

Understanding abortion stigma experienced by health workers in Nigeria: a mixed methods study

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Making Abortion Safe

RCOG's global initiative to advocate for women's health

Background

- Unsafe abortion is a leading cause of preventable maternal deaths and morbidities¹
- Despite international and national efforts at reducing the burden of unsafe abortion, barriers to safe abortion care still exists in Nigeria.
- These include but are not limited to restrictive abortion laws, poor understanding of the law, unavailability of services and abortion stigma.
- This research analysed a subset of data from Nigerian healthcare professionals exploring the drivers, and impact of stigma towards healthcare professionals (HCPs) providing abortion care, collected under the RCOG Making Abortion Safe “Global Provider Stigma Study”

Objective

To understand the extent and impact of abortion-related stigma towards HCPs delivering abortion care in Nigeria.

Methodology

A mixed-method study combining survey data from 204 healthcare professionals working in abortion care and Key Informant interviews with 10 providers from the6 geo-political regions of Nigeria. Primary data collection tools were the Abortion Provider Stigma Scale (APSS)² and an attitudinal scale using items from the Stigmatising Attitudes, Behaviors, and Actions Scale (SABAS)³.

Data Analysis

Univariate and multivariate linear regression modelling identified variables associated with stigma and correlations between demographics, Abortion Provider Stigma Scales (APSS) scores, attitude and reported levels of “burn out”. Coding and identification of themes from the key informant interviews were completed according to a coding frame based on the themes in the topic guide. Additional codes were identified using an inductive approach and a thematic approach was used for analysis.

The APSS scale

A 35-item scale of stigmatizing/positive experiences related to abortion, using a 5-point Likert scale to indicate how often, if at all, a respondent has experienced each. It has 5 subscales: “disclosure management”, “internalized states”, “judgment”, “social isolation”, and “discrimination”.

	N=204
gender	
women	83%
men	17%
job type	
doctor	14%
nurse	78%
other	7%
age	
18 to 34	36%
35 to 44	34%
45 +	30%
Years service	
< 2 years	48%
3-5 years	25%
6-9 years	15%
10+ years	13%
Mean APSS item score	
Disclosure management	1.83
Internalised states	1.85
Judgement	1.99
Social isolation	2.91
Discrimination	1.31
APSS total	1.99

Results (Phase 1)

- The majority of respondents in Nigeria were female (83%) nurses (78%) working in the public sector (60%). They spanned a range of ages however the majority had been working in abortion care for < 2 years (48%).
- 54% offered first trimester abortions and PAC only, 33% offered PAC only
- Respondents scored lower on the total revised APSS scale (57.94) than the Africa regional average (64.42) and the total sample (62.71). Disclosure Management was the largest contributor to these differences.
- Respondents scored highest on the “social Isolation” subscale (2.91 mean) and lowest on “discrimination”. This was consistent with other countries in Sub-Saharan Africa (Zambia and Uganda) and highly legally restricted countries in general.
- There were no clear and consistent patterns of variations in most APSS subscale scores in relation to gender, age group or HCP type.
- Social Isolation was higher (>0.20 difference in mean) in Nigeria among male HCPs, doctors and was highest amongst older staff.
- There were statistically significant differences (all at p<0.05) between male providers vs female providers for Discrimination, Burnout and Fear with male providers experiencing higher scores for each of these aforementioned variables.
- Abortion attitudes overall were more negative for doctors (35.66) than for nurses (29.82); this was driven primarily by abortion shame (p<0.05) and lack of support (p<0.05).
- Self-reported participation at either a Values Clarification and Attitude Transformation (VCAT) training or support workshops was low (22%), however 95% overall expressed a wish to engage in such activities.

manifestations of stigma

pride, positivity and resilience

THEMES

personal & professional consequence

drivers

Results: (Phase 2) (analysis includes data from Nigeria, Sierra Leone and Rwanda combined)

- All participants either directly identified, or described being or feeling stigmatized as a result of their work in abortion/PAC.
- Stigmatizing behaviours were acknowledged as occurring across the community and also within the work-setting by fellow HCPs.
- The majority felt that stigmatization occurred to both female and male workers alike, however in Nigeria there were some reports that women were held to higher ‘levels of morality’ and therefore more stigmatized
- Providers of abortion care (within the law) expressed greater levels of internalized stigma in providing later gestational terminations.
- Respondents felt there was a clear distinction with those offering PAC only viewed more favorably, as “life-saving”, and judged less.
- Rumours, cultural idioms and stories, religious doctrine and the legal status of abortion were identified as key driving forces
- Participants described great personal and professional consequences to their work in abortion.
- Personal consequences included; feeling negatively about themselves, mostly as a result of the stigma from others, social exclusion, conflict in personal relationships and emotional exhaustion.
- Professional consequences included; judgement from colleagues, a loss of income and direct harassment and/or violence
- Many providers reported that the stigma they experience as providers impacts on the quality of care women receive
- Despite challenges with stigma, many reported feeling positive about their work and a sense of pride. Some also demonstrated a strong sense of resilience.
- HCPs identified sensitisation on legal frameworks, non-clinical trainings including; value-clarification, counselling skills, ‘codes of conduct’ and conscientious objection, psychosocial support for providers and community sensitisation using real-stories to build empathy as ways to support them with stigma.

HCPs working in abortion care in Nigeria universally reported experiencing stigma with ‘social isolation’ as the highest scoring sub-domain. This was highest among the males, doctors and oldest HCPs. Male HCPs also reported higher levels of discrimination, fear and “burnout”

Conclusions

Stigma is driven by rumours, cultural idioms, religion and legal status, is experienced across home and the workplace and may be felt more amongst those providing later gestation care causing both professional and personal consequences

Organizations have a responsibility to address the issue of stigma towards HCPs providing abortion care to ensure this sector of the workforce are supported to continue providing these vital services

References

1 WHO.2021.Abortion .Key Facts (<https://www.who.int/news-room/fact-sheets/detail/abortion>).2 L. Martin et al. 2012, Measurement of stigma in abortion provision: the abortion provider stigma scale 3 Shellenberg et al. 2014 Developing a scale to measure stigmatizing attitudes and beliefs about women who have abortions: Results from Ghana and Zambia