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Exploring stigma and social norms in women's abortion experiences and their expectations of care

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Abstract: *Abortion is a common and essential component of sexual and reproductive health care, yet social norms and stigma influence women's decision-making and create barriers to safe abortion care. This qualitative study in Kenya and India explores abortion-related fears, expectations and perceptions of stigma among women who have obtained abortion services. In 2017, we conducted 34 semi-structured interviews and 2 focus groups with women who had obtained abortion services in Maharashtra state in India and Thika and Eldoret in Kenya. Thematic analysis was informed by the individual-level abortion stigma framework and theory of normative conduct. We aimed to learn about the diversity of women's experiences, analysing pooled data from the two countries. Most participants reported that before seeking abortion they had little prior knowledge about the service, expected to be judged during care, and feared the service would be ineffective or have negative health consequences. Many reported that community members disapprove of abortion and that a woman's age or marital status could exacerbate judgement. Some reported limiting disclosure of their abortion to avoid judgement. Negative stories, the secrecy around abortion, perceived stigma, social norms, and fear of sanctions all contributed to women's fears and low expectations. These findings elucidate the relationship between social norms and stigma and how expectations and concerns affect women's experiences seeking care. The results have implications for practice, with potential to inform improvements to services and help organisations address stigma as a barrier to care. This may be particularly relevant for younger or unmarried women.* DOI: 10.1080/26410397.2019.1661753

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Background

Globally, abortion services are annually accessed by an estimated 35 of 1000 women aged 15–44.[1] Despite being a common procedure and an essential component of sexual and reproductive health care, many women still face barriers to safe abortion, and their pathway to care is influenced by a number of social, cultural and legal factors. Among these, social norms — the unwritten rules of acceptable behaviour in a group[2] — have been found to play a key role.[3–6]

Social norms are generally characterised in the global health literature as people's beliefs about

(1) what others in a group do (descriptive norms) and (2) what others in a group approve or disapprove of (injunctive norms). These norms are often kept in place by the anticipation of positive or negative social sanctions, such as rewards or punishment for engaging in certain behaviours that are considered acceptable or unacceptable.[7] Social norms contribute to the abortion stigma that women may face when seeking or obtaining an abortion; abortion stigma is "a shared understanding that abortion is morally wrong and/or socially unacceptable."[8] A framework of individual-level abortion stigma presents the categories of perceived stigma (fears or expectations of being stigmatised), internalised stigma (self-judgement or negative feelings about one's abortion) and felt stigma (experiencing negative treatment for having an abortion).[9] Each of these categories has overlap — directly or indirectly — with the concept of injunctive norms around abortion — beliefs about what the community approves and disapproves. Abortion stigma is common across the world, although its manifestations can vary by social, legal, religious and cultural contexts as well as in relation to individual factors such as age, marital status and religion, among others.[3,10,11]

Social norms and stigma can manifest in a variety of ways that may limit access to safe abortion. Norms that can affect women's abortion-related decisions and experiences include the primacy of procreation and motherhood for women,[3] cultural expectations around pregnancy and parenting,[5] the unacceptability of adolescent sexuality and premarital sex[12,13] and women's responsibility for contraception.[14] In places where norms condemn abortion, women might be worried about revealing their abortion because they perceive stigma or anticipate negative reactions such as being ostracised, gossiped about or judged by family, community members or healthcare providers.[5,6,11,15] Young and unmarried women in certain cultural or religious contexts may be particularly susceptible to abortion stigma and, relatedly, concerned that others will find out about their abortion.[16,17]

In order to explore the manifestations of social norms and stigma, and to better understand how they contribute to women's expectations of abortion care and their experiences with services, our study aimed to speak to abortion clients from a range of service providers and settings. We chose study locations based on the presence of local research partners with clinics providing abortion care with high volume client loads. We selected two countries with distinct legal and social environments to provide a broad understanding of women's experiences in different settings. Therefore, this qualitative study focused on women in two countries, India and Kenya, where the abortion rates are similar (47 and 48 per 1000 women aged 15–49, respectively)[18,19] but the laws are distinct. Not only are the legal contexts different, but the social and cultural contexts of these two countries also differ in ways that can influence women's expectations of and experiences with abortion.

In Africa, approximately 76% of abortions are classified as unsafe[20] and in Kenya, it is estimated that the cost of treatment of unsafe abortion in 2016 reached approximately $6.3 million, demonstrating the high incidence of least safe methods of abortion in the country.[21] The Kenyan Constitution article 26(4) states that abortion is permitted when, in the opinion of a trained health professional, there is a need for emergency treatment, or if the life or health of the mother is in danger, or if permitted by any other written law.[22] However, studies have shown that many women do not know whether and under what circumstances abortion is legal.[4,17] In 2013, the Kenyan Ministry of Medical Services withdrew the previously published national "Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion in Kenya" without explanation and warned health providers against participating in abortion training.[23,24] These actions, possibly in response to pressure from anti-abortion groups, resulted in confusion among service providers and people seeking care with regards to the legality of abortion service provision.[23] The withdrawal of the guidelines and the confusion about the law have been found to contribute to abortion stigma, which can hinder access to care and result in women seeking unsafe abortion.[24,25] High levels of abortion stigma have been linked to high incidence of unsafe abortion, particularly impacting young and unmarried women who may experience more acute abortion stigma when seeking the service in Kenya.[24] Younger women in Kenya are among those who most commonly experience severe complications from unsafe abortion.[26]

In India, abortion is legal and accessible up to 20 weeks of gestation under a wide range of indications.[27] Despite the liberalisation of India's abortion laws over 30 years ago, many women access

abortion outside of formal health facilities. Of the 15.6 million abortions estimated to occur annually in India, fewer than one in four are provided in health facilities and close to three in four are induced using medical abortion drugs bought from chemists and informal vendors.[19] Barriers to access of facility-based abortion care include insufficient facilities offering abortion services, lack of certified staff, failure to protect women's privacy, lack of knowledge on the legality of abortion, and the stigma associated with abortion, with nearly half of the participants in one study citing stigma as a barrier to care.[28] Access to safe abortion for young or unmarried women, in particular, can be made difficult by the taboo around premarital sex or pregnancy.[12,29] A study in the states of Bihar and Jharkhand in India found that unmarried young women were more likely to encounter barriers to timely abortion care and to prioritise confidentiality in abortion-related decision-making than married young women.[30] In addition, aspects of the Indian law can create obstacles to care for younger women, such as the legal requirement for guardian or parental consent for women younger than 18 years old seeking abortion[27] and the 2012 Protection of Children from Sexual Offences (POCSO) Act, which criminalised sexual relations with a minor (under 18 years), even if consensual.[31] The latter also requires anyone aware of sexual acts involving minors, including those resulting in pregnancy, to report these to the police. Other legal barriers to access include the prohibition of sex selection through legislation introduced in 1994,[32,33] creating barriers to second-trimester abortion care.[34,35]

Despite the studies on how legal and social contexts can hinder access to timely and safe abortion care in India and Kenya, particularly for young or unmarried people, not much is known about women's experiences of stigma and expectations about abortion services, and the influence of these on abortion-related decisions. Expectations plausibly play a role in access to safe abortion, for example by influencing how quickly women are able to obtain services, their perceptions of abortion safety prior to seeking care, fears of stigma and discrimination in care, and their ability to assess the services they receive or advocate for the quality care they deserve. This qualitative study broadly aimed to examine the experiences of women who obtained an abortion in Kenya and India with regard to stigma, expectations, and perceptions of abortion quality of care. The analysis specifically presents findings related to the women's fears and expectations before seeking abortion services, their perceptions of and experiences with abortion-related stigma, and their overall experience seeking care. Ultimately, the findings can be used to inform improvements to abortion programmes and services to address stigma as a barrier to care.

Methods

We conducted semi-structured interviews and focus groups between October and November 2017 with women aged 18–46 who had an abortion in India and Kenya. We recruited clients in partnership with Family Health Options Kenya (FHOK) in Thika and Eldoret in Kenya and with Family Planning Association of India (FPAI) in the Thane district of Maharashtra state in India.

To ensure confidentiality and maintain participant privacy, women were invited to participate in the study by service providers or clinic staff who already knew that the individual had obtained an abortion service. They were approached after their service or during a follow-up appointment. Study staff in Kenya also contacted other private service providers and community health workers to recruit women who had obtained an abortion outside of FHOK. Women were eligible for the study if they were between 18 and 49 years of age, spoke a study language (English, Kiswahili, Marathi, Hindi), and had a medical or surgical abortion in the previous two months (India) or six months (Kenya). We aimed to recruit a diverse sample, with a mix of medical and surgical abortion experiences, ages, marital status, and women from various clinical sites across two countries. The samples in the two countries were not intended to match on demographic or other characteristics, and there are some differences based on local considerations. First, due to the stigmatising environment around premarital sex in India, the local team did not recruit women who identified as unmarried. Second, the abortion timeframe in each site (past two months in India versus past six months in Kenya) was determined according to service volume at each study site, allowing for a sufficiently large pool of clients from which to recruit in each country. Finally, the team in Kenya was able to recruit women who had sought abortion outside of FHOK in order to diversify the experiences included in the sample, while the team in India recruited only at

FPAI due to logistical difficulties recruiting beyond their own clients.

We conducted 24 interviews in Kenya, and 10 interviews and 2 focus groups in India. Given the more restrictive legal environment and acute manifestations of abortion stigma in Kenya, the study team there anticipated challenges recruiting women to group discussions about abortion experiences and opted to conduct only interviews. Interviews and focus groups were conducted in an appropriate space at the clinic or a safe alternative location. Women provided written consent to participate in an audio-recorded interview or focus group and were provided INR 330 in India and 1000 shillings in Kenya (each equivalent to roughly 5–10 USD) in compensation for their time and travel costs. The study in Kenya was approved by AMREF's Ethics & Scientific Review Committee. In India, the study was reviewed by the Secretary General of FPAI and approved as ethical on behalf of the organisation, and was also approved by the Allendale Institutional Review Board (USA).

Interview and focus group guides incorporated open-ended questions addressing women's knowledge of, beliefs about and experiences with abortion care, expectations before coming to the clinic, experienced or perceived stigma, and service quality. Some questions were designed to learn about social norms, exploring women's perceptions of the social sanctions for seeking abortion and of how providers would treat women of different ages and marital status seeking the service. The intention of the study was to understand the experiences of women who had obtained an abortion and how stigma influenced their expectations of and experience with abortion care. We did not seek to examine a woman's reason for abortion nor how stigma influenced her decision to have an abortion or not.

The interviews and focus group discussions were audio-recorded and transcribed in the original language, then translated into English. Local professionals carried out transcription and translation. The research team conducted data analysis using the software Dedoose 8.0 (Dedoose, SocioCultural Research Consultants, Los Angeles, CA). Our analysis was informed by the individual-level abortion stigma framework[9] and theory of normative conduct.[7] A codebook was developed with a priori and emergent codes. At the beginning of data analysis, two researchers independently coded two transcripts and examined discrepant coding, revising the codebook as needed. This updated codebook was applied to two additional transcripts, further refined, then applied to all transcripts. We did not sample to reach theoretical saturation within each country, and thematic analysis, using code summaries to identify patterns in the data, was based on core topics relevant to the entire sample. We aimed to learn about the diversity of women's experiences, focusing on commonalities that emerged from the data across the two countries. This approach was developed so that findings that emerged across contexts could be used by the study partners to inform programmatic decisions for multi-country and multi-regional projects. While the analysis focused on common experiences across the sample, we also identified noteworthy differences between countries and patterns unique to one setting, and we report on these in light of the local social and legal context. In addition, we were interested to identify specific fears, expectations, or aspects of stigma particular to young people in the sample, defined as participants aged 18–24 years. This is in accordance with the United Nations Population Fund definition of young people as 10–24 years old,[36] using 18 as the lower age limit for this study for purposes of child protection.

Results

We conducted individual interviews with 34 women and 2 focus groups with 11 women overall, totalling 45 study participants — 21 in India and 24 in Kenya. The mean age of participants was 27 years with a range of 18–46. Sixteen women were younger than 25 years old — 7 in India and 9 in Kenya. The sample in India had lower educational attainment than the sample in Kenya, with only 3 of the 21 women in India having completed secondary school or enrolled in higher education, compared to 17 of the 24 women in Kenya. Overall, two-thirds of women in the sample were married, including all participants in India and 9 of the 24 in Kenya. Two-thirds of women in the sample had one or more children, the large majority of women in India and just over half of those in Kenya. Approximately half of the sample had a medical abortion, specifically 9 of the 21 participants in India and 15 of the 24 in Kenya. Eleven women reported having more than one abortion — nine in India and two in Kenya. The large majority of women (38 of the 45 participants) received their service at FHOK or FPAI. In accordance with the sampling plan, all 21

Table 1. Characteristics of participants receiving abortion services in Kenya and India

	Total *n* = 45, (%)	Kenya *n* = 24* (%)	India *n* = 21** (%)
Age			
Mean	26.9	26.9	27.0
18–24	16 (35.6)	9 (37.5)	7 (33.3)
26–35	27 (60.0)	13 (54.2)	14 (66.6)
>35	2 (4.4)	2 (8.3)	0 (0.0)
Education			
None/informal	4 (8.9)	1 (4.2)	3 (14.3)
Some primary	3 (6.7)	0 (0.0)	3 (14.3)
Completed Primary	6 (13.3)	3 (12.5)	3 (14.3)
Some secondary	12 (26.7)	3 (12.5)	9 (42.9)
Completed secondary	4 (8.9)	3 (12.5)	1 (4.8)
Higher education	16 (35.6)	14 (58.3)	2 (9.5)
Marital status			
Married	30 (66.6)	9 (37.5)	21 (100.0)
Unmarried	15 (33.3)	15 (62.5)	0 (0.0)
# of children			
0	14 (31.1)	11 (45.8)	3 (14.2)
1–2	24 (53.3)	9 (37.5)	15 (71.4)
3 or more	6 (13.3)	4 (16.6)	2 (9.5)
Missing	1 (2.2)	0 (0.0)	1 (4.8)
Type of procedure			
Medication	24 (53.3)	15 (62.5)	9 (42.8)
Surgical	21 (46.7)	9 (37.5)	12 (57.1)
# of prior abortions			
0	32 (71.1)	22 (91.6)	10 (47.6)
1 or more	11 (24.4)	2 (8.3)	9 (42.8)
Missing	2 (4.4)	0 (0.0)	2 (9.5)
Type of facility			
FHOK or FPAI	38 (84.4)	17 (70.8)	21 (100.0)
Other private clinic	6 (13.3)	6 (25.0)	0 (0.0)
Chemist	1 (2.2)	1 (4.1)	0 (0.0)

*All 24 were in-depth interview participants.
**Eleven of the 21 participated in focus groups and 10 in interviews.

women in India obtained an abortion at an FPAI clinic, whereas in Kenya 17 women obtained an abortion at FHOK, 6 at a private provider, and 1 at a pharmacy. These data are summarised in Table 1.

Data from the interviews and focus groups are presented below in relation to women's attitudes towards abortion, perceptions of community attitudes, knowledge about abortion, fears and expectations for the service, and experiences seeking care. We present findings that emerged across the sample in both countries. When relevant, we also highlight any noteworthy divergence between findings from women in Kenya and India.

Women's attitudes towards abortion generally and their own abortion

The majority of participants said that before their own service experience they had unfavourable views towards abortion or women who seek it. For example, several women said that before their abortion they had considered women who seek the service to be "irresponsible" or "immoral," and others referred to abortion as a "sin" or "crime." Women mentioned different factors that influenced their negative feelings about abortion, including the role of religion or hearing that it was unsafe. Despite widespread negative views about abortion among women in both countries before seeking care, it is worth noting that four women in Kenya reported having positive or non-judgmental feelings towards abortion before obtaining an abortion service. As one of them said:

"I was indifferent [about abortion]. […] I'm an open-minded person, I don't judge. I say that for whatever choice anyone makes, there must have been particular circumstances that led them to that choice." (Kenya, age 24)

Among those who said they supported the right to abortion, some spoke about a women's right to choose. "*Whether to give birth and raise the child or not is totally the mother's decision*" (India, age 22). A few women also linked the right to legal abortion services with the concept of safety, for example saying that abortion was important to save women's lives. However, a substantial number of women in both countries expressed limitations to their support of abortion, particularly in relation to other women's circumstances. One woman said, "*you don't have the right [to abortion] […] unless you have […] genuine reasons*" (Kenya, age

22). Another stated, "*it is wrong to just terminate a pregnancy, unless it is an emergency and it is mandatory that an abortion happens*" (Kenya, age 26). One participant connected her support for abortion under particular circumstances with her belief about parenting among low-income women: "*There are those who are poor. […] Instead of giving birth, and [then] the child grows to become a thief, or you are not able to educate him, it's better to just have an abortion*" (Kenya, age 31).

Some participants told us about their limited support for abortion in relation to a woman's marital status. Specifically, some participants said they thought unmarried women should not access abortion services, and a few said that women should not have an abortion without family approval. For example, one participant said, "*[Firstly], I think the girls who are unmarried should [receive] permission from their family members before having an abortion. Secondly, I think that if the husband doesn't want it, then how [can] a woman have an abortion?*" (India, age 34). This type of sentiment was more frequently expressed in India than in Kenya.

Women in both countries talked about their feelings of self-judgment when making the decision to have an abortion. Several women mentioned feeling that "it was wrong" to seek abortion or spoke about feeling "guilt." One woman said that having an abortion is "*not respecting myself. It's like [I] am doing something wrong to myself*" (Kenya, age 21). Another said, "*I felt I have done a very big sin*" (Kenya, age 26). Some women were specific about the source of these feelings, with a number mentioning religion. For example, one woman told us about the "*religion versus morality interplay*" and described her inner conflict about abortion as a "*war within*" (Kenya, age 24). Kenyan women more frequently described feelings of internalised stigma related to their abortion, such as self-judgement or guilt, than Indian women.

Many women said they felt they had to obtain an abortion despite their conflicted feelings. "*What I have done is […] wrong, but I had to go in for it finally*" (India, age 24). Some women talked about the difficulties they would face if they had another child. This was their reason for choosing an abortion despite having negative feelings about that choice. For example, one woman said:

"I never thought I would find myself in such a situation … of getting an abortion. […] My husband was even scared when he told me […] that [it] is not a good period to have another child. So I had very negative thoughts." (Kenya, age 26)

Not all women talked about having negative feelings about their own abortion, however. As one woman said: "*I think, for me, I felt like I did the right thing*" (Kenya, age 27). In both countries, women described how their experience seeking and receiving abortion services allowed them to reflect upon their previous views on abortion, and in some cases, those views changed. One woman said, "*When it [abortion] happened to me it changed my perspective. It made me feel like when people are [having an] abortion, they have their own reasons*" (Kenya, age 34). Another told us, "*I used to think that abortion shouldn't be done. [That] it's a sin. When I had to undergo this [abortion], then I realized it is necessary and I should not think like this*" (India, age 34).

In these ways, women who sought abortion in both Kenya and India expressed feelings of internalised stigma with regards to their own abortion, as well as a range of feelings that sometimes shifted over time about abortion in general and women who seek abortion.

Community stigma, secrecy, and disclosure

Beyond describing their own feelings about abortion, women in Kenya and India also talked about their perceptions of how community members felt about the subject. Many women said they thought people in their communities disapproved of abortion in general. One participant said that most community members think abortion "*is like an abomination*" (Kenya, age 25), and a few mentioned the role of religion in people's negative perceptions of abortion. While women in both countries talked about community stigma, this topic was more commonly mentioned in Kenya.

While many women said they believed people in their community had negative beliefs about abortion, very few told us about situations in which they directly experienced abortion-related stigma. Only one woman gave an example of enacted community stigma, in which someone attempted to dissuade her from having an abortion.

"When I took [medical abortion] pills my neighbor told me, 'Don't do it […].' She was trying to convince me […] [not to] abort it. But I said [to] her that no one is there to look after my baby. I have to do it." (India, Focus Group)

When asked if the age or marital status of women seeking an abortion were potential sources of community judgement, women in both countries said they were. There were clear differences in how women in the two countries talked about this. In Kenya, women more often mentioned young age as a reason that women might be judged. For instance, one woman said an 18-year-old might not have an abortion because "*people think this is too young and reckless*" (Kenya, age 25). In India, participants tended to emphasise being unmarried as a source of potential stigma, especially when women were both young and unmarried. For example, one young woman described how she thought community members would think of her had she not been married when she obtained an abortion.

"If I had not worn [a] mangalsutra and [my] husband [was] not accompanying me, people will gossip about me. They would have talked if I had taken medicines and [about] the reasons. It would have been very troublesome if people spoke like that."* (India, age 19)

While many women told us that being unmarried might be a source of stigma, one woman said that seeking abortion services while being married could also be perceived negatively: "*It is weird for a married woman to have an abortion […], according to people*" (Kenya, age 25). This highlights that women who are married and potentially already mothers can also face abortion stigma.

Some participants said that abortion is commonly kept secret because women feared judgement or criticism in their community. As one woman said, "*In society, the way people view [abortion negatively] … that's why people do it secretly*" (Kenya, age 24). Another said, "*when someone knows that you had an abortion […] they make it a big deal, they see you as if […] you are evil, […] you've got bad manners*" (Kenya, age 18). Some participants suggested that unmarried women, in particular, try to keep their abortion a secret, as they are more likely to be judged. This participant hypothesised that unmarried women might consider self-inducing an abortion (outside a health facility) to avoid the potential lack of secrecy that comes with seeking care at a clinic: "*If they [unmarried women] don't want to disclose, then they will not come here*" (India, age 22).

*A necklace identifying a woman as married.

Many participants said they limited who they told about their abortion. One woman reported she would recommend the clinic to a friend seeking an abortion but would not disclose that she herself had received the service. Another told us that only her husband knew about her abortion. One noteworthy difference between women in the two countries was whether they told their families about their abortion. Most women in Kenya said they did not involve their families in their abortion process, and some mentioned expecting a negative response if others found out about their abortion. Younger women in Kenya tended to talk about the importance of keeping their abortion a secret and mentioned concerns about how their parents would react if they found out. This may reflect the taboo around youth sexuality and pregnancy in addition to abortion stigma.

"My mother even noticed something was up, and I was this close to telling her [about my abortion]. It's just that I [stopped] myself […]. I can live with a secret from within, but I can't stand my mother looking at me differently." (Kenya, age 24)

In contrast to women in Kenya, many participants in India said they involved their husbands and in-laws in the decision to have an abortion and choosing where to seek care. Some women also described the family's decision-making process in relation to what others would think. One woman said that the family decided she should have an abortion because "*it doesn't look good if [a] mother conceives after two big children*" (India, age 34). This example, among others, shows how women's perceptions of community beliefs can influence their decisions about different aspects of seeking abortion, including whether to talk about it with others.

Knowledge, fears, expectations and experiences of stigma when seeking abortion

Before seeking care, most women in this study reported having little or no knowledge about abortion procedures or what these would entail. Several young women in India said that this lack of information was a source of fear. "*Actually, I was very scared as I had never taken an abortion service before. I didn't know much about [it]*" (India, age 22). The information women did have tended to come from stories they heard in their communities or discussions with family or friends. Women said that the information they gleaned about abortion before their service was sometimes a source of

worry for them, particularly among those seeking an abortion for the first time.

While a few women had heard favourable things about the clinic where they sought care and therefore had positive expectations for the service, the majority of women in both countries reported having low expectations of the abortion experience and the care they would receive. Women's principal concerns before seeking an abortion included infertility, incomplete abortion, side effects, and death. Expressing a common sentiment for women in this study, one participant said, "*I was scared. […] I used to hear that you may procure an abortion and not be able to get children any more*" (Kenya, age 18). One concern about abortion that was mentioned frequently in Kenya but not in India was fearing death as a result of abortion. This was often described in connection with knowing someone who had died from an unsafe abortion or hearing stories about unsafe practices, such as going to clandestine providers ("quacks") or using herbs. Several women in Kenya talked about considering traditional methods for abortion but deciding against them because they had heard these were "risky," "dangerous" and "something might go wrong."

Among study participants, young women's stated concerns about the safety and physical consequences of abortion did not diverge from those of other participants, but concerns about infertility, pain, and other side effects of abortion emerged particularly strongly among this group. For example, one young woman listed a range of concerns she had before her own service.

"I was most worried whether 100% the abortion would take place, and would it cause any problems in future. Will I be able to conceive again? Will there be any reaction to the tablets, will there be any other reaction, any bleeding, or any problems with my periods in future? […] A lot of questions went through my mind." (India, age 22)

In addition to fears about the abortion procedure itself, women in both countries commonly said they also feared being judged or mistreated during their service. Some women said they expected criticism or judgement from clinic staff for particular reasons related to their pregnancy and contraceptive history, as in the case of one woman who said, "*I just felt like, what is this doctor thinking about me? I have already had kids […]. So how is the doctor going to see me?*" (Kenya, age 34). Few women mentioned potential legal consequences of seeking an abortion, though two in Kenya mentioned concerns the clinic staff would report them to the legal authorities for seeking an abortion.

There were some differences in how women in the two countries described the reasons they thought they would be judged during their service. In Kenya, many women said they expected stigmatising treatment from doctors and other clinic staff for simply requesting an abortion service. Several women said they didn't want to disclose the reason for their visit to the front desk staff at the clinic. Others said they feared the provider would dissuade them from having an abortion or would deny them the service. One woman said, "*I did not know what to expect, so somehow I did not expect 100 percent I would be given services*" (Kenya, age 26). Another stated, "*I had imagined he [the provider] would tell me abortion is not good, just go, keep the pregnancy or whatever*" (Kenya, age 22). Whereas in India, women gave more specific reasons for fearing judgement, such as not using contraception. For example, one woman shared: "*I was afraid of whether someone would scold me […]. If they asked me why I have not taken [contraceptive] pills, why I have not inserted copper [IUD] and all that, what I should answer them?*" (India, age 28). Similarly, another woman said she felt "*shy to come back to that place [the clinic]*" if she became pregnant after they provided her with contraceptives (India, focus group participant, aged 24–28).

The concerns about stigma from clinic staff expressed by the younger women (aged 18–24) in the sample were similar to those of the rest of the participants. Most younger women did not talk about fearing stigma in relation to their age; only one woman mentioned fearing judgement because of her young age, in relation to potentially being perceived as unmarried. "*People would also think wrongly, my age being less, am I married? Would they ask for an ID proof?*" (India, age 22).

All participants were asked how they thought a woman's age and marital status might influence how she would be treated during her service. One woman said she thought that if her husband had not supported her in seeking an abortion, the clinic staff would have judged her, and many women said they thought an unmarried woman seeking abortion services might be scolded or treated differently.

"In my opinion, what the girl is doing [having an abortion] is wrong, before marriage […]. So in that context, [the] doctor may shout at her and tell her, 'Why did you do this before marriage? It should not have happened.'" (India, age 29)

While marital status was often mentioned as a factor that women believed might impact women's abortion care, there was more diversity of opinion about the role of age. Many women said they thought age would not influence women's abortion services, as suggested by one participant who said she thought an 18-year-old wouldn't be denied care because she would have an identification card, which means she can vote, in which case "*you have that authority to say, 'this is what I want in life*'" (Kenya, age 27). In contrast, a few participants said they thought younger women might be more likely to face stigma and criticism from staff and doctors, or be denied care, because "*an 18-year-old does not even have a family, she has no kids. It's not good for someone to start having abortions and she has not given birth to even one child*" (Kenya, age 31).

Despite participants' fears about the abortion service and low expectations of how they would be treated, all women in this study ultimately did obtain abortion services, and most said their experiences receiving care were substantially better than they had expected. The large majority of participants in this study (38 of 45) received services at private not-for-profit facilities, and these findings primarily reflect experiences of care at these particular facilities. Expressing a common sentiment among participants, one woman said, "*I thought [the treatment would be] negative, but I didn't get […] that at all. […] [I] was given good treatment*" (India, age 35). Despite this generally positive feedback, the one woman in this sample who obtained her abortion from a chemist — outside the formal abortion care system — said she was treated poorly. "*He didn't ask […] are you sure you want to do this? They didn't counsel me. They just told me okay, get in there. Lie on the bed*" (Kenya, age 21). In addition, several women reported interactions where providers instructed them to use contraception, particularly long-acting methods, told them to avoid having another abortion, or questioned why they would want an abortion if they already had a child. In some of these cases, the women reflected on these encounters as appropriate, or even supportive, as in one case where the participant said the provider told her to use long-term contraceptive methods because she already had many children.

"Actually, she [the provider] told me the right thing. As I already have 4 children, [she said] I should have an operation [tubal ligation], or I should insert [the] copper-T. According to my knowledge, she gave me a proper suggestion. That's why I didn't feel upset. We all know that nowadays, rearing a baby is very expensive." (India, age 35)

Some women contrasted mistreatment in the public sector with the polite treatment they ultimately obtained at the study sites. For example, one woman told us, "*[FHOK staff] are good people, they talk to you very nicely, and there is no shouting at you like … in public hospitals*" (Kenya, age 33). Another said, "*I had heard that they beat you, throw your hands and legs here and there and scream at you, but here [at FPAI] nothing of it happened*" (India, age 35). A few women said that the compassionate care and accurate information they received helped assuage their fears about abortion, as was the case for the following participant:

"After seeing him [the provider], and the way he talked, […] the [fear about] death […] was not there anymore. He just told me, 'This is going to be a quick thing. Don't fear, you are going to be safe.' In fact, he even went further and advised me about family planning that I can use." (Kenya, age 34)

The majority of women in this study emphasised the good treatment they received during their abortion service and said they would recommend the clinic to others or return in the future. One woman said that the favourable treatment she received played a role in her decision to return for follow-up. "*No one has shouted at me and no one has scolded me too. […] If I would have faced any problems here, I would not have come here for the second time [follow up visit]*" (India, age 28).

As these narratives show, stigma had an influence on the abortion-seeking experience of the women in this study in many ways. Misinformation, low expectations for care, concerns about abortion safety and fear of judgement or stigma while seeking care were demonstrated. Despite this, most women in this study said the abortion service they obtained was better than they had expected, and they overwhelmingly described the abortion care they received in favourable terms.

Discussion

Drawing on data from the two distinct legal and social contexts of Kenya and India, this qualitative study adds to the growing literature about women's experiences navigating abortion-related stigma and social norms, and women's fears and expectations when seeking care. This study found that women who obtained abortion services in the distinct legal and social contexts of Kenya and India arrived for care with little accurate knowledge about abortion, negative attitudes towards abortion, fears about the safety and side effects of the service, concerns about being judged, and low expectations for how they would be treated during care. These findings help illustrate the social norms and stigma which may contribute to or cause low expectations among women seeking abortion care in different settings, and have implications for effective practice and future research. First, service-delivery organisations in India and Kenya can consider how to mitigate the impact of abortion stigma and improve women's expectations of abortion services and ultimately inform improvements in client-centred care. This may be particularly important given challenges in eliciting meaningful critiques of abortion services. The high levels of satisfaction with services (and resultant lack of critique), commonly reported by women who seek abortion, may be due to obtaining a wanted service rather than the actual quality of the care received.[37] Second, it would be beneficial to explore further how low expectations and experiences of stigma may impact women's perceptions of how they should be treated by abortion providers.

Findings from this study suggest that young and unmarried women are particularly susceptible to abortion stigma. Participants in both countries said that women's age and marital status when seeking abortion could magnify judgement or contribute to lower quality of care, though particularities differed between countries. In India, where nearly all women are married by age 25,[38] being unmarried was described as the more important factor in influencing stigma. This aligns with another study in India that found that young unmarried women commonly feared disclosure, and were more likely than young married women to prioritise confidentiality when choosing an abortion facility and to encounter barriers to timely care.[30] In contrast, in Kenya we found that women more often mentioned young age, rather than marital status, as a potential reason for judgement, and that younger women mentioned hiding their abortion from their parents. Other studies found that younger women limit disclosing their abortion as a strategy to manage community stigma in Kenya,[39] or avoid parental disapproval in Zambia.[16] The difference in emphasis noted by women in Kenya and India seems compatible with social norms in each country, suggesting that context is an important factor to consider when exploring the experiences of "compound stigma"[3] among younger and unmarried women seeking care. In this case, abortion stigma was compounded with taboos around adolescent sexuality and pregnancy among unmarried women. We found that concerns about abortion safety were particularly strong among younger participants in both Kenya and India, likely reflecting a lack of access to accurate information about abortion among this population. This may also be a result of the compound stigma encountered by young people seeking abortion, which can lead them to keep their abortion a secret, deterring them from seeking information or support. Based on our findings, we suggest that clinics in both countries could develop contextually appropriate youth-friendly services and policies, a strategy that has been found to promote access to sexual and reproductive health services.[40,41] In India, in particular, it is important to consider how to ensure that unmarried women, especially those who are young, are aware of their right to care and informed about how to access safe and legal abortion services. Comprehensive sexuality education has been found to inform young people about sexual health services and promote care-seeking behaviour in various contexts,[41–43] and could be explored as a strategy to inform younger and unmarried women about their right to abortion care and how to access it.

This study identified many similarities in how stigma affects women's abortion experiences in both countries, including attitudes towards abortion, feelings about their own abortion, and perceptions of community stigma. Women not only spoke about fear of sanctions such as being judged, mistreated, denied care, or reported to law enforcement, but also about strategies to cope with these fears, such as withholding the reason for their visit from front desk staff, keeping their abortion a secret, or considering management of their own abortion at home. Other studies have found that Kenyan women keep their abortion a secret

due to community stigma and social norms related to religion, sexual activity and procreation[4,17,24,39,44,45] and that women prioritise providers who they trust to maintain their privacy, regardless of whether these are inside or outside a formal healthcare facility.[17] Similarly, a study in two states in India identified stigma and social norms about abortion as potential barriers to safe abortion care.[46] Previous research shows that stigma can lead women and providers to refrain from discussing abortion.[11,47,48] The secrecy surrounding abortion might limit women from sharing stories of safe abortion, and bad experiences with unsafe procedures can perpetuate misinformation.

The current study also highlighted some noteworthy differences in experiences of stigma between the two countries. Self-stigmatisation and community stigma emerged more strongly in Kenya, and women in India disclosed their abortion to family members, which was uncommon in Kenya. These differences may reflect the different characteristics of the sample in each country (all participants in India were married, compared to less than half of women in Kenya) or the distinct social norms in each country related to abortion and to medical decision-making. Social norms[7] and stigma[9] frameworks each provide a lens to examine how perceived disapproval of abortion and anticipation of related sanctions affect women's experiences and decisions when seeking care, with the concept of perceived stigma (fear of judgement or mistreatment) appearing to overlap with those of injunctive norms (beliefs about what others disapprove of) and anticipated sanctions (expected negative consequences). As such, this study begins to elucidate the relationship between the constructs of social norms and stigma in relation to abortion, how these manifest in different settings, and the subsequent impact on women's experiences seeking and receiving abortion services. These findings are in line with a sociological theory suggesting that social norms are a key factor in creating stigma[49] and also echo research connecting social norms and decision-making in other areas of health such as smoking cessation[50] and unintended pregnancy.[5]

This study has four limitations. First, the range of experiences explored in this study is potentially limited by the sample, which comprised women who had obtained an abortion and were recruited primarily from facilities affiliated with private not-for-profit service-delivery organisations. The finding that abortion services surpassed women's expectations may be specific to the facilities included in this study. Given the high rates of unsafe abortion and abortion outside of formal facilities in Kenya and India, it is likely that some women seeking abortion would obtain lower quality abortion care that is more in line with the fears and expectations expressed by women in this study. Indeed, the only woman in this study who obtained her abortion at a chemist (a provider outside the formal healthcare system) described being mistreated while seeking care. Second, the samples in the two countries were not matched by sociodemographics and data collection methods, as the study did not aim to compare between the two countries and only explored commonalities and diversity between them. Third, this analysis is limited by the small sample of younger women as well as challenges recruiting unmarried women in India. Fourth, recruitment was conducted by healthcare providers, and the interviewers were affiliated with the service-delivery organisations where most women in this study obtained their abortion. This may have led women to withhold negative feedback about their abortion services. To ensure that women were as honest as possible, we engaged interviewers who did not work at the clinical sites where women were recruited. We also trained them to emphasise that participant responses would be kept confidential and have no bearing on women's ability to receive care in the future, and included prompts and reminders throughout the interview guide to elicit candid responses.

Conclusion

These findings help elucidate how social norms and abortion stigma interplay with women's perceptions about abortion in Kenya and India, including their low expectations of care and concerns about safety or mistreatment. Women's perceptions of community disapproval of abortion may have derived from local social norms related to religion, motherhood, responsibility for contraception, and sexual mores for young and unmarried women. Negative stories women heard in their communities, the prevailing secrecy around abortion, perceived stigma, and the related fear of sanctions for having an abortion were all factors that contributed to their low expectations and fears. These findings have implications for practice, highlighting the importance of developing

strategies that can be adapted for different settings to address women's fears of being judged and help women cope with stigma in their communities. Approaches suitable for service-delivery organisations may include clearly communicating information about the right to care, ensuring youth-friendly services, or providing support services for women who choose not to disclose their abortion to family and friends and therefore feel isolated. Given the influence of local context in women's abortion experiences, interventions seeking to improve access, provide accurate information, and ensure high-quality client-centred services would benefit from efforts to develop and refine such approaches locally, as well as applying a stigma or social norms lens. These types of interventions may be particularly relevant for younger or unmarried women, who are more likely to experience abortion stigma.

Informed consent

Informed consent was obtained from all individual participants included in the study.

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Data availability statement

The data that support the findings of this study are available on reasonable request from the corresponding author, SB. The data are not publicly available due to the confidentiality required by our ethics approval.

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Résumé

L'avortement est un élément commun essentiel des soins de santé sexuelle et reproductive; pourtant les normes sociales et la stigmatisation influent sur la prise de décision des femmes et créent des obstacles à des soins d'avortement sûrs. Cette étude qualitative au Kenya et en Inde porte sur les craintes relatives à l'avortement, les attentes et les perceptions de la stigmatisation chez les femmes qui avaient obtenu des services d'avortement. En 2017, nous avons réalisé 34 entretiens semi-structurés et organisé deux groupes de discussion avec des femmes qui avaient obtenu des services d'avortement dans l'État de Maharashtra, en Inde, ainsi qu'à Thika et Eldoret au Kenya. L'analyse thématique a été guidée par le cadre de stigmatisation de niveau individuel en cas d'avortement et la théorie du comportement normatif. Nous souhaitions en savoir plus sur la

Resumen

El aborto es un componente común y esencial de los servicios de salud sexual y reproductiva; sin embargo, las normas sociales y el estigma influyen en la toma de decisiones de las mujeres y crean barreras para obtener servicios de aborto seguro. Este estudio cualitativo realizado en Kenia e India explora temores, expectativas y percepciones del estigma relacionado con el aborto entre mujeres que han obtenido servicios de aborto. En el año 2017, realizamos 34 entrevistas semiestructuradas y dos discusiones en grupos focales con mujeres que habían obtenido servicios de aborto en el Estado de Maharashtra, en India, y en Thika y Eldoret en Kenia. El análisis temático se basó en el marco del estigma del aborto a nivel individual y en la teoría de conducta normativa. Nuestro objetivo era adquirir conocimientos sobre la diversidad de experiencias de las mujeres,

diversité de l'expérience des femmes, en analysant les données des deux pays. La plupart des participantes ont indiqué qu'avant de demander un avortement, elles connaissaient peu ce service, s'attendaient à être jugées pendant les soins et craignaient que la prestation ne soit inefficace ou ait des conséquences sanitaires négatives. Beaucoup ont signalé que les membres de la communauté désapprouvent l'avortement et que l'âge d'une femme ou son statut matrimonial peut exacerber le jugement. Certaines femmes ont déclaré qu'elles avaient limité la divulgation de leur avortement pour éviter d'être jugées. Les récits négatifs, le secret entourant l'avortement, la stigmatisation perçue, les normes sociales et la crainte de sanctions sont autant de facteurs qui ont contribué aux peurs et aux faibles attentes des femmes. Ces conclusions expliquent les relations entre normes sociales et stigmatisation, et elles montrent comment les attentes et les préoccupations influent sur l'expérience des femmes qui demandent des soins. Les résultats ont des répercussions sur la pratique, avec le potentiel d'inspirer les améliorations des services et d'aider les organisations à s'attaquer à la stigmatisation comme obstacle aux soins. Cela peut être particulièrement pertinent pour les jeunes femmes et les célibataires.

analizando los datos recolectados de los dos países. La mayoría de las participantes informaron que antes de buscar servicios de aborto tenían pocos conocimientos del servicio, esperaban ser juzgadas durante el servicio y temían que el servicio fuera ineficaz o que tuviera consecuencias negativas para su salud. Muchas informaron que la comunidad desaprueba del aborto y que la edad o el estado civil de la mujer podría exacerbar los prejuicios. Algunas informaron limitar la revelación de su aborto para evitar ser juzgadas. Historias negativas, secretismo en torno al aborto, estigma percibido, normas sociales y miedo a ser castigadas, todos estos factores contribuyeron a los temores de las mujeres y sus bajas expectativas. Estos hallazgos aclaran la relación entre las normas sociales y el estigma, y cómo las expectativas y preocupaciones afectan las experiencias de las mujeres que buscan servicios de aborto. Los resultados tienen implicaciones para la práctica, con el potencial de influir en mejoras a los servicios y ayudar a organizaciones a abordar el estigma como una barrera a los servicios, lo cual es de particular importancia para mujeres jóvenes y solteras.