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Disrespect and Abuse in Abortion Care: A Systematic Review

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Disrespect and Abuse in Abortion Care: A Systematic Review

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2017

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An abstract of
A thesis submitted to the Faculty of the
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Abstract

Disrespect and Abuse in Abortion Care: A Systematic Review

By Meghana Munnangi

Disrespect and abuse during facility-based abortion and postabortion care manifests through various forms including disrespect, abuse (physical, verbal, and/or sexual), stigma, neglect, breaches in privacy/confidentiality, discrimination, misinformation or a lack of information, procedures without consent, humiliation, condescension, mistreatment, undignified care, and/or protests. These are direct violations to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which was adopted in 1979 and states that all parties must "eliminate discrimination against women in the field of health care...including those related to family planning" (UN General Assembly, 1979). Despite the World Health Organization (WHO) releasing an official statement on the importance of preventing disrespect and abuse during childbirth, there is still little research on the prevalence and impacts of this form of discrimination and violence against women (World Health Organization, 2014). There is even less research on the forms of disrespect and abuse against women during abortion care when compared to research on women during childbirth. To prevent and eliminate disrespect and abuse in sexual and reproductive health care, we must understand the global impact of this issue for obstetric, contraceptive, and abortion care. This review synthesizes existing evidence of women's experiences of disrespect and abuse during abortion and postabortion care to better understand the scope of this issue and to add to existing literature.

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Introduction

An estimated 56 million abortions occur every year, representing an annual global rate of 35 abortions per 1000 women of reproductive age (WRA; 15-49 years old) (Ganatra et al., 2017). Abortions are common around the world; 25% of all pregnancies end in an abortion (Ganatra et al., 2017). In many countries, legal, economic, and structural barriers effectively restrict abortion access. In restrictive settings, women seeking abortions turn to untrained providers or undergo unsafe abortions in environments that do not conform to minimal medical standards (Singh, Remez, Sedgh, Kwok, & Onda, 2018). In developing nations, unsafe abortion is an important detriment of maternal deaths, due to complications such as sepsis, hemorrhage, or uterine perforation (Singh et al., 2018). In addition to well known legal and economic barriers to abortion, women may seek abortions outside of the health care system because of social stigma, a lack of privacy, and/or a fear of mistreatment from health care providers (World Health Organization, 2011). Healthcare institutions and providers can perpetuate these additional barriers through their practices, attitudes, and policies. Researchers have used a variety of terms to describe the negative experiences women face when seeking obstetric care including but not limited to obstetric violence, mistreatment, dehumanized care, and disrespect and abuse (Savage & Castro, 2017).

Recently, there has been a growing recognition of obstetric violence, a form of gender-based violence that violates the fundamental rights of a woman who requests medical assistance when giving birth or when having an abortion procedure (Muñoz, Moreno, Gil, & Velez, 2015). Obstetric violence research focuses on women's experiences during childbirth and does not describe patients' during abortion and postabortion care. To highlight the broad range of

experiences women face during abortion care, the term disrespect and abuse is used to describe the literature in this review.

In 2010, Bowser and Hill categorized disrespect and abuse into seven terms including physical abuse, discrimination based on patient attributes, abandonment of care, non-consented clinical care, non-confidential care, non-dignified care, and detention in health facilities (Bowser & Hill, 2010). Bowser and Hill's (2010) research was a landscape analysis of publications on disrespect and abuse in facility-based childbirth and was one of the first published categorizations of forms of disrespect and abuse. Freedman and Kruk expanded on this definition in 2014 and defined disrespect and abuse during childbirth as "interactions or facility conditions that local consensus deems to be humiliating or undignified, and those interactions or conditions that are experienced as or intended to be humiliating or undignified" (Freedman et al., 2014). Their definition focuses on a set of behaviors that all stakeholders (patients, families, providers, and administrators) agree constitutes disrespect and abuse (Freedman et al., 2014). By developing normative standards around disrespect and abuse, Freedman and Kurk present a theoretical diagram that can be used at various stakeholder levels to better understand what drives disrespect and abuse, how to challenge these normalized behaviors, and how to develop a response to this problem (Freedman et al., 2014). Freedman et al. (2014) aimed to create a more conceptual definition that included the importance of intent to disrespectful and abusive interactions. Most recently, Bohren and colleagues presented a new categorization that considered disrespect and abuse at both the individual level (between the woman and the provider) and at the institutional level (failures within the healthcare system) (Bohren et al., 2015). This categorization included physical, sexual, and verbal abuse, stigma, discrimination, failure to meet standards of care (lack of consent or confidentiality, painful procedures, neglect

and abandonment), poor rapport between patients and providers, and health system conditions and constraints (Bohren et al., 2015). Health system constraints include a lack of supplies and providers, as well as, a lack of infrastructure to ensure privacy, a lack of policies to stop inappropriate behaviors, facility cultures that encourage bribery, and unclear payment systems (Bohren et al., 2015). Laying out the work these authors have done to conceptualize and categorize disrespect and abuse in obstetric case, allows us to build on existing frameworks. Understanding women's experiences during abortion care through the lens of disrespect and abuse, as defined by scholars through the years, allows us to synthesize a complex body of literature for this review.

For the purposes of this research, disrespect and abuse refers to any form of disrespect, physical, verbal, and/or sexual abuse, stigma, neglect, breaches in privacy and/or confidentiality, discrimination, misinformation or a lack of information, procedures without consent, coercion, humiliation, condescension, mistreatment, undignified care, lack of standards in care, and experiences with protestors. Different forms of disrespect and abuse overlap and are not intended to be mutually exclusive (Bowser & Hill, 2010). Defining disrespect and abuse is especially complex for research on abortion care where stigma and disrespect are considered a normal, expected part of women's abortion care experience. Women's perceptions of disrespect and abuse vary importantly across cultures and contexts (Freedman et al., 2014). Furthermore, healthcare providers may not perceive their behaviors as disrespectful or abusive if they are learned behaviors from mentors or colleagues. Paternalistic healthcare, which is characterized by medical professionals making decisions with little regard for the patient or their values, may encourage disrespectful and abusive behaviors (Delaney, 2018). Paternalistic healthcare is so deeply ingrained and normalized at societal and institutional levels, that providers and patients

are often unaware of these behaviors and attitudes. Highlighting the effects of disrespectful and abusive behaviors that result from paternalistic healthcare is critical to improving the quality of abortion care and reducing the rate of unsafe abortions around the world. Disrespect and abuse within abortion and postabortion care is not only a driver of maternal mortality and morbidity, but also an urgent human rights issue.

Disrespect and abuse during abortion care represents a human rights violation that infringes on a woman's right to bodily integrity and autonomy. The disrespect and abuse outcomes listed above violate the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which was adopted in 1979 and states that all parties must "eliminate discrimination against women in the field of health care...including those related to family planning" (UN General Assembly, 1979). Women are guaranteed the right to sexual and reproductive health (SRH) services and that these services are provided free of coercion, discrimination, and violence (United Nations, 1995). For the past few decades, human rights bodies like the United Nations (UN) have advocated that States should reform any laws that criminalize or impede women's access to safe abortion services. States have a constitutional obligation to respect, protect, and fulfill women's right to life, right to non-discrimination, right to highest attainable standard of health, the right to be free from cruel, inhumane and degrading treatment, and the right to private, confidential information and education (UN General Assembly, 1979). It is imperative that healthcare institutions and staff uphold and protect the rights of their patients when providing care.

Additionally, disrespect and abuse can erode an individual or community's trust in the healthcare system subsequently leading to poorer health outcomes (Manning & Schaaf, 2011). For example, a study in Tanzania found that women who experienced disrespect and abuse

during childbirth were less intent to return to a facility to deliver another child (Kujawski et al., 2017). Women that deliver at home rather than at a facility have a higher risk of maternal morbidities and mortality (Costello, Azad, & Barnett, 2006). Also, women who have experienced poor quality of care are less likely to use health care systems or providers in the future for themselves and for their children (Kujawski et al., 2017). Eliminating disrespect and abuse during abortion care and ensuring high quality care is an important step in reducing unsafe abortions and improving health outcomes for women and girls around the world.

Stigma is a key disrespect and abuse outcome strongly associated with abortion care. Abortion stigma is a deeply ingrained, social process that can be defined 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). Abortion stigma persists in both developed and developing nations due to cultural, religious, and political values and beliefs. Kumar, Hessini, and Mitchell (2009) theorize that abortion stigma exists because of the way in which abortions challenge societal and cultural norms that are placed on women and their roles in motherhood. Abortion stigma manifests itself across all levels in society whether it is at the individual, community, institutional, or governmental level (Kumar et al., 2009). Furthermore, Cockrill and Nack (2013) described abortion stigma across three domains: felt stigma (negative judgments of others), enacted stigma (experiences of abortion-related prejudice or violence), and internalized stigma (personal negative beliefs). Little research has been done to understand felt and enacted abortion stigma at the institutional level and more specifically within the healthcare system. Although abortion providers face stigma associated with their own profession, many healthcare providers also perpetuate stigma towards patients' during abortion care. Providers may not support abortions due to personal values or may not understand reasons

why women seek abortion services. Some of the most common reasons women undergo an abortion include socioeconomic concerns, a desire to postpone childbearing, partner-related concerns and preferences such as the partner did not want the child or the partner was abusive, interference with future opportunities, and risks to personal health (Chae, Desai, Crowell, & Sedgh, 2017). However, providers often believe that women receiving abortions are irresponsible or ignorant for not using a contraceptive method or for contraceptive method failure. Abortion stigma perpetuated by providers within the formal healthcare system may influence women to seek unsafe abortion or illegal abortion services outside of the formal healthcare system (Appiah-Agyekum, 2018; DePineres et al., 2017; Gerdts et al., 2017; Jayaweera, Ngui, Hall, & Gerdts, 2018; Jewkes et al., 2005; Kebede, Middelthon, & Hilden, 2018; Mutua, Manderson, Musenge, & Ochieng Achia, 2018; Penfold, Wendot, Nafula, & Footman, 2018; Yegon, Kabanya, Echoka, & Osur, 2016). Reducing abortion stigma among healthcare providers is one important step in the fight to eliminate unsafe abortions and disrespect and abuse from abortion care.

Although the WHO recently released an official statement for preventing disrespect and abuse during childbirth, there is still little research on the prevalence and impacts of obstetric violence (World Health Organization, 2014). There is even less research on the forms of disrespect and abuse against women during abortion care when compared to research on disrespect and abuse against women during childbirth. This review aims to synthesize existing literature on experiences of disrespect and abuse during abortion care to better understand the scope of this issue to identify gaps in the existing literature.

Methods

The goal of this systematic review is to synthesize existing literature on firsthand abortion care experiences in order to comprehend the extent of this issue, how and where disrespect and abuse in abortion care has been measured, and the various forms of disrespect and abuse individuals face during abortion care. The search strategy, which combined Medical Subject Headings and text-based terms related to abortion and disrespect and abuse, was developed with the help of a reference librarian at Emory University **(Appendix Tables 1 & 2 for the Embase, Medline, and Pubmed search strategies)**. A search for peer-reviewed literature was performed using the databases PubMed, Embase, and Medline. Due to the scarcity of literature around disrespect and abuse in abortion care, grey literature documents were reviewed through Google Scholar.

Searches were not limited by language, publication type, or geography and included published literature from January 1, 1980 to February 19, 2019, the date the search was conducted. Many countries did not legalize abortion until the mid to late 1970s and did not begin to publish research on this topic until after that. Since our review is looking specifically at facility-based abortion care, we believe 1980 is an appropriate time point to begin looking at globally published research on this topic. The systematic review protocol was registered to PROSPERO International prospective register of systematic reviews on February 6, 2019 (CRD42019124667). Due to the heterogeneity of the types of studies reviewed, a meta-analysis was not conducted. This study did not undergo or require review by the Institutional Review Board (IRB).

After the search strategy was applied to the included databases, all citations were exported to EndNote (N=8,005) and duplicate citations were removed (N=6,717). All references

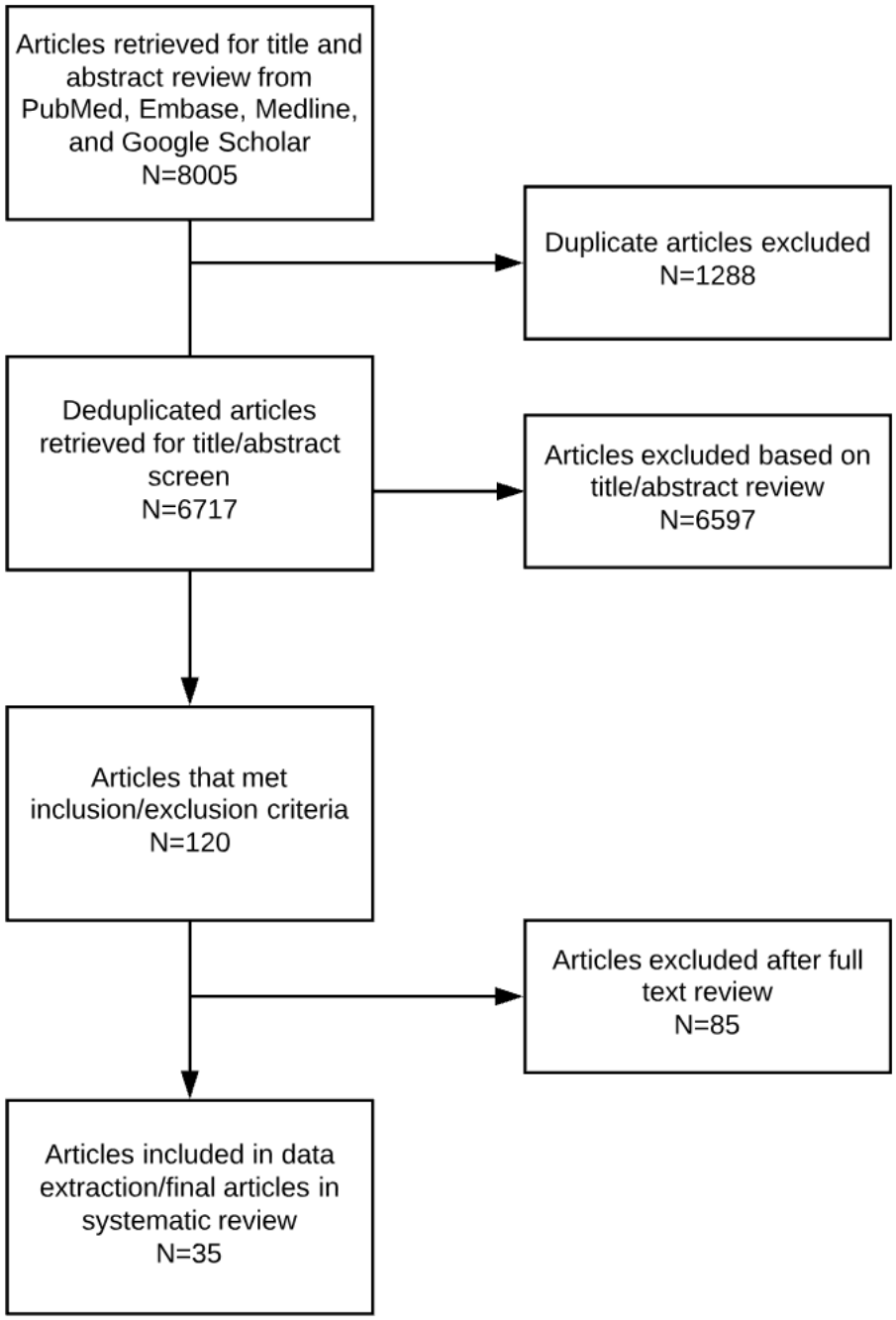
were then moved to the systematic review software DistillerSR (Evidence Partners, Ottawa, Canada) where a title and abstract screen was conducted. All titles and abstracts were independently screened by two reviewers (MM and HL) using the following inclusion criteria:

1. Published after January 1, 1980
2. Collected primary data related to abortion care
3. Measured a relevant disrespect and abuse outcome including disrespect, physical, verbal, and/or sexual abuse, stigma, neglect, breaches in privacy and/or confidentiality, discrimination, misinformation or a lack of information, procedures without consent, coercion, humiliation, condescension, mistreatment, undignified care, lack of standards in care, and protests on route to or coming from abortion-related care.

A total of 120 articles were chosen for full text review. Two reviewers independently read each full text to ensure all inclusion criteria were met (MM and HL). Of the 120 articles included in the full text review, 35 articles were included in the data extraction phase. A PRISMA flow diagram that depicts the different phases of the search and article inclusion process of a systematic review is shown below (**Figure 1**).

Relevant data was extracted by two independent reviewers (MM and HL) using a standardized form in DistillerSR, with the exception of a Portuguese-language article which was extracted by one reviewer (LM). Data extracted included: study setting, sample population, study design, detailed methodology, outcome measures, and sources of bias. Any discrepancies during the title/abstract screen, the full text screen, and data extraction were resolved by discussion between the reviewers until consensus was reached.

Figure 1. PRISMA flow diagram of search and article inclusion process



Results

Of the 35 articles selected for full-text review, six studies were conducted in the US, five in Kenya, three in the United Kingdom, two in Brazil, Sweden, Ethiopia, South Africa, Colombia, Mexico, Nepal, and one in Canada, Uganda, Australia, Turkey, Indonesia, Uruguay, and Ghana. These 17 countries (Figure 2) represent the only areas where we have publications that explore the forms and prevalence of disrespect and abortion care.

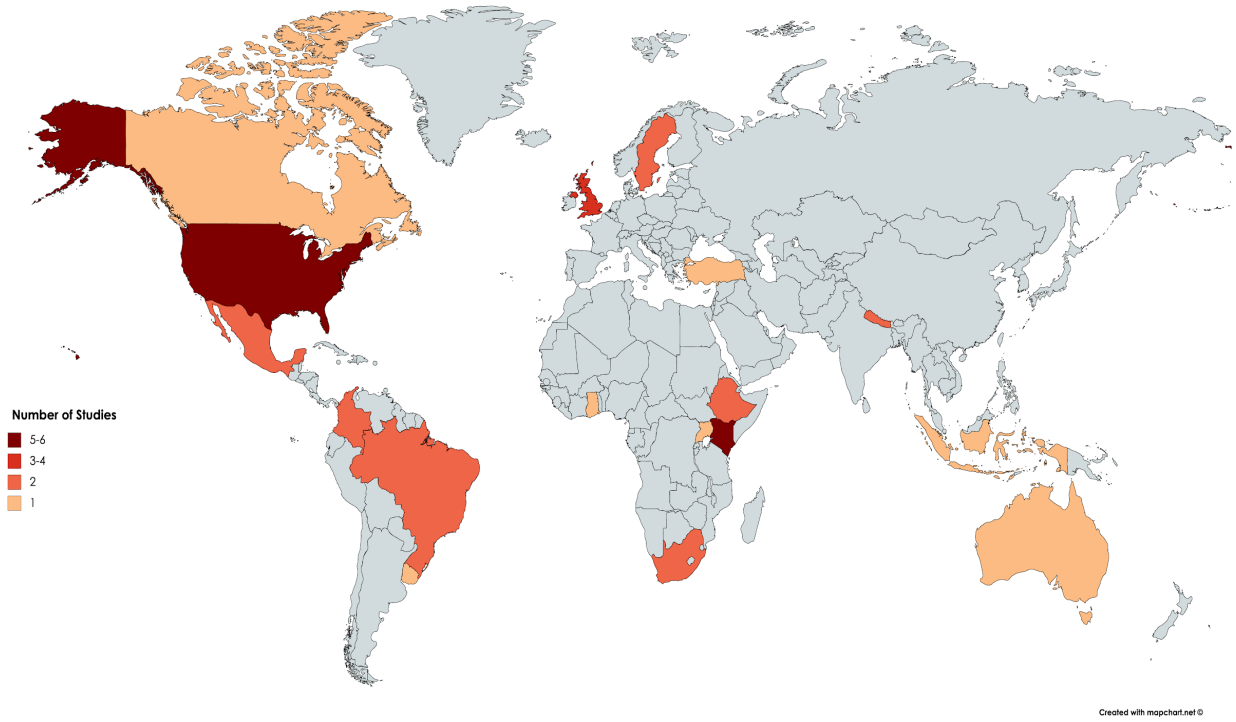


Figure 2. The global distribution of research on disrespect and abuse in abortion care

The earliest article reviewed was published in 2001 (Bennett, 2001) and the most recent articles were published in 2018. Twenty-eight of the 35 articles (80%) reviewed were published on or after January 1, 2015. Thirty-three articles were published in English, one article was published in Spanish, and one article was published in Portuguese. An overview of all articles included in this review can be found in **Appendix Table 3**. Twenty-eight articles reported experiences of stigma before or during abortion care, 19 articles reported misinformation or a

lack of information, 19 reported mistreatment or undignified care, 13 reported breaches in confidentiality or privacy, 13 reported disrespect, nine reported humiliation or condescension, eight reported neglect, six reported facing protesters outside of the abortion facility, six reported distrust of the healthcare facility, five reported verbal abuse, five reported discrimination, two articles reported on contraceptive coercion after abortion care, one article reported physical abuse, and one article reported medical procedures without consent. No articles included in this review reported any instances of sexual abuse. Finally, of the thirty-five articles reviewed, 25 used qualitative methods, including in-depth interviews (IDIs), focus group discussions (FGDs), participant observations, mystery client visits, life histories, and case studies, to explore the experiences of individuals receiving abortion care. Five articles used quantitative methods and five used a mixed-methods approach. Quantitative measures of disrespect and abuse in abortion care included strucutred and open questionnaires in six studies (Becker et al., 2011; Gerdts et al., 2017; Jewkes et al., 2005; McCallum, Menezes, & Reis, 2016; Mossie Chekol, Abera Abdi, & Andualem Adal, 2016; Regmi & Madison, 2010), validated questionnaires, including the Quality from the Patient's Perspective (QPP) questionnaire, the Hospital Anxiety Depression Scale (HADS), and Screen Questionnaire-Posttraumatic Stress Disorder, in two studies (Purcell et al., 2017; Wallin Lundell et al., 2015), validated surveys in one study using the Nationwide Abortion Patient Survey (Shellenberg & Tsui, 2012), and surveys in one study (Clyde et al., 2013). Details of the methodologies employed in each study are included in **Appendix Table 4.**

Disrespect and Abuse Experiences

Stigma

Abortion stigma was described in almost all of the articles reviewed. Individuals seeking abortions reported experiencing stigma at various levels during their abortion care. Whether

individuals faced stigma from protesters outside of the health facility or from health facility staff during their abortion care, many felt that stigma influenced the quality of care they received. In nine articles, women reported experiencing externalized stigma when entering or leaving a facility that provided abortions (Altshuler, Ojanen-Goldsmith, Blumenthal, & Freedman, 2017; Appiah-Agyekum, 2018; Cleeve, Faxelid, Nalwadda, & Klingberg-Allvin, 2017; Dennis, Manski, & Blanchard, 2015; Doran & Hornibrook, 2016; Jayaweera et al., 2018; Kebede et al., 2018; Margo et al., 2016; Yegon et al., 2016). In the Altshuler et al. (2017) article, a 31-year old woman recalled her experience receiving abortion care at the age of 15 in a Northern California abortion clinic. She reported that her doctor, at the time, made stigmatizing and judgmental comments after learning she was 15 years old. Looking back on her experience, this woman expressed disappointment with her care and felt that the judgment and stigma from her healthcare provider made her question her morals and her decision-making (Altshuler et al., 2017). Abortion stigma within the healthcare facility led some women to seek unsafe abortions. In one study in South Africa, a women reported that her first encounter with the healthcare staff at the abortion facility included nurses accusing her of being a murderer and asking her why she wanted to kill her baby, which led her to seek out a traditional healer for medication to self-abort (Jewkes et al., 2005). Other women experienced internalized stigma, especially when having to return to the same facility for a repeat abortion. Women who received abortion care at health centers in Alberta, Manitoba, New Brunswick, Ontario, or Quebec province in Canada were interviewed regarding their experiences seeking out a repeat abortion. One woman stated that she "felt very stupid for getting pregnant again and...very immature, irresponsible, and I felt really guilty", while another woman stated that she avoided going to the same provider by traveling to

another city for her abortion because she thought the provider would judge her (LaRoche & Foster, 2018, p. 330).

Restrictive national abortion laws and health facility policies can both stigmatize and perpetuate a culture of stigma. Participants in twelve studies in ten countries perceived facility policies as stigmatizing and negatively affected their abortion care experiences (Aiken, Broussard, Johnson, & Padron, 2018; Altshuler et al., 2017; Appiah-Agyekum, 2018; Becker et al., 2011; Brandi, Woodhams, White, & Mehta, 2018; Cárdenas et al., 2018; DePineres et al., 2017; Grindlay et al., 2017; Heller, Purcell, Mackay, Caird, & Cameron, 2016; MacFarlane, O'Neil, Tekdemir, & Foster, 2017; Madeiro, Rufino, & coletiva, 2017; Mutua et al., 2018). Ten abortion patients and ten abortion providers at a major public hospital in Montevideo, Uruguay were recruited to participate in a qualitative study to understand their opinions and attitudes towards abortion and Uruguay's national abortion law (Cárdenas et al., 2018). Several of the patients and healthcare providers that were interviewed felt that the legally required five-day reflection period before having an abortion was a stigmatizing policy that undermined the patient's decision-making power (Cárdenas et al., 2018). Similarly, a qualitative study of 30 women living in Northern Ireland felt that traveling to England, Scotland, or Wales to access legal abortion services was stigmatizing and restrictive. Due to Northern Ireland's extremely strict abortion laws, women have to either travel a far distance to receive legal abortion services or use misoprostol or mifepristone they access online to self-induce an abortion at home (Aiken et al., 2018). One 40-year old woman with two children and one 33-year old woman with three children felt that leaving their children or taking off work to fly to another location for an abortion was isolating, especially when they were unable to access post-abortion care or mental health support from healthcare providers at home due to stigma and the restrictive legal

environment (Aiken et al., 2018). In another study, a woman in her early 30s with three small children living in Istanbul, Turkey detailed a number of stigmatizing healthcare facility policies such as the requirement to have her husband accompany her, the lack of privacy, nurses shaming women for getting pregnant, and the lack of a hospital gown for the procedure (MacFarlane et al., 2017).

Misinformation/Lack of Information

Many individuals seeking abortion care deal with healthcare staff refusing to provide information or providing incorrect information. One article measured the quality and sufficiency of information provided to 402 women at three public sector sites (a general hospital, a maternity hospital, and a primary health center) offering abortions in Mexico City (Becker et al., 2011). (Becker et al., 2011)Women seeking a first trimester abortion were recruited to fill out a questionnaire regarding the quality of care they received. Although 90% of women felt they had received sufficient information, only 48% felt they had received information regarding post-abortion care and the emotions surrounding an abortion experience (Becker et al., 2011). Women also evaluated their care negatively when they did not receive information regarding the psychological and emotional aspects of an abortion (Becker et al., 2011). In a qualitative study that included seven FGDs with 71 women and girls aged 15 to 35 living in an informal settlement in Nairobi, Kenya who had participated in a local SRH organization's workshops, participants commonly cited a lack of information regarding safe abortion services as one of the main reasons women and girls undergo unsafe abortions (Jayaweera et al., 2018). Many participants reported ingesting concentrated leaves, solvents, cleaning solutions like bleach, and traditional herbal methods because they did not know of any safer methods (Jayaweera et al., 2018). Focus group participants also mentioned that information on the legal status of abortion

and how to access abortion within the health system would be extremely useful and might convince more women to access safe abortion services (Jayaweera et al., 2018).

Women frequently reported not receiving post abortion contraceptive counseling services from their healthcare provider, such as discussing available contraceptive options or the benefits/side effects associated with each contraceptive method (Brandi et al., 2018; Cleeve et al., 2017; Jayaweera et al., 2018; Kilander, Berterö, Thor, Brynhildsen, & Alehagen, 2018; McCallum et al., 2016; Penfold et al., 2018; Purcell et al., 2017). Research participants from seven studies in six countries expressed an unmet need for postabortion contraceptive counseling services, including the benefits, efficacy, and side effects associated with each method and contraceptive guidance on navigating different contraceptive methods based on a patient's values, needs, and reproductive goals (Brandi et al., 2018; Cleeve et al., 2017; Jayaweera et al., 2018; Kilander et al., 2018; McCallum et al., 2016; Penfold et al., 2018; Purcell et al., 2017). In a qualitative study of abortion patients recruited at nine Marie Stopes clinics in Western Kenya (N=22), three women reported that providers gave them no information regarding contraception after their abortion and that they would have liked to learn more about how contraception worked and how to prevent future pregnancies (Penfold et al., 2018). In another qualitative study of 13 women, aged 20-39, receiving abortion care from five hospitals in Sweden, a common theme participants reported was an unmet need for contraceptive information, including a lack of or unclear information regarding the positive and negative side effects of contraceptive methods (Kilander et al., 2018). One woman from this study stated "I don't want to use contraceptives with hormones and I was quite clear about it…but we did not talk about that at the visit." (Kilander et al., 2018, p. 105). Participants were also expected to have made a contraceptive decision before their conversation with the provider or were "forced to choose a certain method,"

which caused some women to end up choosing no contraceptive method at all (Kilander et al., 2018, p. 106). One woman in the study stated "I did not experience understanding and did not dare to talk about difficulties and fear regarding using hormones. I felt bad; I had already failed in using contraceptives" (Kilander et al., 2018, p. 105). Study participants mentioned that they would have preferred information detailing the contraceptive methods to take home and review before making a decision. Three women who did not receive adequate information regarding contraceptives left without choosing any method leaving them at risk for an unplanned pregnancy and a future repeat abortion. For example, "women described fears of negative side effects…they had little or no experience of contraceptive use and were influenced by friends who had negative experiences of contraceptive use. Their fear of hormones was rarely discussed during the contraceptive counseling and these women said that they declined contraceptives due to fear." (Kilander et al., 2018, p. 105). Another patient reported her experience with an abortion provider in South Africa where he inserted a hard needle into her, made her bleed, and then sent her home without any explanation or instructions (Jewkes et al., 2005). Providers commonly failed to explain procedures or to provide instructions on post-abortion care.

Coercion

While contraceptive counseling is an important part of quality, comprehensive abortion care, the counselor must be clear that contraceptive use is voluntary and the counseling should not become coercive or otherwise become a way to stigmatize women receiving abortion services. Two qualitative studies from Sweden and the US found instances where trained healthcare providers coerced patients to choose a contraceptive method following their abortion (Brandi et al., 2018; Kilander et al., 2018). Forty-two percent of 31 women having a first trimester abortion in a US academic medical center experienced some form of provider pressure

to choose a contraceptive method, with some women reporting that they understood contraception to be a "mandatory requirement" for every patient after an abortion (Brandi et al., 2018, p. 331). One study participant who felt her providers were pressuring her to choose contraception immediately after her abortion stated, "that's the least I'm thinking about. I feel depressed and sad because I'm doing this already, and then for you to just throw birth control methods in my mind...I feel like you're judging me because it's like you should have been on birth control" (Brandi et al., 2018, p. 332). Eight of the study participants (N=31) perceived their providers as pressuring them to choose long-acting reversible methods (LARCs) because of their efficacy, which made the patients less likely to choose LARCs (Brandi et al., 2018). Participants assumed that LARCs were the only contraceptives available because the provider "barely had mentioned any other method but that one" (Brandi et al., 2018, p. 332) and one participant reported that when "she declined method initiation, her provider was uncomfortable with offering time to decide, resulting in her feeling judged." ((Brandi et al., 2018, p. 333).

Mistreatment and Undignified Care

In several facilities, women reported mistreatment and/or undignified care from healthcare providers during abortion care. In a qualitative study conducted by purposively sampling patients treated for post abortion care from six of the 16 hospitals across Kenya, women reported abortion providers who failed to treat them with respect or courtesy or openly condemned them and their abortion decision (Mutua et al., 2018). In another qualitative study in Bogota, Colombia, women at a private non-profit health clinic were placed inside birthing rooms next to women in labor which facilitated provider mistreatment. An abortion patient placed next to an obstetric patient's provider told her, "Ironic, don't you see? She wants a baby and you're tossing one out." (DePineres et al., 2017, p. 6). Once doctors realized that a woman in the

birthing room was having an abortion rather than a delivery they refused to give pain medications, and neglected them (DePineres et al., 2017). In one study that included FGDs with married and unmarried women in Western Kenya, three of the five focus groups with younger women, aged 20 and below, expressed being treated poorly and insulted by doctors at health facilities for not using family planning or for having many children (Marlow et al., 2014). A few women interviewed at a public hospital in Brazil stated that their experiences were mainly negative because of how poorly the doctors treated them (McCallum et al., 2016). After performing an abortion, one participant reported that their doctor showed her all the blood removed from her uterus "as a kind of torture, implying: 'Oh, see what you have done to your child, everything is putrid inside'" (McCallum et al., 2016, p. 13). One woman in a study that conducted IDIs with 21 women at a private clinic in Bogota, Colombia, reported that police were called after healthcare providers accused her of seeking an illegal abortion and she had to make a statement to the police (DePineres et al., 2017, p. 6). After the police were called on another woman in the Colombia study, she had to travel to another hospital to seek services but the provider there stated he would not help her due to his "personal integrity" (DePineres et al., 2017, p. 6). In a similarly restrictive legal environment, a qualitative study conducted with postabortion care patients at a public hospital in Teresina, Brazil found that 22 women or 28.2% (N=78) reported that healthcare staff threatened to report them to the police (Madeiro et al., 2017). Several other articles included in this review described mistreatment and undignified care by providers during abortion care (Cárdenas et al., 2018; Gerdts et al., 2017; Heller et al., 2016; Kilander et al., 2018; Margo et al., 2016; Penfold et al., 2018; Puri, Vohra, Gerdts, & Foster, 2015; Regmi & Madison, 2010; Wallin Lundell et al., 2015; Yegon et al., 2016).

Breaches in Privacy or Confidentiality

A common theme from interview data with twenty-five unmarried women aged 18-24 who received post-abortion care due to an unsafe abortion in three hospitals and five health centers in Addis Ababa, Ethiopia was the importance of privacy and confidentiality during abortion care (Kebede et al., 2018). Similarly, a study that included twenty-six FGDs with community members in Machakos and Trans Nzoia counties in Kenya found that married and unmarried women were primarily concerned about their confidentiality when seeking legal abortion services. (Yegon et al., 2016). Women in eleven of the 26 focus groups reported refusing to go to local abortion clinics in Kenya because they feared breaches in privacy, especially with clinic staff that might recognize them or gossip about them (Yegon et al., 2016). Rather than risk a breach of confidentiality, women reported seeking out private, unskilled providers where they could receive traditional medicines to self-abort (Yegon et al., 2016). Breaches in privacy or confidentiality were quite common among individuals receiving abortion care around the world (Dennis et al., 2015; DePineres et al., 2017; McCallum et al., 2016; Wallin Lundell et al., 2015). One study conducted in Kathmandu, Nepal found that 88% of the 50 women recruited at a maternity hospital and medical college using a structured questionnaire were dissatisfied with the level of privacy and confidentiality they received during their abortion care (Regmi & Madison, 2010). Patients receiving abortion care in the US also faced a lack of privacy and confidentiality. A qualitative study of 21 active-duty US military servicewomen found that military healthcare facilities report a patient's pregnancy status to their commanding officers without informing the patient per military protocol (Grindlay et al., 2017). Three servicewomen reported that their commanders were informed about their pregnancies before they had a chance to inform them. Two servicewomen chose specific abortion methods that

allowed them to subvert the military protocol and maintain their privacy. For example, one air force officer chose surgical abortion without anesthesia rather than medication abortion because all prescription medications have to be reported to their commanding officer (Grindlay et al., 2017). She stated that although "it was an invasive procedure, it was more invasive to my privacy, and I preferred that they didn't know" (Grindlay et al., 2017, p. 247).

Disrespect and Neglect

Disrespect and neglect during abortion and postabortion care were reported by participants in 13 of the 35 studies (Bennett, 2001; Brack, Rochat, & Bernal, 2017; Cárdenas et al., 2018; DePineres et al., 2017; Kilander et al., 2018; MacFarlane et al., 2017; Margo et al., 2016; Marlow et al., 2014; McCallum et al., 2016; Mutua et al., 2018; Puri et al., 2015; Wallin Lundell et al., 2015; Yegon et al., 2016). Many disrespectful behaviors committed by healthcare providers occurred along with other abusive behaviors, such as neglect. One participant in a qualitative study at a private, non-profit clinic in Bogota, Colombia described how she was hospitalized for multiple days without receiving any abortion care and faced disrespect from all the doctors and nurses on shift, whether or not they were directly involved in her care (DePineres et al., 2017). In a qualitative study, participants receiving abortion care at three freestanding abortion clinics in different regions around South Carolina experienced disrespectful providers who either refused to refer them to an abortion provider or who simply wrote 'Planned Parenthood' down on a pamphlet, handed it to the patient, and left (Margo et al., 2016). No further follow-up information or support was given to these patients. Another qualitative study of 11 young women, aged between 15 and 24 years old, were interviewed at a public maternity hospital in Salvador, Brazil described how health professionals referred to abortion patients as "curettes" rather than their names (McCallum et al., 2016, p. 9). Referring to patients as the

instrument used for curretage is disrespectful, stigmatizing, and dehumanizing. Two studies conducted at a public maternity hospital in Brazil and at a government hospital in Nepal found that healthcare providers chose to perform abortions at the end of the day, prioritizing women in labor and forcing women to wait hours and even sometimes days in agonizing pain and emotional distress before receiving care (McCallum et al., 2016; Puri et al., 2015).

Protests

One study conducted at three public sector clinics that provide abortion services in Mexico City found that 67% of patients (N= 402) saw anti-choice protesters before entering the facility and of those patients 62% were bothered by these protesters (Becker et al., 2011). Protesters outside of clinics affected participants' perception of the quality of abortion care. In another qualitative study, women who have experienced both birth and abortion in Northern California were recruited from the community rather than medical facilities (Altshuler et al., 2017). One patient interviewed in this study reported facing aggressive protesters outside of an abortion clinic in Northern California where groups of women were holding images of dismembered fetuses, religious icons, and declaring "May God forgive you for murdering your child" (Altshuler et al., 2017, p. 112). This experience affected the patient's quality of care stating she "felt judged…felt like everything I was doing was wrong" and ultimately stating that she wished her care had been provided differently because the "aggressive anti-abortion messaging outside the clinic" left her questioning her morals and her decision-making (Altshuler et al., 2017, p. 112). In a qualitative study of 27 women aged 24-46 in Massachusetts (MA), US, one participant reported arriving at the abortion clinic in Boston and seeing so many protesters that she travelled to a different clinic in Massachusets rather than enter the clinic with the protesters (Dennis et al., 2015). (Dennis et al., 2015)While most of the literature on the effect of

protesters on abortion access and care comes from the US, one qualitative study that interviewed 13 women aged 18-46 who received an abortion in rural New South Wales, Australia found that (Doran & Hornibrook, 2016) two women faced protesters on the way to an abortion clinic and felt these experiences and public stigma intensified the secrecy and shame they already felt (Doran & Hornibrook, 2016).

Mistrust/Distrust

Although mistrust and/or distrust in healthcare facilities and providers was not commonly expressed by women accessing abortion services, five articles explored these attitudes and beliefs (Aiken et al., 2018; Gerdts et al., 2017; Kebede et al., 2018; Mossie Chekol et al., 2016; Yegon et al., 2016). One qualitative study of 25 young, unmarried women accessing post-abortion care in three hospitals and five health facilities around Addis Ababa, Ethiopia identified the theme of uncertainty around the safety of their abortion services in in depth interviews (Kebede et al., 2018). In the same study, three women reported distrusting their clandestine providers, but felt an unsafe abortion was less important than the social implications of having a premarital or unplanned pregnancy (Kebede et al., 2018). Study participants did not trust that the abortion clinic staff would maintain their privacy and confidentiality which lead them to seek out unsafe abortion providers outside of the formal health system. One healthcare provider stated that women "don't come here because they are afraid of being seen in this place...they are also afraid of us [the staff]. We live in the same community. They know us and we know them and their families." (Kebede et al., 2018, p. 201).

Verbal Abuse and Humiliation/Condescension

Several of the stigmatizing and disrespectful comments described above could also be classified as verbal abuse. Similarly, many of the disrespectful and abusive behaviors displayed

by healthcare providers could be seen as humiliating and/or condescending to patients. Referring to patients as the instrument used for an abortion could be considered verbal abuse, as it denies individual's their rights as a human being and reduces them to their medical procedure (McCallum et al., 2016). This type of verbal abuse reflects a paternalistic healthcare system that condones the humiliating/condescending remarks and treatment that push women away from healthcare facilities and legal abortion services. A mixed-methods study conducted at three hospitals in Gauteng Province, South Africa found that seventeen percent of women (N=46) refused to use legal services because they expected to face verbal abuse, including rude insults and condescending comments from nurses and hospital staff (Jewkes et al., 2005). One 30-year old participant in the study described her experience at a local abortion clinic where a doctor interrogated her about her baby's rights and questioned her relationship status and the father's knowledge and support of the abortion (Jewkes et al., 2005). These types of abusive comments can be traumatic and emotionally exhausting for a patient who is already physically and emotionally vulnerable. Facility-level policies that place abortion patients in the maternity ward are disrespectful and humiliating. A woman receiving abortion care at a public maternity hospital in Salvador, Bahia, Brazil told investigators, "it was embarrassing to be with new mothers, since the people visiting them usually asked: 'Where is your baby?" (McCallum et al., 2016, p. 14). She highlighted how hard it was to be around new mothers who were discussing ways to bathe and feed their newborns, and instead thought it would have been more appropriate to be around other women who had abortions (McCallum et al., 2016).

Physical Abuse and Medical Procedures without Consent

Only one article reported any form of physical abuse during abortion care (Madeiro et al., 2017). In that study, twenty of the 78 women or 26% who had had an induced, unsafe, or illegal

abortion and received postabortion care at a public hospital in Teresina, Piaui, Brazil were not offered or were refused pain medication during their abortion care (Madeiro et al., 2017). Four women at the same hospital experienced procedures without consent where providers gave blood transfusions without any explanation or consent (Madeiro et al., 2017). Ten women reported that providers would touch their vagina without a prior explanation or any consent and one woman even reported undergoing a hysterectomy without any prior discussion with the healthcare provider (Madeiro et al., 2017).

Discrimination

Five of the 35 articles included in the data extraction measured women and girls' experiences of discrimination against women during their abortion care. These studies found that vulnerable populations, including adolescents; young, unmarried women; women who have had multiple abortions; and women with mental health issues were more likely to experience discrimination during abortion care (Bennett, 2001; MacFarlane et al., 2017; McCallum et al., 2016; Wallin Lundell et al., 2015). One quantitative study surveyed 708 women aged 15-52 receiving abortion care before the end of the 12th gestational week at six obstetrics and gynecology departments in Sweden (Wallin Lundell et al., 2015). This study found that 53 women or 21% of women aged 24 and younger (N=250) reported their abortion care deficient when compared to 63 women or 14% of women aged 25 and above (N=458) (Wallin Lundell et al., 2015). These younger women reported deficiencies in respectful treatment from healthcare staff, good care and support, and effective analgesia (Wallin Lundell et al., 2015). In another qualitative study of 14 women aged 18 or older who received abortion care at a public hospital in Instanbul, Turkey, one young university student reported perceived discriminatory treatment liking having to pay higher prices and receiving lower quality care because of her age and

marital status (MacFarlane et al., 2017). She told the interviewer that "personnel at the hospital accused her of lying about her age and made her show three pieces of ID before accepting that she was over 18. The staff also publicly discussed that she was unmarried and Yasemin believes that she would not have had to pay had she been married." (MacFarlane et al., 2017, p. 158). One unmarried woman, aged 24, that was interviewed in this study stated "There is no law that states that women can't be in a sexual relationship before marriage, but the moral, unwritten laws [make] it difficult to seek and receive reproductive health care." (MacFarlane et al., 2017, p. 157) In a third qualitative study drawing on ethnographic fieldwork (IDIs, life histories, and case-studies) of 35 young, single women aged between 16 and 24 living in Mataram, Lambok, East Indonesia, women faced discrimination related to their age and marital status (Bennett, 2001). One 20 year old, single, Muslim woman stated that a local abortion doctor lectured her before offering care "on the immorality of her behavior and warned her of having sex outside marriage" (Bennett, 2001, p. 40). The eight healthcare providers interviewed in the study all expressed beliefs that married women receiving abortion care should be treated with compassion because they are prioritizing their family's welfare, while unmarried women should be warned about the immorality of premarital sex and the sin of abortion (Bennett, 2001).

Discussion

In this review, we synthesized published evidence from qualitative, quantitative, and mixed methods studies on disrespect and abuse in abortion and postabortion care. This systematic review highlighted several deficiencies in the quality of abortion care around the world. The Global Doctors for Choice Network outline a series of determining factors for violence during abortion in their Obstetric Violence and Abortion: Contributions to the Debate in Colombia report (Muñoz et al., 2015). These determinants include legislative, institutional, community, and individual mechanisms. Applying their conceptual framework to this review allows us to explore the different institutional, societal, and legislative factors that influence disrespectful and abusive behaviors and the resulting health implications to individuals seeking abortion care.

Societal Factors

Disrespect and abuse during abortion care operates on both the individual and societal level. Disrespectful and abusive behaviors from healthcare providers are influenced by social and cultural norms. Social stigma and discrimination around premarital sex and abortion was identified in a number of studies. Discriminatory practices and attitudes against younger, unmarried women are evident around the world and reflect deeply ingrained societal and cultural beliefs about premarital sex. Healthcare providers perpetuated social stigma around sexual activity and abortion through judgmental comments and disrespectful practices towards women, while protesters outside abortion clinics used religious and moral justifications to prevent women from receiving abortion care and to further stigmatize abortion patients. The normalization of mistreatment in abortion care reflects established beliefs around abortion. Lack of education around sex, abortion, and women's rights operates on the societal level to normalize

mistreatement and abuse in abortion care. Many research participants were not aware of their rights to legal abortion services or their rights to bodily autonomy and empowered decision making around pregnancy and contraception. Educating women and girls on these rights and providing them with information on where to access safe abortion or postabortion services is essential to reducing the rate of unsafe abortions and abortion-related morbidity and mortality (Guttmacher Institute, 2006; Haddad & Nour, 2009; Roberts, Fuentes, Berglas, & Dennis, 2017). Community-wide discussions and educational campaigns around the importance of family planning can reduce societal stigma around abortion and increase use of family planning services which influences the disrespect and abuse of abortion patients in the healthcare system (Guttmacher Institute, 2006; Wegs, Creanga, Galavotti, & Wamalwa, 2016).

Institutional Factors

The level of training and knowledge around quality abortion care differs importantly across healthcare institutions and their providers. Participants described hospital staff who neglected them for several days and institutional policies that placed women receiving abortion care in the maternity ward, which are both disrespectful and humiliating and may reflect insufficient staffing or infrastructure. Healthcare institutions, like those in Colombia and Brazil, do not prioritize creating a private space for women to request and receive abortion services. Paternalistic health care was deeply embedded in institutions around the world from Boston, Massachusetts to Lombok, Indonesia. Doctors and nurses often undermined women's decision-making and questioned their morals and values, especially towards younger and unmarried women. Policies that enforce a certain standard of care for healthcare staff who provide abortions would be useful in shifting paternalistic healthcare towards patient-centered care (Delaney, 2018). Patient-centered care, including abortion and postabortion care, should focus on

upholding a patient's basic human rights, including their rights to bodily autonomy, highest quality care, and privacy (Entwistle, Carter, Cribb, & McCaffery, 2010). Because of the societal stigma that surrounds abortion, women in countries like the United States and Kenya will go to great lengths to maintain the privacy of their abortion (Grindlay et al., 2017; Jayaweera et al., 2018). Healthcare facilities should ensure their policies and staff maintain the privacy and confidentiality of all of their patients. Women undergoing abortion care want to be affirmed as moral decision-makers, determine their involvement in their care, and receive care that is provided discreetly and judgment-free (Altshuler et al., 2017). In order to provide quality abortion care, institutions must abide by these tenets and implement policies and education programs to train and support healthcare staff to provide safe and ethical comprehensive abortion care.

Legislative Factors

Legal access to abortion varied importantly across the 17 countries included in this review. Certain countries included in this study (Ireland, Uganda, Indonesia, Brazil, Ethiopia, and Kenya) ban abortion outright or only permit abortions to save the woman's life/preserve her physical health (**Table 4**). In legally restrictive environments, abortions occur as frequently as they do in countries with fewer or no legal restrictions to abortion access, 37 to 34 per 1,000 women respectively (Singh et al., 2018). Forty-two percent of WRA live in the 125 countries, located mainly in developing regions, where abortion is highly restricted (Singh et al., 2018). These restrictive laws influence women to seek out unsafe, illegal abortions outside of the health system. International health organizations, like the WHO and the United Nations Population Fund (UNFPA), have introduced guidelines for countries to reduce barriers to safe abortion services but societal values that condemn abortion persist. Some countries like the US, that have

less restrictive abortion laws, have increasingly introduced measures that restrict access to abortions like targeted regulation of abortion providers (TRAP) laws (Guttmacher Institute, 2019). TRAP laws disproportionately affect low-income women, women of color, and women living in rural areas in the US. Certain US states have approved TRAP laws that require abortion clinics to have certain hallway widths or force abortion providers to have admitting privileges to the nearest hospital (Guttmacher Institute, 2019). Many of these requirements are medically unnecessary and reduce the quality of abortion care women receive (Austin & Harper, 2018). National laws and restrictive policies perpetuate the stigma around abortion and encourage disrespectful and abusive behaviors from healthcare providers (Aiken et al., 2018; Altshuler et al., 2017; Appiah-Agyekum, 2018; Becker et al., 2011; Brandi et al., 2018; Cárdenas et al., 2018; DePineres et al., 2017; Grindlay et al., 2017; Heller et al., 2016; MacFarlane et al., 2017; Madeiro et al., 2017; Mutua et al., 2018).

Although the WHO acknowledged the extent of disrespect and abuse against women in obstetric care and encouraged countries to implement laws that address this issue in 2014 (World Health Organization, 2014), most countries do not have a defined set of policies to prevent this form of violence during abortion care (Muñoz et al., 2015). There is little to no legal recourse or compensation for victims of disrespect and abuse and a lack of accountability for healthcare providers that violate their patient's human rights (Muñoz et al., 2015). More countries need to propose and enforce laws that reject any form of violence against women, including disrespect and abuse in SRH services. National and local laws and institutional policies must uphold women's basic rights to access safe, quality healthcare and must hold healthcare providers accountable for disrespectful and abusive treatment of women seeking abortions and postabortion care.

Health Implications

Negative experiences with healthcare facilities and healthcare providers led women to seek out unsafe abortion services, a significant contributor to maternal mortality and morbidity, especially in developing nations (World Health Organization, 2011). In order to reach Sustainable Development Goal 3, which aims to ensure healthy lives and promote well-being for all, countries must prioritize access to safe, confidential, quality abortion services. The National Academies of Sciences, Engineering, and Medicine report of quality abortion care in the US (2018) defines high quality abortion care as providers trained in education, counseling, informed consent, skilled clinical assessment, pain and side effects management, identification and management of serious complications, and contraceptive counseling and provision (2018). Quality abortion care should also incorporate respectful providers that protect and uphold patient's rights, privacy, and decision-making processes without judgment.

Disrespectful, abusive, and stigmatizing behaviors and attitudes experienced during abortion care affected women's emotional and psychological health and well-being. For many women, undergoing an abortion can cause emotional distress and it is critical that healthcare staff provide emotional support and resources based on individual patient needs (Cleeve et al., 2017; Clyde et al., 2013; Dennis et al., 2015; Grindlay et al., 2017; Jayaweera et al., 2018; Marlow et al., 2014; McCallum et al., 2016; Mutua et al., 2018; Penfold et al., 2018; Purcell et al., 2017; Regmi & Madison, 2010). Some studies found that women appreciated staff who talked to them about the emotional and psychosocial impacts of an abortion (Altshuler et al., 2017; Becker et al., 2011; Cárdenas et al., 2018; Dennis et al., 2015; DePineres et al., 2017; Doran & Hornibrook, 2016; Kilander et al., 2018; MacFarlane et al., 2017; Margo et al., 2016; Mutua et al., 2018; Penfold et al., 2018; Wallin Lundell et al., 2015). Restrictive policies can also be

detrimental to a woman's emotional health, especially if they are denied access to an abortion. Continuing an unwanted pregnancy can be emotionally taxing and may prolong women's contact with violent partners (Roberts et al., 2014). Developing evidence- and rights-based post-abortion counseling could be one way to improve the quality of abortion care (Gemzell-Danielsson, Kopp Kallner, & Faundes, 2014; RamaRao, Lacuesta, Costello, Pangolibay, & Jones, 2003).

Recommendations

Changes at the institutional, societal, and legislative levels are needed to eliminate disrespect and abuse in abortion care. Education on the risks of unsafe abortion and women and girls' rights to quality sexual and reproductive healthcare is a critical part of addressing abortion-related stigma and other forms of disrespect and abuse. Educating and training providers on patient-centered abortion and postabortion care is essential to improving the quality of care in healthcare institutions. Abortion values clarification and attitude transformation (VCAT) workshops should be held with community leaders, religious leaders, policy makers, and health workers around the world to shift stigmatizing attitudes and behaviors (Turner, Pearson, George, & Andersen, 2018). A systematic review of attitudes and behaviors of maternal health care providers towards patients performed by Mannava et al. (2015) found that negative attitudes towards women seeking abortions held by physicians in low and middle-income countries suggests a need for long-term investments in infrastructure, education, and communication skills in order to prevent disrespectful and abusive behaviors towards abortion patients in the next generation of healthcare workers.

Research participants in a number of studies highlighted the need for more social support during abortion care. Training providers, creating support groups, and adding mental health resources are ways to address the emotional and psychosocial aspects post-procedure. Also,

protections for marginalized or at risk populations like adolescents, LGBTQ individuals, low-income women, women of color, and sex workers should be put in place and enforced in all healthcare institutions. Marginalized populations not only have a harder time accessing SRH services but also have a heightened risk of experiencing disrespect and abuse during sexual and reproductive healthcare (Ngilangwa et al., 2016). This review found that younger, unmarried women, women with mental health issues, and women undergoing a repeat abortion may be at a higher risk of experiencing disrespect and abuse in abortion care. These disparities should be addressed through policies and education. Women want to be respected and trusted, regardless of their age or marital status, and healthcare providers must support and encourage them to be the decision-makers of their bodies and lives.

The WHO released guidelines in 2015 stating that healthcare facilities should offer accurate and clear contraceptive education and counseling to women as an element of quality post-abortion care (World Health Organization, 2015). Quality post-abortion contraceptive counseling must be voluntary and should always incorporate the patient's values and needs. The provision of contraception is a key component of quality abortion care but providers should consider the most appropriate time to offer contraceptive options and counseling to women based on the patient's preference and their emotional health and well-being. Contraception must be voluntary and healthcare professionals should provide clear, judgment-free information on the range of options to each woman, regardless of abortion history, race, ethnicity, marital status, age, etc (The American College of Obstetricians and Gynecologists, 2018).

Limitations

This review synthesized findings from 35 studies in 17 countries. Given the subjective nature of this topic, many experiences may have been classified differently based on the setting of the study and the research team's perceptions of disrespect and abuse outcomes. The disrespect and abuse experiences classified in the results of this review are not mutually exclusive and may overlap or have been characterized differently across studies. However, by comparing and contrasting data extraction among two independent reviewers we can minimize some of the subjectivity associated with this process. There are also several sources of bias within the articles reviewed, including social desirability bias, recall bias, and sampling bias. Three articles interviewed women 5-15 years after their abortion, which can impact the accuracy of their reports of disrespect and abuse (Doran & Hornibrook, 2016; LaRoche & Foster, 2018; MacFarlane et al., 2017). Several studies conducted their interviews or questionnaires on-site at the facility so it is likely possible that social desirability bias occurred. Women may not have felt comfortable reporting their negative experiences with a research team that they perceive as working for the same healthcare facility where they faced disrespect and abuse. Also, this review only considered facility-based abortion care experiences and does not look at disrespect and abuse that might occur with traditional healers or pharmacy staff that provide medication abortion to women inducing an abortion. Most of the research only considers women who overcame physical, financial, and emotional barriers to receive an abortion. This research excludes women who were turned away and either continued on with their pregnancy or underwent an unsafe abortion outside of a health facility. It is also important to note that, while we use the term "women" to describe abortion care experiences in this review, female-to-male transgender men also experience unplanned pregnancies and access abortion and postabortion

care (Light, Wang, Zeymo, & Gomez-Lobo, 2018). Published literature on disrespect and abuse focuses on the experiences of women and girls; the exclusion of transgender men and non-binary individuals from this literature limits our understanding of the scope and forms of disrespect and abuse in abortion care and is both a limitation of this review and a recommendation for future research.

Conclusions

This systematic review provides a comprehensive search of the literature around disrespect and abuse women face during abortion care. This review provides evidence on the prevalence of research on this topic and identifies the different forms of disrespect and abuse in abortion care. More research needs to be conducted to quantify and describe disrespect and abuse during abortion and postabortion care. Moving forward, we recommend that legislative policies at national and institutional levels are implemented that reduce the stigma and violence associated with abortions. Healthcare institutions must promote and protect women's rights to safe, quality abortion care and healthcare providers should be held accountable for violating these rights. Shifting away from paternalistic health care towards patient-centered care will improve women's experiences with healthcare providers and reduce the risk of unsafe abortions. Future research that focuses on disrespect and abuse in abortion care and incorporates marginalized populations should be conducted.

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Appendix

Table 1: Embase and Medline Search Strategy

Search conducted: February 19, 2019

	#	Searches	Results
ABORTION	1	'unsafe abortion':ti,ab OR 'unsafe abortions':ti,ab OR 'induced abortion':ti,ab OR 'induced abortions':ti,ab OR 'legal abortion':ti,ab OR 'legal abortions':ti,ab OR 'abortion':ti,ab OR 'abortions':ti,ab OR 'spontaneous abortion':ti,ab OR 'spontaneous abortions':ti,ab	65.415
DISRESPECT & ABUSE	2	'disrespect':ti,ab OR 'disrespects':ti,ab OR 'disrespectful':ti,ab OR 'disrespected':ti,ab OR 'respectful':ti,ab OR 'abuse':ti,ab OR 'abused':ti,ab OR 'abusive':ti,ab OR 'abuses':ti,ab OR 'neglect':ti,ab OR 'neglected':ti,ab OR 'neglects':ti,ab OR 'confidentiality':ti,ab OR 'confidential':ti,ab OR 'non-confidential':ti,ab OR 'informed consent':ti,ab OR 'violence':ti,ab OR 'violent':ti,ab OR 'humiliation':ti,ab OR 'humiliate':ti,ab OR 'condescend':ti,ab OR 'condescending':ti,ab OR 'condescension':ti,ab OR 'intimidation':ti,ab OR 'intimidate':ti,ab OR 'yelling':ti,ab OR 'yell':ti,ab OR 'non dignified':ti,ab OR 'non-dignified':ti,ab OR 'undignified':ti,ab OR 'discrimination':ti,ab OR 'discriminate':ti,ab OR 'abandon':ti,ab OR 'abandonment':ti,ab OR 'detention':ti,ab OR 'human rights':ti,ab OR 'maltreatment':ti,ab OR 'mistreatment':ti,ab OR 'humanization':ti,ab OR 'humanized':ti,ab OR 'dehumanized':ti,ab OR 'dehumanization':ti,ab OR 'dignified':ti,ab OR 'undignified':ti,ab OR 'stigma':ti,ab OR 'dignity':ti,ab OR 'bullying':ti,ab OR 'bully':ti,ab OR 'protest':ti,ab OR 'protests':ti,ab OR 'protested':ti,ab OR 'protesting':ti,ab OR 'protestation':ti,ab OR 'protestations':ti,ab	600,713
	3	#1 AND #2	2542

Table 2: PubMed Search Strategy

Search conducted on February 19, 2019

	#	Searches	Results
ABORTION	1	"abortion" [tiab] OR "abortions" [tiab] OR "unsafe abortion" [tiab] OR "unsafe abortions" [tiab] OR "abortion, induced" [MeSH] OR "induced abortions" [tiab] OR "legal abortion" [tiab] OR "legal abortions" [tiab] OR "abortion, spontaneous"[MeSH] OR "spontaneous abortion" [tiab]	90517
DISRESPECT AND ABUSE	2	"disrespect"[tw] OR "disrespects"[tw] OR "disrespectful"[tw] OR "disrespected"[tw] OR "respectful"[tw] OR "abuse"[tw] OR "abused"[tw] OR "abusive"[tw] OR "abuses"[tw] OR "neglect"[tw] OR "neglected"[tw] OR "neglects"[tw] OR "confidentiality"[tw] OR "confidential"[tw] OR "non-confidential"[tw] OR "informed consent"[tw] OR "violence"[tw] OR "violent"[tw] OR "humiliation"[tw] OR "humiliate"[tw] OR "condescend"[tw] OR "condescending"[tw] OR "condescension"[tw] OR "intimidation"[tw] OR "intimidate"[tw] OR "yelling"[tw] OR "yell"[tw] OR "non dignified"[tw] OR "non-dignified"[tw] OR "undignified"[tw] OR "discrimination"[tw] OR "discriminate"[tw] OR "abandon"[tw] OR "abandonment"[tw] OR "detention"[tw] OR "human rights"[tw] OR "maltreatment"[tw] OR "mistreatment"[tw] OR "humanization"[tw] OR "humanized"[tw] OR "dehumanized"[tw] OR "dehumanization"[tw] OR "dignified"[tw] OR "undignified"[tw] OR "stigma"[tw] OR "dignity"[tw] OR "bullying"[tw] OR "bully"[tw] OR "protest" [tw] OR "protests" [tw] OR "protested" [tw] OR "protesting" [tw] OR "protestation" [tw] OR "protestations" [tw]	613665
	3	#1 AND #2	5225