stigma (Upadhyay, Cockrill, & Freedman, 2010).

Peer support processes also hold promise for many individuals who experience stigma. A support group model for HIV-positive individuals led to increased disclosure among the group post intervention (Kaleeba et al., 1997). The literature on abortion stigma has only one study focusing on an anti-stigma intervention. In this pilot study, 22 women who had recently had abortions were enrolled in an intervention with the goal of introducing patients to a "culture of support" around abortion. Participants received "validating messages," information about after-abortion support, and information about how to avoid services and websites providing

misinformation about abortion. Women also received a brochure, watched a film about women's experiences with abortion, and had a conversation with a counselor about abortion stigma (Littman, Zarcadoolas, & Jacobs, 2009). Though the effects of the intervention on stigma were not directly assessed, at its conclusion the majority of the women agreed with the statement, "I feel strong enough to not let these people bother me" in reference to people who "make it difficult for women who have abortions" or people who "make women feel worse about their decision instead of offering support."

Peer support groups may also be a way for abortion providers to cope with stigma. To this end, a group of researchers designed the Provider Share workshop, a six-session workshop in which abortion clinic staff discuss their experiences with a particular focus on how stigma impacts their professional and personal lives (Harris, et al., 2011). In a pilot study in one abortion clinic, participants stated that the workshop fostered personal connections and served as a stigma management tool; after evaluation, the researchers concluded that the workshop may alleviate some of the burden of abortion stigma (Harris, et al., 2011).

For some individuals who experience stigma, in-person counseling or support groups may not be a possible outlet for sharing experience or finding community. This is especially true when the stigmatized identity is concealable or when the people experiencing the stigma are geographically remote. In these cases, less frequent opportunities for meeting in private "safe spaces" such as professional meetings or ongoing online interaction through listservs or online communities may provide peer support opportunities where members can experience shared understanding and community. These environments can reduce the need (at least for a short period of time) to manage disclosure, increase resilience and may even prompt additional disclosures outside of the supported group space (Harris, et al., 2011; Kaleeba, et al., 1997; McKenna, Green, & Smith, 2001)

Contact

The contact hypothesis, first described by Gordon Allport, suggests that in-person

interactions between majority and minority individuals can lead to reductions in prejudice between the groups (Allport, 1954). Allport used the word “majority” to refer to the non-stigmatized group (for example, women who have not had abortions) and “minority” to refer to the stigmatized group (such as women who have had abortions). There are many models for creating an experience of personal contact including live testimonials, workshops, and speaker’s bureaus.

When a stigma is concealable, disclosure might be necessary to create knowledge about the divergent statuses or identities. Disclosures such as these are often called “coming out” based on the use of that terminology in the LGBT community. Opportunities for disclosure may happen within families, medical interactions, friendships, and social groups. Extended forms of contact do not happen in person but might involve fictional and nonfictional media or visualizations. Whether in person or extended, contact is usually employed to increase knowledge about the experience of stigma and comfort with a stigmatized individual, and to reduce social distancing.

Extensive research on the contact hypothesis has been conducted related to mental illness, minority sexual orientation, race, and HIV/AIDS. A meta-analysis reviewed 515 studies testing contact and found that contact consistently leads to reductions in prejudicial attitudes toward a variety of stigmatized experiences; the greatest reductions in prejudice in interactions between gay and lesbian individuals and heterosexuals (Pettigrew & Tropp, 2006).

The reviewers found that across studies, reductions in prejudice through contact were generalizable outside of the intervention group and also appear to sustain over time. Consideration of the complexity of relationships among group members, including power dynamics and potential for cooperation, seems to improve outcomes (Pettigrew & Tropp, 2006).

The disclosure of abortion experience through “coming out” or story-telling has been cited as a potentially potent tool for reducing stigma. A recent intervention developed by Cockrill explored how women’s book clubs

could provide opportunities for disclosure of abortion experience and reductions of negative attitudes. Thirteen all-female book clubs were recruited to discuss a book featuring 22 true stories of pregnancy, including several about abortion. Using confidential surveys and group observation, the researchers found that 15 out of 19 women who had previously had abortions shared these experiences with their book club members. Measures of attitudes before and after the book club discussion showed that attitudes toward abortion improved after the book clubs and remained improved four months later (Cockrill, 2013). The greatest improvements in attitudes toward abortion were found among women with the lowest attitude scores (most negative attitudes) pre-intervention (Cockrill, 2013).

Education (Information and Skills-Building)

Providing information about the stigmatized group and their concerns and experiences is likely a part of most strategies for stigma reduction. This has been done in many ways, including through educational programs, modules, trainings, videos, conversation guides, and sharing these with specific target groups to achieve specific goals. Sometimes these sessions involve some skills-building exercises (see below), but often they are intended to reduce myths and address stereotypes while increasing empathy and tolerance.

Educational interventions with the goal of reducing stigma have met with very mixed results (Brown, et al., 2003). Increased knowledge is often found post-intervention but lasting improvements in attitudes are rare (Brown, et al., 2003; P. W. Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012). For example, Corrigan found that mental health literacy improved knowledge, desire, and confidence to help among adult target groups but did not drastically improve attitudes (P. W. Corrigan, et al., 2012). Across different types of stigmas, information-only methods show lower overall effect than education with a skills-building component and contact (P. W. Corrigan, et al., 2012). A few important notes about information interventions: the research around mental illness and racism suggests that informational

interventions may be more effective with youth than with adults and that these interventions are more likely to be effective at reducing negative attitudes when combined with in-person or extended contact (P. W. Corrigan, et al., 2012).

Health and social service workers are often selected for educational rather than contact interventions because their ongoing contact with stigmatized groups can be a contributing factor to negative attitudes. Workers often benefit from educational interventions which provide strategies for combating negative behaviors, as well as explicit and implicit biases. Participants acquire coping mechanisms for their own stress such as role playing, scenarios, guided meditations, and script following (Brown, et al., 2003). If contact is involved in this type of an intervention, it is important that the individual who bears the stigma (and is sharing their story) is a credible speaker from the perspective workshop participants. For example, a psychotherapist who has previously used mental health services might be able to talk with other therapists about what is like to be on the 'other side' of the stigma. Like informational interventions, skills building can take many forms: multi-day workshops, free tool kits, web-based learning tools, and DVDs. (Brown, et al., 2003) Education with a skills-building approach can reduce negative attitudes and increase willingness to treat. However, Brown et al. found that in several of their studies, the interventions did not reduce a fear of HIV infection (Brown, et al., 2003).

B. Structural-Level Interventions

Social Marketing

Social marketing is a strategy that uses marketing techniques, often coupled with other techniques, such as education or contact, in order to achieve behavioral and/or health-related goals at a mass level. Corrigan defines the components of social marketing as "problem identification, description of target audiences, development of the change technology, and process and outcome evaluation" (P. Corrigan & Gelb, 2006). It may be difficult to measure the impact of mass social marketing stigma reduction campaigns because of their large target population (P. W. Corrigan, et al., 2012).

Puntos de Encuentro, a feminist organization in Nicaragua, uses a comprehensive media strategy to promote gender equality, specifically awareness around domestic violence (Encuentro, 2013). Though this campaign had many goals including stigma reduction, this project shows how social norms and attitudes can change through media. Using soap operas, music videos, and video games, Puntos de Encuentro spread their messages on a broad scale to their target audience. They have their own TV series, radio program, and magazine. Puntos de Encuentro conducted an evaluation of their project's impact on a representative group of young people, specifically focusing on stigma reduction, gender equity, living without discrimination and violence, and HIV prevention (Solórzano et al., 2008). Their evaluation found that their multi-level media strategy encouraged change on both the individual and collective levels and that the project had a large-scale impact on national HIV-prevention efforts (Solórzano, et al., 2008).

In another campaign, the US-based National Latina Institute for Reproductive Health (NLIRH) launched a campaign called Yo Te Apoyo or I Support You, to lift up the voices of people who support the women who have abortions in their communities (National Latina Institute for Reproductive Health, 2013). After performing messaging research related to the Latino community's attitudes on abortion, NLIRH found that the majority of respondents said they would support a friend or family member through an abortion. Drawing on these exciting results, NLIRH launched this campaign to shift the conversation away from the morality of abortion and instead focus on supporting women who have abortions.

Evaluation of social marketing campaigns involves assessing two main components: the campaign's impact on the target audience's behavior, attitudes, and emotions and whether the campaign's messages penetrated into the culture of the target audience (P. W. Corrigan & Shapiro, 2010). Examining impact and penetration on a mass population level may be difficult; Corrigan states that it "requires cognitive assessment of recall or recognition measures about which the participant is aware" (P. W. Corrigan & Shapiro, 2010). Other social

marketing campaigns directed at stigma reduction have measured knowledge, attitudes, and intended behavior using validated and reliable scales on a sample of the campaign target population. These evaluations have found that social marketing campaigns may have more success in influencing knowledge about stigmatized groups than attitudes and behaviors (Evans-Lacko, London, Little, Henderson, & Thornicroft, 2010).

Protest

Protest is generally defined as an action that publicly calls attention to stigmatizing attitudes and/or behaviors that promote these attitudes (P. W. Corrigan et al., 2001). For groups that are isolated because of stigma, such as women who have abortions, abortion providers, and advocates, protest may be a way of addressing both internalized stigma and felt stigma. It may also reduce the need for stigma management (or it could be seen as a form of positive stigma management). By providing temporary experiences of power, pride, visibility, and safety in numbers for individuals who ordinarily experience the powerlessness, shaming, invisibility, and vulnerability of stigma, protest can bring necessary positive energy to exhausted movements.

In-person protests have been a vital part of many social movements aimed at reducing stigma and prejudice. In June 1969 police raided a bar that catered to gay and transsexual clients in New York. In response, groups of gay and transsexual people rioted in the streets in what are now called the Stonewall riots. Advocates who were intent on not losing the momentum of this protest against the police formed a committee and designed the first Pride parade to show support for gay people. The organizers called for the parade to be an annual event that could happen in communities across the country. Today the Pride parade is a worldwide event and is a potent symbol of resisting stigma.

Not all protests happen in the streets. One example of an online protest is one that has been started by immigrant activists, and is supported by Colorlines a blog of the Applied Research Center. The campaign applies pressure to mainstream news publications

to drop the word “illegal” as a descriptor for undocumented immigrants (Applied Resource Center, 2013). Several mainstream publications, including the San Francisco Chronicle and the LA Times, responded to this campaign and changed the language they use to describe undocumented immigrants.

Whether in-person or online, protest focuses on injustices in community norms, business practices, laws, and policies or even media representations. Though this is not always the case, some protest strategies employ a shaming and chastising tone toward those who hold negative attitudes or structural power. Corrigan et al. raise the concern that protest can have unintended rebound effects, worsening prejudicial attitudes in the target group (P. W. Corrigan, et al., 2012). When selecting protest as a method for challenging injustice and power structures, groups may want to consider where attitude transformation falls in their theory of change. There are very few rigorous evaluations of the impact of protest strategies on reducing stigmatizing attitudes and beliefs.

From Self-Help to Social Reform

The phrase “nothing about us, without us,” appeared in the title of one of the documents we reviewed and has been cited as a principle by stigma scholars (P. W. Corrigan, 2004). Several articles in this review of HIV/AIDS stigma interventions underscored the importance of involving consumer groups or affected groups in the process of stigma reduction (Ti, Tzemis, & Buxton, 2012). This was often associated with structural or policy-level change. Mahajan summarizes the need this way:

Thus, interventions based on community organizing and building among [people living with HIV/AIDS] PLHA as well as potentially sympathetic social and community entities, that aim to ‘unleash the power of resistance on the part of the stigmatized,’ are important avenues for the root causes of H/A stigma and discrimination. (Mahajan et al., 2008)

Well-supported and organized self-help programs have the potential to grow to address structural issues. For example, STEP is a program in Nepal which organized a stigmatized group

of individuals to become agents in their own social change (Cross & Choudhary, 2005). The program began in 2002, when 10 people affected by leprosy were appointed to act as facilitators to develop self-care groups in their villages. Each facilitator was trained in self-care and asked to recruit people from their villages to initiate self-care groups. During the first year, self-care groups developed and became cohesive. By 2003 the groups adopted economic self-help practices through credit unions and micro enterprise. Within a few years, the groups developed beyond self-help and began to identify a community-level agenda, with some groups eventually evolving into independent NGOs and a national collective.

While the involvement of the stigmatized in reform may be ideal, stigma itself can be a barrier to participation in social change efforts. Ti et al. conducted a review of literature examining barriers to the engagement of people who use drugs in policy and program development (Ti, et al., 2012). Stigma manifested in negative attitudes of policy and program staff toward potential advocates and internalized stigma on the part of potential advocates. Lack of funding for consumer-led processes was another barrier preventing newly-formed groups from having lasting power. Despite these barriers, the authors point out that the involvement of people who use drugs in drug policy and program development has led to key advances in the field (Mahajan, et al., 2008; Ti, et al., 2012).

C. Limitations and Considerations across Studies

There are several limitations to our review of the literature on stigma interventions. Several studies noted that stigma is a clear contributor to health care disparities, poor health outcomes, a lack of well-being, and social and political stagnation. Yet, little of the research on interventions is of a high quality. A primary issue is related to measurement; there is a lack of valid and reliable measures for stigma and researchers do not use the same measures across stigmas or across interventions, making comparisons of the data challenging (Sengupta, Banks, Jonas, Miles, & Smith, 2011). Few studies on stigma interventions randomize participants or even use control groups (Sengupta, et al., 2011).

Some even fail to articulate the perceived benefits of intervention (Chattopadhyay, Sengupta, Chattopadhyay, Zaidi, & Showail, 1983). Finally, there are few interventions which measure long-term effects (Sengupta, et al., 2011). Smartly, many of the interventions adopted more than one intervention strategy in their program, combining information, skills-building, counseling, and testimonials, for example (Sengupta, et al., 2011). The increased performance of these programs may suggest a cumulative effect related to using multiple intervention strategies, but also makes it difficult to determine which aspects of the program were effective in reducing stigma (Brown, et al., 2003; Monjok, Smesny, & Essien, 2009).¹

PART II. INTERVIEWS WITH SERVICE-DELIVERY ORGANIZATIONS

In this next section of our paper, we outline findings from our interviews with staff at five service-delivery organizations that serve women in sub-Saharan Africa and Latin America. The goal of our interviews was to document areas of their work such as abortion provider training, community outreach, and advocacy programs which may directly and indirectly affect the stigma experienced by women, providers, institutions, and the general public.

SECTION I. DEFINING ABORTION STIGMA

I think that silence is the seedbed, or the fertile ground, for stigma...People, women especially, aren't supported to talk about what is really going on. So, in my view, that is the stigma, all the negative charge, the negative values that have been attributed to abortion.

In our interviews, we asked each participant to define abortion stigma. We reviewed their answers and looked for themes across responses and also sought unique perspectives on what stigma encompasses. Most participants identified two main manifestations of abortion

¹Advances include: "policies around supportive housing and supportive assistance, decriminalizing drug use, informing appropriate drug paraphernalia needed for safer drug use, increasing access to naloxone, informing best practices for harm reduction and addiction treatment and health promotion initiatives such as effective messaging for over dose prevention and response as well as relevant educational materials."

stigma: 1) personal and cultural silence around abortion and 2) discrimination and negative connotations of abortion. Participants also described how abortion stigma serves as a barrier to receiving “good abortion care.”

Participants identified silence as an element of abortion stigma that works in multiple ways. First, silence functions on an individual level, meaning, “not disclosing, sometimes, if you work on abortion or if you’ve had an abortion.” Stigma also affects abortion providers on an individual level, because “it causes providers to be invisible because they cannot promote their services.” Second, silence functions on a structural level, where abortion is “taboo” and thus “women have less access to information and feel less secure to ask for support.”

Participants described how abortion stigma is embodied in discrimination against anyone who is involved in abortion care, including providers, patients, and administrative staff. Discrimination takes many forms, including harassing abortion providers, shaming women who have abortions, or withholding public funding or support from organizations that perform abortions.

[Abortion stigma] is discrimination and discrimination of anyone that is involved in an abortion process from any side -- negative feelings, negative attitudes, negative reactions to anything that has to do with abortion.

The most detailed explanations of abortion stigma addressed the negative connotation of abortion held by the public and perpetuated by the media and political figures. This aspect of stigma, a sort of ubiquitous negative association, was something that participants found hard to put into words. One participant shared that, “stigma is so woven into everyday life so that it’s almost invisible.” Another example was a participant explaining the roots of abortion stigma: “we’re still indoctrinated growing up with, you know, the social norm that abortion is bad or wrong.” Some participants saw abortion stigma as a universal understanding that abortion is immoral, which stems from both religious groups and secular culture.

Though there was a lot of agreement between interviewees about what constitutes abortion stigma, no organization had a specific, organizationally-operationalized definition of abortion stigma.

B. Stigma as experienced by providers and patients

We asked participants to describe how providers and patients experience abortion stigma in their communities. They discussed several manifestations of stigma, including explicit or overt community condemnation of abortion, abortion provision as an isolating profession, and providers and patients fearing judgment and legal ramifications for providing or having abortions. Participants also described a mainstream media that perpetuates abortion stigma.

We sought to learn more about how the experience of stigma differs for providers and patients. Participants explained that providers are weary of community condemnation of abortion, expressing worries about what their community members might think of them if their provision of abortion services was public knowledge.

I think that there are concerns among all levels of staff. What that means for them personally -- you know, if everyone, their neighbors and family know that the institution they work for has somehow openly worked on the issue of abortion.

We asked participants to reflect on how stigma might be connected to the legal status of abortion in the countries in which they work. Participants explained that providers also fear the legal ramifications of providing abortion services, especially in countries where abortion is criminalized. Several participants described how providers specifically fear jail time and police raiding their clinic.

So even where we haven’t been jailed necessarily, the risk means we constantly have to be assessing what we can do and what we can’t do. And what level of risk is acceptable at any given point in time.

Participants also talked about abortion provision as an experience of isolation in which providers

“feel like they can’t talk to almost anybody about their work or the feelings of stigma or stress that come along with it because it is such a stigmatized and often legally restricted subject.” We asked participants to expand on how patients might experience abortion stigma. They described that patients experienced community condemnation, particularly from churches and schools, where they are taught from a young age that abortion is murder.

Most adult women, in church, every week... the priest say[s] horrible things about abortion, that it is murder, it is killing children.

Participants also talked about how patients experience abortion as a socially isolating event, in which they “didn’t want anyone to find out” about the abortion because “they believed they were doing something wrong” and feared judgment from their families and friends.

Similarly to providers, participants described how patients also fear legal ramifications, particularly in countries where abortion is illegal, thus making asking for an abortion an even more difficult and potentially stigmatizing task.

I think their biggest fear, usually is opening up their mouth and asking for help from the provider while knowing full well what they’re asking for help for is illegal.

Although it wasn’t expressed by all participants, one participant indicated that many patients fear that having an abortion may have a negative impact on their health based on the misinformation they’ve heard about the safety of abortion.

What most worries them is their health, on account of what they have been told about abortion through medications or what they have read in the Internet or rumors that say you’re going to bleed terribly.

C. Stigma in media

We asked participants to reflect on how mainstream media may or may not contribute to the stigmatization of abortion in the countries in which they work. Participants talked about national broadcasts of the anti-abortion

propaganda film “The Silent Scream,” and how this film perpetuates misinformation about abortion that impacts people across the country.

A famous video is still shown in Mexico...“El Grito Silencioso” [“The Silent Scream”] and anti-rights groups...have promoted it so much that young women think of abortion as the butchering of babies. So, most people have that image and think that abortion is the same as murder.

Participants also described a fear of surveillance and exposure by anti-abortion media. One participant described how a journalist posing as a patient specifically targeted one of their clinics:

We’ve been infiltrated a number of times. You know, where people pose as clients but then they’re really journalists and then they write about it....Some people had been jailed from our staff because a client had actually been a journalist.

They also discussed that the media promotes the idea that some women deserve access to abortion, while others do not.

The cases they want [to] involve, like, a one-legged, indigenous woman who came crawling on her knees. It’s very sad to see that those are the cases in which abortion is okay, when a woman desperately needs one. But not because a woman simply decided that she didn’t want to have a baby at that moment.

D. Managing abortion stigma

We investigated how participants and their colleagues manage the stigma of abortion. One participant explained that reframing abortion was one organizational-level strategy to deal with stigma.

I think this idea of taking it out of the religious debate and moral debate, and the presentation of abortion, particularly unsafe abortion in these countries, as an issue of public health and human rights helps people feel more comfortable.

Another organizational-level strategy was to encourage providers to engage in self-care activities, such as stress-relief exercises and risk-management assessments. Two participants mentioned that their groups don’t have any

organizational strategies for helping their staff manage abortion stigma.

Quite honestly, I don't think we're good at distinctly addressing dealing with stigma on an organizational level. I think individuals have found their own ways to deal with it in their own comfort zone...in terms of dealing with stigma; we really don't have organizational guidance around that.

Participants explained that both providers and patients communicate with sympathetic and like-minded people about their work and experiences in order to cope with stigma.

Talking about it with co-workers is really common because they feel like they can't talk to anyone else about it, even within their own households.

A major stigma management strategy that participants described was how providers manage information related to abortion and manage their identity as it relates to abortion. Providers are “very cautious about how they share information, especially in-country,” which can mean that they do not share that they work for a specific reproductive health organization, but use vague terminology such as “women’s health” to describe their work. Providers disclose their work selectively in their personal lives, judging whether to be honest about their affiliation with an organization based on a person’s political opinion about abortion.

They don't talk about the work they do in their professional organizations, or if they teach in a university -- you know, that's sort of kept very hidden... I think they probably talk in general terms about maybe sexual and reproductive health or family planning, and they don't say that they do anything related to unwanted pregnancy or abortion.

For some organizations, catering to the rules and values of some donors means a strict separation of funds between abortion work and other work.

We don't know whether to say if the event is going to be for abortions. You don't know if they are going to give you the donation, you don't know what kind of face they'll make. In training events where everyone else works on totally different issues, sometimes we say we work in

human rights, or in access to women's health services, but not necessarily abortion.

Similarly, silence about their experience with abortion was a tactic used by women who seek abortion services. Participants described how silence is present at every level of the abortion experience: patients are “too ashamed or afraid to ask for services” and “can’t openly talk about abortion” because it’s a “sin.” Participants also emphasized that silence makes it difficult for patients “to make the decision [to have an abortion] when no one’s willing to discuss [it].”

We were also interested in how participants help their patients manage the stigma of abortion. They noted that explaining the abortion procedure itself to patients was one way to address stigmatizing attitudes and beliefs about abortion, and helped patients dismantle the myths they held about abortion.

[We had] the opportunity to explain to them what abortion is, and isn't; the medical procedures; how medical science has progressed; about abortion through medication, curettage; to explain that it isn't a person yet.... we could see how those myths disappeared in women.

Other stigma-management strategies mentioned by some participants included providers distancing themselves from abortion and leaving an organization that provides abortion, and creating organizational protocols to deal with anti-abortion harassment.

SECTION II. CURRENT INTERVENTIONS, OUTCOMES, AND EVALUATION

Throughout the interviews, participants described their organization’s projects and programs that addressed abortion-related stigma. They were asked to describe programs that dealt with stigma both directly and indirectly. In this section, we present the types of ongoing interventions that address stigma and the observed or desired outcomes and impacts associated with the interventions.

A few participants discussed programs that were developed explicitly around stigma; in these cases the organization recognized and

defined the stigma of their target group and implemented an intervention with the direct objective of decreasing stigma. However, the majority of participants identified activities and projects, or portions of projects, which they felt did address stigma, regardless of whether it was specifically acknowledged in the objectives. There were very few evaluations reported to measure abortion stigma-related outcomes. The vast majority of organizations were using tools to evaluate their work, but the instruments were not specifically attentive to levels of stigma.

Overall, there were six types of abortion-stigma interventions discussed in the interviews: training and workshops, coalitions, service provision, accompaniment, dialogue, and education.

Training & Workshops

Interventions

- *Values Clarification workshops*
- *General abortion information training*
- *Service provision training*
- *Provider champion training*

Trainings and workshops were one of the most common types of interventions addressing abortion-related stigma among participants. The majority of trainings were targeted at service providers and tended to focus on one of three topics: values clarification, service provision, or general abortion information. Values clarification and sensitization workshops provided a venue for providers to discuss personal beliefs and perceptions about abortion provision and women seeking abortion.

You need to create space for people to be able to start to explore their feelings, especially on religious belief around the issue, because it's still a taboo. The word [abortion is] never mentioned, you know, within member associations, many were long-time recipients of USAID funding; they're a member of the gag rule.

One participant highlighted that values clarification workshops (sometimes referred to as attitude transformation sessions) were intended to move staff, providers, and/or organizations along the “abortion continuum.” According to their organization, the abortion provision continuum describes clinic service provision that

starts offering post-abortion care, transitions to offer information and counseling on unsafe abortion for women who present with unwanted pregnancy, and continues on to provide safe legal abortion.

Service provision trainings provided clinicians with skills in preparation for direct work with clients. When country abortion laws provided an exception such as health or rape, providers were trained to provide abortion services. In countries where the laws were highly restrictive, trainings tended to focus on harm-reduction counseling. The harm-reduction model, which originated in Uruguay, aims to provide information to women who induce abortions on their own, including the risks of unsafe abortion, ways to decrease negative health effects, accurate use of misoprostol, and access to post-abortion care. Participants explained that the main goal of service provision trainings was to ensure that providers are able to offer abortion services.

As an additional resource for new abortion providers, one organization recently started to train providers to be what they called “Provider Champions”. These were providers “who had been particularly comfortable or sensitive around [abortion] issues” and were interested in mentoring new abortion providers for six months to one year. Training for Provider Champions was specifically developed to address provider stigma.

Trainings that focused on general abortion information were facilitated differently depending on the target audience and country context. In one Latin American country, clinicians, psychologists, and lawyers who were not directly involved in abortion service provision participated in trainings that focused on abortion facts, myths, and stigma. The training aimed to create support for women seeking abortions by building a network of allied professionals who may interact in their work with women who have unwanted pregnancies or are seeking abortion services. In reflecting on these trainings, one participant felt that “the scientific information is what makes the stigma disappear for people.”

While most trainings and workshops were facilitated among service providers, participants also discussed the importance of

training other key stakeholders at the clinics, including members of the Board of Directors, administrative executives, and other staff. One participant explained why values clarification with executive directors and administrators is an essential step in building safe abortion into their organization's mission and increasing abortion services at the clinics:

A first intervention was creating trainings and workshops on values clarification and sensitization around the issue of abortion. And I think it's worth it to point out that this was really focused at some point - not at the provider level, but more at the board of directors, for example, level, and the executive directors...to have institutional buy-in. You can't go to a clinician level if they don't feel like they're getting a clear message from management about saying, "This is where we're going. This is why we're doing it. This is why it's important. This is why it's in line with our institutional method."

No formal evaluations have been carried out to assess how trainings and workshop can impact the stigma associated with abortion among participants. One organization mentioned using KAP (Knowledge, Attitudes, and Practices) surveys to obtain baseline attitudes towards abortion to help develop trainings. A few participants expressed interest in implementing pre- and post-questionnaires to assess knowledge and attitude change in their values clarification workshops.

Coalitions & Networks

Interventions

- **Provider support networks**
- **Legal or policy coalitions**

Many participants agreed that coalitions and networks play a crucial role in reducing stigma by connecting abortion providers and advocates to one another. There were common characteristics across the coalitions discussed in the interviews. Coalitions consistently provided a safe space and moral support for those working in abortion provision or abortion advocacy. Sometimes, participants reported, people working in the field were so isolated that they did not know anyone like them existed. One participant, who organized a "pro-choice"

coalition in Central America, illustrated the power of bringing people together from diverse communities who share a common belief. Earlier in the interview, she was careful to note that she uses the words "pro-choice" and "anti-choice" to describe the situation, but those were not the exact words that members of the coalition used to describe themselves.

In almost every [individual] meeting, someone would take me aside and say, "This is an anti-choice country. But, I'm not." And, I have that conversation like 50 times. And, so what I decided to do was put those people in a room together and they didn't necessarily know each other, because, these are people from the legal community or the academic community or the media or whatever. So, I put them all together in a room and said, "Each one of you told me secretly you were prochoice. You are all prochoice. What does that say to you?"

In addition to support and recognition of shared goals, the coalitions provided a venue to share skills, develop strategies, train advocates, and gain exposure to similar global networks. One participant described the role of her organization in coordinating a support network for abortion providers and the change they have observed among members:

Our work is to broaden their skills, give them new skills, expose them to the larger sexual and reproductive rights movement globally. There are providers that we have worked with for many years who used to not even say a word out loud and now literally stand up in these international conferences and say -- as long as they're outside their own countries and say, 'I provide abortions'.

Building confidence and interest in speaking publicly did not happen quickly within this provider support network. The participant describes the transition she has witnessed as providers begin to see themselves as agents of change.

It was challenging for the first five or six years. I could not get this network to talk about advocacy or even talk about how they even had any role in advocacy because, by and large, they want to be the silent, quiet providers who just save women's lives day in and day out and the advocacy was someone else's job. That has radically changed. They all see themselves as agents in the advocacy movements in their

countries even though their role may not be like the one T.V. spokesperson. And, then we bring new people in.

Multiple participants also discussed their involvement as members of existing coalitions. Sometimes they had a leadership role and other times they worked as “a sort of silent but engaged partner to try and de-stigmatize at a higher level.” One participant in Mexico explained how being part of a policy coalition and working with organizations in other states was a priority for her organization. The goal was to improve policies that expand access to abortion services and thereby decrease stigma.

We are interested in changes in the states but we know we can only do this through alliances with organizations in the states, which can be difficult. It's complex because from here, we're more interested in creating tools that can be useful for them. We don't want to be an organization that intervenes in the states from the capital. We think that is the work of the states; it is their territory, their state.

Service Provision

Interventions

- **Increase access to misoprostol**
- **Increase access to safe legal abortion**
- **Provide economic support for women seeking abortion**

All of the participants identified aspects of their service delivery that were addressing abortion-related stigma. The majority spoke about increasing access to safe, legal abortion care with the goal of normalizing abortion. One participant explains, “the more services that are available and provided, the more people that access them, the more normal it becomes. So we've kind of taken this normalization approach.”

Increasing safe abortion care included expanding harm-reduction services, providing telephone support for women who are self-inducing, and increasing the number of community health workers in the community to disseminate information about safe abortion. A few participants described a “revolving fund” for women. One organization that dispensed misoprostol to women was

able to expand their services because women who received misoprostol donated pills for other women. Another organization that provided economic support for women had a high number of women who received their services contribute to the fund immediately after obtaining their abortion.

The work we do is to provide economic support, so one thing that we seek to do is get away from the idea of charity. We are a group; we don't support individuals. The support shouldn't be personalize[d], rather, it should be understood that we are a team of people that is supported by another team of people. The idea is also that we are a revolving fund. We want women to make a commitment of some kind to increase abortion access for other women. We're interested in diffusion. We want the women to contribute so that other woman can have access to [the] support. In this sense, they are supporting the decisions of other women.

Organizations that were increasing safe, legal abortion discussed providing technical skills training for more providers, vouchers to women to get safe abortion, and economic support for women to travel for care.

Organizations conducted evaluation of service provision by collecting data from clinics and providers such as number of abortion performed or number of abortion providers trained. One organization conducted a brief evaluation by phone or email both with misoprostol users and women who received economic support to obtain an in-clinic abortion. The evaluation assessed pregnancy outcome and women's experiences. Only one organization explicitly discussed measuring the impact of service delivery on abortion-related stigma. They were in the process of conducting evaluations in three countries. Data collection included a pre- and post-questionnaire with abortion providers and women seeking abortion, as well as qualitative interviews to better understand the experience of abortion providers.

Accompaniment

Interventions

- **Accompaniment**

There was one organization in particular that described their program as providing “accompaniment” to women seeking to terminate their pregnancy. Accompaniment is defined as assistance to women through emotional support, medical support including provision of misoprostol, and occasional legal guidance throughout the abortion process. This program aims to “gradually eliminate stigma in the concrete lives of each woman who has access and her surroundings, family, or even community where the stigma was.”

When the program first started, the organization provided accompaniment to women who found them through word-of-mouth. The service has grown exponentially in part because women who have previously used the service are now reaching out to help other women in their communities.

So, we began to realize this when some women expressly asked for pills or information because they were accompanying other women. So, we were just accompanying the women who were accompanying other women. That is how the networks have been exponential.

The organization recently started a database to collect information from women who use the service, but has not completed any formal evaluation of the program. Informally, they have observed significant shifts among women, as well as community members; shifts that they believe suggest a decrease in abortion-related stigma.

In the fast five years, we have also seen a gradual elimination of the stigma. Women used to come alone but now with greater access they bring people with them. And we can see how the subject has been changing in the community thanks to safe abortions. More women are coming and most come with their partners, families, parents—even a grandmother in one case. That the family comes, that partners come, and that it is totally open, means something new for us.

Over 13 years of accompaniment services, their observations of change include: women used to exclusively seek accompaniment services alone, and now they often come with support people; women used to only find out about the

service from other women who had used it, and now they are referred by university professors, conference speakers, and friends; women used to come worried about criminalization and feel the need to validate why they were seeking services, and now they come more often with questions about their health and the safety of misoprostol; they used to meet women in private homes and offices only, and now they meet women in public places; women used to present for assistance as far along as 12 weeks, and now they tend to arrive as early as 4 weeks.

Public Discourse

Interventions

- *Peer-to-Peer discussion*
- *Video testimonies*
- *Social media campaigns*

Participants mentioned a few projects that were building community dialogue and promoting positive messaging around abortion to a larger audience. One organization was combining their service delivery with promotion of “peer-to-peer” discussions among women. The goal was to encourage women to help sensitize and disseminate information about safe abortion to other women. Another organization was in the process of creating video testimonies to put together in a documentary about women’s abortion experiences. They plan to create clips to share on social media networks and “to show the public how to utilize the mass media to tell the world, people, that you can experience abortion in another way. That, fundamentally has to do with gaining access to safe abortions.” Another organization is using social media to promote positive messages about abortion. They are also planning to train activists “how to present abortions in the media from a positive perspective and not use phrases like, ‘Nobody wants abortion.’”

Increasing Access to Information

Interventions

- *Training peer educators*
- *Online medical information*
- *Raising political consciousness*
- *Social media campaigns*

Increasing access to information was seen as a valuable element of decreasing stigma by getting accurate information into the hands of women and their communities. Education programs included information about abortion in general, accurate medical information, and information about reproductive and human rights. Organizations disseminated information both in-person and online. One organization, which provides financial support for women seeking abortion, offers a “misoprostol protocol” online. They have not measured the number of women who visit the website, but stated that there are women who contact them to seek assistance after visiting the website. Another organization was providing education to youth in the community by training peer educators in safe abortion information in order to include it in their organized activities. Still another organization is committed to educating “women and girls from the most marginalized areas of the state so that they can understand their rights and know where they can go to demand them.” However, the discussion is not only about their own rights:

One thing that most women repeated was “It’s okay for me, but not for other women.” That is, yes, I need it but I am not in favor of abortion. And we’re there, working a lot with them, saying, “No, if it’s okay for you, then it’s okay for all women; it’s a right for all women.” And I think that that is how we learned to build a kind of political consciousness. That is, if it’s okay for one woman then it’s okay for all women and none of us can judge other women. This gave us lots of opportunities to talk with women about the myths around abortion.

All organizations with education programs were committed to providing information that was “scientific and free of prejudice.”

SECTION III. GOALS FOR REDUCING STIGMA

We asked participants to consider what programs, interventions, or projects they would undertake to address abortion stigma if money was not an issue. They brainstormed a range of projects that encompassed three main components: individual-level projects, community-level projects, and structural-level projects.

On an individual basis, one participant wanted to create a database to register the impact of their stigma-reduction programs and collect experiences of individual women they helped. Another participant wanted to engage health care providers across her target countries in values clarification exercises around abortion. Another participant wanted to invest in figuring out how to engage their clients in speaking about safe abortions.

Trying to engage some of our clients and their willingness to more openly engage about their abortions or safe abortions generally are a good thing, but it’s tricky to actually implement in practice.

On a community-level, participants expressed interest in exploring empowerment models and relating abortion stigma to a broader framework of gender justice and women’s rights. They also voiced an interest in reaching out to unlikely allies and finding creative ways to support abortion access, such as partnering with religious communities to work on decreasing maternal mortality.

“In practically every community I have ever been in...you invariably find people who are very, very just practical and realistic and wouldn’t even necessarily classify themselves as pro-choice. But, they just have a practical view of abortion. And, I feel like if there was enough outreach to find those people and pull them out and show them that they are not alone, that would change things.”

One participant mentioned specifically working with communities who have conservative attitudes towards abortion, and developing tools and policies to engage these communities in abortion stigma work. Another participant mentioned “working with medical schools to improve education of doctors about sexual and reproductive health and rights.”

On a structural level, participants discussed working with the media and working on policy change. Specifically, participants are interested in developing “messaging around abortion for the public” and addressing stigma and legality through “a massive PR campaign and communications training.” They want to work with policy makers to address how laws impact

stigma, and work with government officials in addition to public health workers. They also want to develop key talking points to explain to government officials “why it’s important to kind of commit to this issue.”

PART III. CONCLUSIONS AND RECOMMENDATIONS

Recall that at the beginning of this white paper we introduced the story of the elephant and the blind men to illustrate how complex problems can be misinterpreted when they are seen from only one perspective. We also shared that communication across perspectives can help to bring into focus a fuller understanding of the problem at hand, in this case abortion stigma. This paper has drawn on many perspectives: psychologists, sociologists, epidemiologists, public health researchers, service delivery providers, doctors, women who have had abortions, and community members. Drawing on these various perspectives we take a substantial first step to fully conceptualizing the problem of abortion stigma.

We share the perspective with many social science researchers that abortion stigma is a problem that occurs at multiple levels of society. The manifestations of abortion stigma can be highly problematic for those who are associated with abortion, primarily women who have abortions and abortion providers. At the structural level, abortion stigma contributes to unfair laws and policies, social silence, and the unequal distribution of health care services. Abortion stigma is particularly challenging because it can be self-perpetuating. Our key informants shared how fears of surveillance, persecution, and negative judgments cause many providers and patients to avoid sharing their work or personal abortion experiences. Research on women who have abortions suggests that they too employ strategies such as providing excuses and justifications or keeping the abortion secret, to manage stigma. These behaviors which can protect individuals and organizations from the negative consequences of stigma, may unintentionally contribute to social silence, myths and perception of illicitness surrounding abortion.

Yet, stigma management is not the only response. Our key informants shared that they are taking direct action to reduce stigma in many ways: training new providers, increasing public access to information, supporting women who have abortions, providing harm reduction services, and changing the public discourse. We drew on the research related to other stigmas to identify additional strategies for reducing stigma such as contact theory, protest, and social marketing.

Despite many years of work to increase the safety and availability of abortion around the world, our review of the abortion stigma literature suggests that we have a long way to go. Abortion stigma remains a persistent and under-researched phenomenon. We hope to use the information in this paper to help the service delivery community and other that are committed to eradicating abortion stigma to set an agenda for changing the status quo. Below we provide a set of recommendations for individuals and organizations as they continue their work.

1. Incorporate abortion stigma into organizational goals

The vast majority of organizations did not focus on stigma in their main program objectives or organizational mission and none had an official organizational definition. However, all key informants identified stigma as a primary barrier to providing quality reproductive health care services to women. We offer a few suggestions for organizations that might want to incorporate abortion stigma in to their organizational goals: (1) share this white paper with other individuals in your organization, (2) consider adopting a definition of abortion stigma for your organization, (3) conduct a scan of the work your organization is doing that might affect stigma using the conceptualization provided in this paper, (4) consider evaluating existing programming that might address abortion stigma, (5) consider developing additional programming that directly addresses abortion.

2. Identify the targets of your intervention or program

Many organizations work with several populations: women who have abortions, abortion providers, the media, and others. The most successful programs for reducing stigma carefully select target groups for intervention. Targets may be chosen because they are especially at risk for the negative consequences of stigma, because their work is impeded by stigma, or because they are at risk of stigmatizing others. Targets also may be chosen because they are in a position to influence individual attitudes and behaviors or social norms. Explicitly defining the targets of a program also makes it easier for organizations to evaluate changing attitudes, beliefs, and behavior of that target group.

3. Define the manifestation of stigma that you are seeking to change

Successful interventions are clear about which manifestation(s) of stigma they are trying to address. Interventions aimed at improving the experience of the stigmatized often work to reduce internalized stigma, build social support, and increase resilience. Interventions aimed at community attitudes work to reduce negative affective responses to abortion, change behavioral responses (eg. gossip, finger-pointing), and reduce stereotypes. Clarifying not only the targets but the manifestation can help organizations to develop effective evaluation strategies.

4. Develop interventions and practices that draw on research and local knowledge

Abortion is not the only health-related stigma. There are many other health-related stigmas that share important characteristics with abortion stigma such as concealability and perceived responsibility. Drawing on the research related to these stigmas can help organizations design effective interventions and practices.

At the same time, it is important to note that abortion stigma (and other health-related stigmas) is highly contextual. The research alone will not help to tailor an intervention or

practice for the local setting. Paying attention to customs, cultural stories, idioms, and local history can help organizations design interventions that feel relevant and are attuned to the needs of local communities.

5. Identify tools that will help evaluate the success of the intervention

Many of our key informants described services and programs that are likely to reduce abortion stigma. Incorporating monitoring and evaluation protocols to explore reductions in stigma can help organizations to better document the impact they are having. Evaluation is another area where organizations do not have to reinvent the wheel. We have shared the existing scales for abortion stigma at the end of this white paper. In addition, many of the references in the literature review of measures might be helpful for organizations to explore. Adopting a concrete definition of abortion stigma could help organizations determine what they are measuring. Organizations may want to consider the following key questions as they develop their evaluations:

- *Is the program well targeted?*
- *Does it produce the intended change?*
- *Does it draw on local knowledge and culture?*
- *Is it replicable, is it sustainable, and is it scalable?*

6. Participate in coalitions and community groups to share practices, tools, and results

If the story of the blind men and the elephant teaches us anything, it is that we are more effective when we communicate across our varied perspectives. The more that organizations can network across agencies and regions to share strategies, lessons learned, and evaluation tools, the more that we can learn about what works in different contexts and the better we can provide the information and evidence to support organizations to implement services and programs that will ultimately decrease abortion-related stigma.

Also, our research suggests that abortion stigma is truly a global problem. No one organization can address stigma at all levels. Collaborative efforts with other reproductive health organizations, as well as leaders in others fields, may provide the opportunity for broader impact.

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