Article

Youth & Society
1–25

DOI: 10.1177/0044118X211011015
journals.sagepub.com/home/yas
SAGE

Understanding the Abortion Experiences of Young People to Inform Quality Care in Argentina, Bangladesh, Ethiopia, and Nigeria

Laura E. Jacobson[1,2], Ana Maria Ramirez[2], Chiara Bercu[2], Anna Katz[2], Caitlin Gerdts[2], and Sarah E. Baum[2]

Abstract

Young people face social and structural barriers when accessing abortions. High-quality, sexual and reproductive healthcare is needed; however, literature on youth-informed abortion services is limited. This study assesses accounts of youth who obtained an abortion in Argentina, Bangladesh, Ethiopia, and Nigeria and provides recommendations to improve person-centered aspects of abortion quality. We analyzed 48 semi-structured interviews with clients recruited from clinics, safe abortion hotlines, and patent and proprietary medicine vendors. We coded transcripts and conducted a thematic analysis. The mean age was 21 years (range 16–24), and the majority had a first trimester, medication abortion. Prominent themes included access to information; privacy; stigma associated with age or marital status; the decision-making process; and comfort and rapport with providers. Youth-centered abortion care should anticipate the distinct needs of younger clients. Supportive providers have an important role in

[1]OHSU-PSU School of Public Health, Portland, OR, USA
[2]Ibis Reproductive Health, Oakland, CA, USA

Corresponding Author:
Laura E. Jacobson, OHSU-PSU School of Public Health, 181 SW Sam Jackson Park Road, Mail Code GH230, Portland, OR 97239, USA.
Email: jacobsonlaura@gmail.com

offering a non-judgmental service that makes young clients feel comfortable and prepared.

Keywords
health, abortion, quality of care

Introduction

Youth aged 15 to 24 (United Nations, 1981) around the globe have the right to access comprehensive sexual and reproductive healthcare including abortion services (World Health Organization, 2018b). The possibility of unwanted pregnancies is rising worldwide as the age of first sex is declining and youth are aspiring for higher levels of education and postponing marriage (Singh et al., 2018). Each year approximately 10 million unintended pregnancies occur among adolescents in developing regions (World Health Organization, 2020) and more than half of these pregnancies end in abortion (Darroch et al., 2016). Induced abortion can be completed safely and effectively through a range of gestational ages using medications, including a combination of mifepristone and misoprostol or misoprostol alone, or surgical options such as uterine aspiration or dilation and evacuation (Kapp & Lohr, 2020). Estimates of age-specific abortion rates for countries with available data are 21.4 per 1,000 for women aged 20 to 24, the highest abortion rate of any age-group (Singh et al., 2018).

Despite high rates of abortion, youth often face social and structural barriers when accessing abortion services (Braeken & Rondinelli, 2012; Salam et al., 2016). Travel and system navigation issues (Jerman et al., 2017); financial constraints (Singh et al., 2018); and lack of knowledge of legal restrictions (Coast & Murray, 2016; Gelaye et al., 2014); as well as confidentiality concerns and fear of judgment (Rehnström Loi et al., 2015; Warenius et al., 2006) complicate youth's ability to receive safe abortion services and the impact of these barriers increase when encountered simultaneously (Jerman et al., 2017). These challenges assume special importance among youth as they may face compounding perceived or experienced stigma with providers, family, or community members related to the social norms of sex, pregnancy, and abortion (Levandowski et al., 2012; Millar, 2020; Nyblade et al., 2017; Woog et al., 2015). Further, adolescents are less willing to disclose abortion decisions to others, thus limiting opportunities for social support (Coleman-Minahan et al., 2020). Given the barriers and stigma, young people may be less likely to have accurate information about safe abortion or use less-safe

methods that carry a higher risk of complications (Gelaye et al., 2014; Singh et al., 2018).

An increasing body of evidence has demonstrated a need to develop, implement, and evaluate youth-friendly sexual reproductive health services and education in order to address the unique needs and preferences among adolescents and young people (Chandra-Mouli et al., 2015; Gelaye et al., 2014; Mazur et al., 2018; Salam et al., 2016). Much of this literature focuses primarily on reproductive health education (Brieger et al., 2001; Kim & Free, 2008), contraceptive access (Fikree et al., 2017; Vahdat et al., 2013), and sexually-transmitted infection testing and prevention (Biddlecom et al., 2007). Studies have shown that youth tend to use more sexual and reproductive health services when outreach activities occur; the services are free; and the professionals involved are young, nonjudgmental, and hold a positive attitude toward young people's sexuality (Braeken & Rondinelli, 2012; van Reeuwijk & Nahar, 2013). Additionally, youth prefer services that are not necessarily separate from the overall health system, but where existing infrastructure is better organized to address their needs (Barden-O'Fallon et al., 2020; Zuurmond et al., 2012). While many of these studies indicate the need to expand youth-friendly sexual and reproductive health services to include abortion care, few draw conclusions on the characteristics of youth-informed abortion services. Quality abortion care will only be fully realized when improvement efforts are centered around the client and young people are represented in such efforts.

While the World Health Organization (WHO) recently published guidelines for the medical management of abortion (World Health Organization, 2018a), no globally accepted consensus exists on how to measure abortion quality (Dennis et al., 2017). The Institute of Medicine's Framework of Health Systems Quality defines quality as safe, effective, timely, efficient, equitable, and person-centered (IOM, 2001), where person-centered care (PCC) takes into account the preferences of the individual, the culture of the surrounding community, and the context of the setting (Rubashkin et al., 2018). However, because these contextual factors are difficult to measure, satisfaction is often used as a proxy for person-centered aspects of quality. While abortion clients typically report high satisfaction with services (Swica et al., 2011), it is unclear whether these measures of satisfaction are, in fact, indicative of high-quality care, as they may be influenced by an individual's reluctance to report negative experiences and lack of context for assessing quality (Darney et al., 2019). These concerns are magnified in the youth population as young people typically have had fewer experiences and relationships, may have (or be perceived as having) less agency in health care interactions, and experience more social vulnerabilities/marginalization than their adult counterparts.

While there is no standardized PCC framework for abortion care, exploratory research adapting scales and frameworks from other areas of sexual and reproductive health services have been tested in the abortion context. A recent study demonstrated the potential applicability of a PCC maternal health framework to abortion and post-abortion care experiences in Kenya (Cotter et al., 2021). The Person-Centered Care Framework for Reproductive Health Equity, organizes eight domains of PCC into principals for maternal and reproductive health: dignity, autonomy, privacy, communication, social support, supportive care, trust, and facility environment (Sudhinaraset et al., 2017). When applied to abortion care in Kenya, the findings suggested that clear communication and information provision that is individualized to each abortion client are associated with better experiences in care and a sense of autonomy (Cotter et al., 2021). Additionally, Donnelly et al., (2019) adapted a scale measuring quality in family planning to abortion care to measure three key domains including decision support, interpersonal connection, and adequate information (Donnelly et al., 2019).

In order to improve PCC for young people who obtain abortions and develop youth-friendly services, an understanding of the facets of an abortion experience that matter to youth in diverse settings is needed. This study aimed to assess young people's reflections on their abortion experience and identify recommendations to improve person-centered aspects of abortion quality from the youth perspective.

Methods

We analyzed semi-structured in-depth interviews with youth abortion clients (age 15–24) in Argentina, Bangladesh, Ethiopia, and Nigeria. The data for this analysis are from a larger study that aimed to gain a deeper understanding of abortion clients' perception and priorities in a quality abortion service, as well as their expectations and experiences obtaining care. The full study included 98 in-depth interviews and seven focus group discussions with women aged 15 to 41 who had an abortion in Argentina, Bangladesh, Ethiopia, and Nigeria. These countries were selected based on the diversity of service-delivery models present in each country and their varying legal frameworks for abortion. At the time of data collection, the law in Ethiopia permitted abortion up until fetal viability (28 weeks' gestation per guidelines), under broad indications (Federal Ministry of Health Ethiopia, 2013), while in Nigeria and Argentina, abortion was highly restricted and legal only in cases of risk to the woman's life (Nigeria) and health (Argentina). In Bangladesh, people could obtain menstrual regulation (MR) services—a similar procedure to abortion, without confirmation of pregnancy-, up to 12 weeks' gestation (Center for Reproductive Rights, 2020).

For the full study, clients were recruited between December 2018 and March 2019 from a range of service-delivery models: clinic and hospital-based services (all countries), call centers affiliated with a clinic-based site (Bangladesh, Ethiopia), safe abortion hotlines (Nigeria, Argentina), and community-based drug retail outlets (Nigeria). The clinic and hospital sites provided medication and surgical abortion with trained medical personnel; the call centers offered information and referrals to clinic sites; the safe abortion hotlines provided information, and accompaniment through the abortion process; and drug retail outlets (known as "patent and proprietary medicine vendors" or PPMVs) (Beyeler et al., 2015) offered information and medication. At each recruitment site, providers and counselors were trained in recruitment strategies and invited potential participants during initial or follow up visits or calls. At sites in Argentina and Nigeria, some providers also contacted clients who had recently obtained abortion to invite them to participate. Eligible participants were at least 15 years old; able to provide consent; able to speak one of the study languages (Spanish, Bengali, English, Pidgin English, Yoruba, Amharic, or Tigrinya); and had obtained an abortion within the past 3 months (Nigeria, Ethiopia, and Bangladesh) or 6 months (Argentina).

Trained qualitative researchers in each country tracked recruitment and conducted interviews. Participants completed the informed consent and the interview either in person at the recruitment site, at another private location, or by telephone. Consent for minors was dependent on guidance from the local experts and ethics committees. In Ethiopia, Argentina, and Nigeria, minors are not required to obtain parental consent for reproductive health services, therefore they were not required to obtain parental consent for this study (Campbell, 2004). Participants aged 18 or younger in Bangladesh were required to obtain consent from an accompanying adult (i.e., a family member, friend, neighbor, etc.). Interviews were audio recorded with permission from participants, professionally transcribed in the language in which they were conducted, and then translated to English when necessary for analysis. Participants were given the equivalent of $3 to 10 USD as compensation for their time and travel; the amount and format of remuneration in each country was based on recommendations from local research partners. This study was approved by Fundación Huésped (Argentina), Bangladesh Medical Research Council (Bangladesh), the Government of the National Regional State of Tigray Bureau of Health (Ethiopia), St. Paul's Hospital Millennium Medical College (Ethiopia), Federal Medical Centre (Nigeria), Marie Stopes International Ethics Review Committee (UK), and Allendale Institutional Review Board (USA).

All interviews, including those used for this analysis of young people, were coded together. We developed an initial codebook based on key themes from the interview guide and prior literature addressing reproductive health

quality of care indicators and frameworks (Akachi & Kruk, 2017; Dennis et al., 2017; Sudhinaraset et al., 2017). We randomly selected two transcripts from each country and two researchers independently coded both. Five members of the research team met to discuss alignment and discrepancies before refining and modifying codes. The research team then revised the codebook and four researchers applied codes to all transcripts using MAXQDA 2018 (VERBI Software, 2019). When new potential codes emerged during coding, we discussed their relevance as a team and added those that were not already captured and applicable to our research aims; we then applied these codes to the entire dataset. We coded approximately 20% of the transcripts twice to ensure consistency.

This analysis included 48 interviews conducted with abortion clients aged 15 to 24 years and aimed to assess the abortion experiences among young people and identify aspects that contribute to youth-centered abortion services. We conducted a thematic analysis using a general inductive approach wherein we drafted summaries on key codes or themes; established links between the study objectives and the summary findings; and developed conclusions from the underlying themes that were evident in the data (Thomas, 2006). We did not recruit to reach thematic saturation in each country among young people specifically, therefore we conducted our analysis across the sample rather than compare across countries. Illustrative quotes of the themes are presented with the age of the participant and recruitment site model of care where clinic-based services included clinic referral call centers as well as clients recruited at hospitals and clinics directly.

Results

Among 48 youth abortion clients, the mean age was 21 years (range 16–24) and the majority had a medication abortion (73%) and were less than or equal to 12 weeks' gestation (83%) (Table 1). Five key themes emerged from the interviews as young people reflected on their abortion experience: access to information, privacy, stigma associated with age or marital status, the decision-making process, and comfort and rapport with providers.

Access to Information

Young people in this study received information about healthcare and abortion from friends and family, media sources, and health providers. Discussions of sources of information first emerged during the interviews when participants were asked to define good and unacceptable health care experiences broadly. Since many did not "have much experience in these things," they

Table 1. Client Characteristics.

Client characteristics ($n = 48$)	*n* (%)
Age (years)	
Mean	21.10
Range	16–24
Married	17 (35.42)
≤12 weeks' gestation	40 (83.3)
Type of abortion	
Medication abortion	35 (72.9)
Surgical abortion	13 (27.1)
Prior abortion	7 (14.6)
Prior birth	17 (35.4)
Country	
Argentina	3 (6.3)
Bangladesh	13 (27.1)
Ethiopia	16 (33.3)
Nigeria	16 (33.3)
Recruitment site model of care	
Clinic-based service[a]	33 (68.8)
Safe abortion hotline	11 (22.9)
Patent and proprietary medicine vendors	4 (8.3)

[a]Includes clients recruited from a clinic referral call center.

often told anecdotes of their friends and family members accessing care and described those interactions with the healthcare system that they witnessed. These stories often included negative experiences such as providers that were "nonchalant," "careless," or "very offensive;" one described a family member who was "treated really badly in the hospital" when giving birth.

When the conversation shifted to accessing information specific to abortion, clients also noted accounts of others such as friends, family members, or advocates that helped them make decisions about their procedure and informed on how to access the service. A 19-year-old client chose pills over a surgical procedure "because my friend told me getting abortion with the instruments is painful." When reading online about abortion options, a 20-year-old client found members of an advocacy group that "explained how the pills are used, and the friendly pharmacies where you could get them." Another client said a friend told her, "I should not worry, that she knows about a hotline that can help me." (Age 23, safe abortion hotline)

Nearly all youth clients in this analysis spoke of experiencing some type of fear prior to accessing an abortion service such as fear of death,

complications, infertility, and pain; these concerns were often shaped by the portrayals of abortion they saw in the media. Youth developed perceptions of abortion from "so many rumors" and images of "those sketchy places" and "girls dying from blood loss" they saw in media sources such as movies, television, or YouTube.

> All I knew about having an MR is that I thought it was some hugely complicated and terrible thing. We belong to a new generation, you see, so everything that we see on YouTube, we watch. And we understand things from what we see there. So, I had the idea that this involved a massive risk. That it could do a lot of damage, and that it was very painful. So, I was immensely afraid. (Age 22, clinic-based service)

In addition to others' accounts and media sources, youth received information from health providers or hotline counselors that helped assuage fears and made them feel prepared for their abortion. This information tended to be about pain, side effects, and what to expect.

> [The information] made me prepared. At least they told me that I will feel pain, meaning that I will see blood, so I was quite prepared, and I just prepared my mind for it. I just knew what I was going to see. I know what I was expecting, it didn't come suddenly, I was prepared for it already. So, I was just waiting, I was just taking it bit by bit. I was not so afraid. (Age 20, safe abortion hotline)

Clients also appreciated that this information was presented in "quite simple terms" so that it was easy to understand.

Privacy

Clients were asked to speak about their perceptions of privacy, what was done (if anything) to protect it, and why it mattered to them. Privacy of place emerged as more important than confidentiality of information. This was particularly important to clients who obtained care at a clinic or hospital and spoke of privacy protections needed because they were often seen in busy locations. A 20-year-old client stated that she felt that the staff "kept my privacy because they talked to me inside alone." There was very little mention during the interviews of confidentiality of information, sharing of health data, or medical records. Clients who accessed care from the safe abortion hotlines also reported that privacy was important to them and felt that the telephone-based nature of hotline care provision was inherently private as it was "only my voice." This client remarked that the interaction with the counselor felt private because it was with only one other person:

> I felt protected, I felt the whole thing was been done confidentially so just between me and [the counselor], no other person, no other third-party was there or involved. It was okay, it was a very nice experience. (Age 17, safe abortion hotline)

Privacy mattered to youth clients specifically because they did not want their family members to find out about their pregnancy or abortion and religion also motivated this desire for secrecy. Participants explained that pregnancy and childbirth as a young person would interrupt their education, limit employment opportunities, and damage their reputations. A 24-year-old client thought a pregnancy and abortion "would cause problems to myself and my family" because she and her partner "aren't the same religion." A 20-year-old client noted her mother "is very religious and doesn't accept abortion." Several other clients indicated that abortion "is a sin," describing their abortions as "not good information [to share]" and something that is "socially and religiously condemned," so they "must keep this a secret."

Stigma Due to Age or Relationship Status

Experienced and perceived stigma emerged as a theme that impacted young peoples' abortion experiences. Some youth who received services through safe abortion hotlines had to obtain abortion pills on their own and experienced challenges accessing the medications. A 17-year-old client "had to go to three pharmacies" to obtain the medications and perceived that these access challenges were related to her age, "I was a young girl. I don't know, maybe they didn't want to sell it to me or something." Another client experienced stigma when a pharmacist refused to sell her the medications because of her age.

> Yes, they refused, they said no. . . . that they will not sell it to me, that it's not for people like me that are my age. That they will not sell unless I bring them a doctor's report. They will not sell and said 'I should go.' (Age 18, safe abortion hotline)

While medication access emerged as a specific challenge that some youth encountered, most clients did not perceive that their age played a role in how providers treated them stating, "I think they wouldn't treat people differently based on their age. I think they treat everyone in the same way" (Age 19, clinic-based service). Instead, youth clients perceived that marital status influenced provider behavior and that this was because of "how our social system operates. In our society, having a relationship before you are married is viewed a little negatively" (Age 24, clinic-based service). A 19-year-old

married client perceived that providers may not treat unmarried clients as well as married clients.

> From what I know, it is the case that there are many girls who perhaps before they get married, they sometimes get pregnant. So when they then go to the doctor, perhaps the doctor realizes this about them, and perhaps then the doctor might, you know, see them in a bad light when they are dealing with them. Yes, so that means that there is a bad opinion developed about them by the doctor. Perhaps because of that, the doctors might behave badly with them. Since I am married, therefore in my case, this was not an issue. (Age 19, clinic-based service)

Another client who was not married mirrored this sentiment; she thought that a married client would be perceived by the provider as more knowledgeable and would receive better treatment as a result.

> I think such a person will be better treated for the sake of being a married person. In addition, as the person will be more knowledgeable than me, there will be a better understanding between the person and the service provider. (Age 21, PPMV)

Additionally, several clients discussed stigmatizing interactions where providers judged, condemned or "advised to keep the child." A 19-year-old client felt judged by the hospital staff when she was asked the reason for her abortion stating, "they don't act nicely when you say you want abortion and you also have to go through so many investigations." Another client said:

> They don't talk to you like a friend. If they are older providers, they will condemn you. They will say 'you are very young. What were you thinking? Why did you do it?' We try to convince them and tell them why we did it. They tell us 'Don't do it again, please take care.' (Age 20, clinic-based service)

Clients also internalized the stigma of pregnancy and abortion and feared it would bring "shame and discord" upon their families. A 23-year-old client believed that if her family found out, they would see her as "a disgrace." A 19-year-old client noted "If you know the tradition in the rural families, they don't understand you even if you try to convince them. So, it was a must for me to have abortion." When she recalled discussing her pregnancy with a counselor, a 17-year-old client said "I told her. . .that 'I want to abort it. I can't go through this, you know, this disgrace because of my age, I won't carry a baby. I won't carry a baby.' And I was scared of course because of my parents." Further, a 16-year-old client told an anecdote of her cousin who

obtained an abortion after her church learned of the pregnancy, citing the shame a youth pregnancy would bring on her family and the church community as the reason.

> My cousin was pregnant, the major reason why they aborted it was because of Catholic church. They were going to remove the mother from [the church]. She was the leader, and they found out her daughter was pregnant and they were going to remove her as leader. And her daughter was a leader of the choir too. So, I don't think they accept it like that. So that's why she aborted it because of those fears or stigma. (Age 16, safe abortion hotline)

Decision-Making Process

Among clients who felt they were involved in the decision-making process, they described having their preferences honored and getting enough information to weigh the pros and cons of different choices. This was observed primarily during post-abortion contraceptive consultation and when clients spoke of setting up the room for the procedure. A 21-year-old client spoke of how surprised she was that the providers let her listen to music during the procedure. By offering this innovative choice to make her comfortable, she perceived that the providers were invested in her experience.

> She told me something that really surprised me, she said, "Put on music if you'd like," which I was pleasantly surprised by the level they're at. I don't know how to say it, like thinking about comfort so the patient can have as good an experience like that as possible. At the time it was like, I was thinking 'Wow.' (Age 21, clinic-based service)

While the majority of clients were not offered a choice in the method of abortion they received, a few were. This client shared how the provider explained the types of abortion procedures, what to expect, and what to do if she experiences a complication.

> [The provider] wanted to know what I wanted to do. What action, or which method, would be the best? What would be a bad decision? What might happen. What might not happen. It goes just fine for many people, but there are problems for many others. And if there were problems, then I was told to return there immediately. (Age 23, clinic-based service)

Another client indicated that she chose a medication abortion but would have liked more guidance from her provider to understand the differences between the methods.

> My friend had told me that the treatment she got with the machine was more painful, despite the pain I preferred to get the machine treatment. But the doctor told me both treatments are the same. I wish he had described the differences, the advantages and disadvantages properly. Because I know they can't be the same. One option should be a better. So finally, I chose to take the pill. (Age 24, clinic-based service)

In addition to aspects of the abortion process, some clients sought choices during post-abortion contraceptive consultations. For some youth clients, choosing a method and having the birth control options explained to them was important as they often lacked information and wanted guidance on which type would be the best for them and how to access it. For example, this client explained:

> It was really important because like lots of the methods [the counselor] was calling out for me, I hadn't heard of them. I never knew there were things like that, it was actually my first time of hearing of such methods. Wow, I never knew things like that existed. I was quite happy to hear about such a method. (Age 17, safe abortion hotline)

However, several youth clients were not interested in, or did not inquire about, contraceptive options because they had the perception that they were not available or intended for those who are not married. A 21-year-old client stated, "I felt family planning was only meant for people who are married" and a 20-year-old did not inquire about contraception because "it was not the right time to think about it since I am not a married woman. So, I didn't ask them." Additionally, several clients noted that contraceptive counseling was not offered after their abortion stating that "[the provider] didn't mention it at all."

Two women shared coercive experiences with post-abortion contraceptive provision. One client described that she was not consulted on contraceptive choices and that a provider "inserted an implant" and "wasn't informed" about any other methods. When asked whose choice it was to receive the implanted contraception she stated:

> It was their choice. I didn't have much knowledge about any of the contraceptives because I only knew about the "choice" tablets which I used to take. Therefore, I didn't choose anything, they chose it for me. (Age 25, clinic-based service)

Another client had a similar experience where she "didn't understand what [the provider] was doing when she implanted the device in my arm." This client was not involved in the decision-making stating, "I wanted to get some

form of contraception, but [the provider] didn't even talk to me about it." (Age 22, clinic-based service)

Comfort and Rapport with Providers

Finally, comfort and rapport with providers mattered to youth clients because it improved their experiences and validated their decisions. Youth described this as supportive, respectful, or encouraging interactions that were "like a friend." This theme was evident across the countries and models of care, both during their experiences with abortion services and other healthcare interactions. This client recalled the comfort and rapport she felt with a doctor when she consulted about a possible pregnancy and called it "the most satisfying service" that she received.

> She advised me like a friend. She didn't act like an older person. She showed me it was beyond getting medical treatment. I don't have a brother or a sister. She was like a sibling for me. Her treatment and her advice was very good. . .. I still send her holiday wish texts, when I send everyone in my contact list. She remembers me and asks me how life is. (Age 20, clinic-based service)

Comfort and rapport was important to youth because it put the client's "mind at ease," and made them feel relaxed.

> I felt very comfortable because they were just treating me like, talking to me as a sister. So I was relaxed. So I was even saying things I couldn't say if it was normal pal. (Age 18, safe abortion hotline)

The rapport that youth built with providers was evident in playfulness and friendly interactions.

> She was very helpful, it was one nurse that I met there. So she was jovial, she attend to me well, even play with me by telling me she loves my bras. (Age 24, clinic-based service)

This client felt that her interactions with the providers validated her choice to end her pregnancy.

> [The providers] made you feel, I don't know, not special but that it mattered what you were feeling, and that your decision was right, no matter what. That your reasons for not wanting to have the baby mattered, and like it was important for them, and for me too (Age 20, clinic-based service)

Discussion

This study provides first-hand accounts of young people's experiences obtaining abortion services in Argentina, Bangladesh, Ethiopia, and Nigeria across a range of models of care and amidst varying abortion laws. We contribute perspectives of youth from low and-middle income countries who have obtained abortions, a group that is under-represented in abortion literature. Young people in this study discussed their experience of interpersonal care during their abortion including privacy, comfort and rapport with providers, and decision-making. These themes highlighted how specific domains in the Person-Centered Care Framework for Reproductive Health Equity Framework such as privacy, supportive care, communication, dignity, and autonomy (Sudhinaraset et al., 2017) can be applied to youth-centered abortion care.

While trust was rarely discussed explicitly by clients as a key priority, elements of a trusting relationship were implied in many of the findings. Trust is a critical element of person-centered health care (Carlström et al., 2017; Morgan & Yoder, 2012) and assumes special importance for youth (Munakampe et al., 2018). This study highlighted specific opportunities to develop a trusting relationship with youth clients such as fostering a personal connection, assuring privacy, involving clients in decision-making, and honoring preferences where possible. It has been established in the abortion literature that satisfaction is an incomplete proxy for patient experience (Darney et al., 2019; Dunsch et al., 2018; McLemore et al., 2014) and that perhaps confidence, trust, and measures of user preferences may be more useful alternatives to satisfaction (Kruk et al., 2018). Other studies have shown that experiences that occur during profound health events such as childbirth are known to have a lasting impression on a women's future health-seeking behavior (Simkin, 1996) and that a patient's experience can impact adherence to health recommendations (Anhang Price et al., 2014). While abortion is not a profound experience for all clients, it has the potential to impact future health-related behaviors, especially if it is one of the first reproductive healthcare experiences for a young person. Implementing non-judgmental, youth-friendly services with reliable sources of information, privacy, and comfort and rapport with providers may increase confidence in the health system and have a lasting impact on youth health outcomes.

The sources of information described in this study were important because they had the power to assuage or perpetuate fear, as well as to help young people feel assured and prepared. In a study by van Reeuwijk and Nahar (2013), interventions to improve sexual and reproductive health services in Bangladesh often focused on physical issues, but the young people in their

study were more concerned with the social and mental aspects of care (van Reeuwijk & Nahar, 2013). Our findings mirror this sentiment and shed light on the need to understand how and with what sources of information youth are developing their fears and perceptions of abortion. For example, YouTube or social media platforms may be a youth-friendly medium through which to deliver evidence-based information on what to expect and how to access services, and to dispel abortion myths and misinformation since these platforms are already a trusted source of healthcare and abortion content. However, the quality of content on YouTube and other social media platforms is difficult to standardize, and clients may need guidance identifying evidence-based sources given the substantial amount of untrustworthy and biased abortion information also available (Han et al., 2020); therefore, caution should be applied when promoting patient education materials through these channels (Gabarron et al., 2013). More research is needed to investigate how young people determine which sources are trustworthy. Additionally, because youth had fewer experiences with the health system, and often developed impressions based on others' accounts, service-delivery providers could consider addressing client fears by asking if they have heard anything worrisome from people they know who have sought abortions services. This insight could help providers better understand their patient's baseline perceptions of abortion care and may be useful for all health providers who serve youth populations. Further, broadening peer support models to include youth abortion services may expand the scope of trusted information sources for youth seeking an abortion. Examples of these programs include peers who conducted intake and follow-up conversations to elicit sensitive information related to HIV testing and treatment as well as general sexual reproductive health care in Kenya and the United States (Brindis et al., 2005; Ndwiga et al., 2014).

Some youth perceived abortion stigma related to their age when interacting with providers in clinic-based services as well as when obtaining medications from pharmacies. Provider bias, which stems from broader social norms and judgments toward youth sexuality (Solo & Festin, 2019), may have contributed to these unsupportive interactions. A recent systematic review showed that pharmacy personnel can serve as an important sexual and reproductive resource to young people (Gonsalves & Hindin, 2017); however, standardization of quality measures and more research is needed to determine how these vendors can best serve young people. Including pharmacies as services providers is important to understand the quality of contraceptive services that adolescents receive (Darney & Saavedra-Avendaño, 2018), and the experiences of youth accessing abortion medications in our study suggest that pharmacies should be considered when addressing youth

abortion barriers as well. In the clinic, age-associated abortion stigma may be mitigated by youth-friendly services providers who employ a positive approach toward sexuality. While empirical research around sex-positivity is only just beginning (Ivanski & Kohut, 2017), innovative, rights-based, provider trainings may be an avenue to dispel stigma and increase recognition of sexuality as a positive aspect of life (Braeken & Castellanos-Usigli, 2018). However, progress in this area may be limited by context specific social norms and public discourse on youth sexuality. Additionally, how marriage shapes sexual and social experience varies by cultural context and is an important consideration when delivering youth-centered sexual and reproductive health services. Sully et al., (2018) found unmarried women were more likely to experience severe complications from unsafe abortions suggesting that being unmarried, rather than age, is associated with unsafe methods (Sully et al., 2018). We add that youth perceive marriage, more so than age, to be a factor in how they are treated by providers and echo prior work in Kenya and India that suggests unmarried women are particularly susceptible to abortion stigma (Makleff et al., 2019). Perhaps this fear of judgment and associated stigma leads unmarried women to seek less-safe abortion methods. Understanding how marital status may influence provider bias should be considered when developing youth-friendly abortion services that improve quality of care.

This analysis also reveals some concerning findings around lack of consultation or choice for contraceptive options among young clients. Professional guidance for health providers states the importance of identifying contraceptive methods for everyone, including adolescents and abortion clients, that is in line with their preferences (WHO/RHR & CCP, 2018). However, previous work has shown that the time of abortion is not always the client's preferred time for contraceptive counseling (Matulich et al., 2014). More research is needed to understand the ideal timing and range of desires of family planning counseling among young people to address their unique needs. This will likely improve reproductive health outcomes for youth and enhance their experience of care (Dehlendorf et al., 2016).

Informed consent is a vital aspect of all health service delivery and special care must be taken when serving youth population's sexual and reproductive health needs. Abortion clients often perceive a form of coercion during contraceptive counseling (Brandi et al., 2018). Contraceptive coercion, including lack of options offered; lack of time to deliberate choices; and pressure to choose a specific method can be subtle or overt and can impede client trust, a critical element of person-centered healthcare delivery (Brandi et al., 2018; Carlström et al., 2017; Senderowicz, 2019). Contraceptive coercion is a particularly important challenge to abortion quality improvement as recent public health efforts designed to decrease unintended pregnancy are

measured by rates of contraceptive uptake (Birgisson et al., 2015), which may center efforts around contraceptive placement rather than client preferences (Holt et al., 2020). Person-centered contraceptive consultation, as an element of abortion services, should be held to high standards of quality of care. To aid in measurement of these PCC quality standards, Holt et al., (2020) developed the Person-centered Contraceptive Framework to ground providers in person-centeredness and health equity and implore them to consider structural and social contexts that shape the client experience. This framework also emphasizes the importance of shared-decision making to respond to patients' needs and values, rather than provider priorities (Holt et al., 2020). In both their abortion decision-making and post-abortion contraceptive choices, adolescents can and should be trusted with agency and guided through a shared decision-making process that integrates information and support (Coleman-Minahan et al., 2020).

This study has limitations to acknowledge. First, as a secondary analysis of a larger research study, the instruments used were not designed specifically with a youth population as the focus. It is possible that other elements of an abortion experience that matter to youth may have emerged with a priori questions designed to elicit factors specific to this population. Additionally, we were unable to address patterns within countries or compare across countries because we did not recruit to reach thematic saturation in any country among young people specifically. Even without thematic saturations, we were able to identify themes that were unique to the youth populations that identify areas for future reasearch. Further, thirty-three clients (69%) obtained clinic-based services, so the majority of perspectives came from this care provision. Only three clients from Argentina were eligible for this sub-analysis based on age, so this country is underrepresented in the analysis. Also, clients were recruited by study staff affiliated with the organizations where most women obtained their abortion. Therefore, youth clients may have limited their negative feelings, and this may have disproportionally impacted the younger clients in the sample due to their vulnerable status. Despite these limitations, this study adds an underrepresented perspective from youth abortion clients, in their own words, and offers recommendations to improve youth-centered aspects of abortion quality and adds to the ongoing conversation of abortion care as a human right.

Conclusions

Adolescents' right to reproductive healthcare is grounded in guarantees of life and health (World Health Organization, 2014). Realizing these rights require youth-centered health services that contribute to gender equity and increase educational, economic, and empowerment activities (Bernstein &

Jones, 2019; Center for Reproductive Rights and UNFPA, 2010), as well as a recognition that youth can and should be at the center of their own reproductive choices (United Nations, 2003). Specifically, there is an urgent need for high-quality abortion services that recognize the values, attitudes, and preferences of youth. Ensuring access to accurate and useful information, privacy, shared decision-making and comfort with nonjudgmental providers is essential to improve the quality of abortion care for young people.

Acknowledgments

The authors thank the Children's Investment Fund Foundation and The David and Lucile Packard Foundation for their support of the Abortion Service Quality (ASQ) Initiative which included this formative study. We would also like to thank the ASQ research partners, Ipas and Metrics for Management, for their contributions to study design and conceptualization. We are grateful for the research coordination by Osasuyi Dirisu, Ewenat Gebrehanna, Tanzila Tabassum, Ruth Zurbriggen, and service-delivery partners in each country for their contributions to instrument design, recruitment, data collection, and translation support.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This study was funded as part of the Abortion Service Quality Initiative by the Children's Investment Fund Foundation and The David and Lucile Packard Foundation.

Ethical Approval

This study was approved by Fundación Huésped (Argentina), Bangladesh Medical Research Council (Bangladesh), the Government of the National Regional State of Tigray Bureau of Health (Ethiopia), St. Paul's Hospital Millennium Medical College (Ethiopia), Federal Medical Centre (Nigeria), Marie Stopes International Ethics Review Committee (UK), and Allendale Institutional Review Board (USA).

ORCID iD

Laura E. Jacobson https://orcid.org/0000-0002-0996-7408

Supplemental Material

Supplemental material for this article is available online.

References

Akachi, Y., & Kruk, M. E. (2017). Quality of care: Measuring a neglected driver of improved health. *Bulletin of the World Health Organization*, *95*(6), 465–472. https://doi.org/10.2471/blt.16.180190

Anhang Price, R., Elliott, M. N., Zaslavsky, A. M., Hays, R. D., Lehrman, W. G., Rybowski, L., Edgman-Levitan, S., & Cleary, P. D. (2014). Examining the role of patient experience surveys in measuring health care quality. *Medical Care Research and Review*, *71*(5), 522–554. https://doi.org/10.1177/1077558714541480

Barden-O'Fallon, J., Evans, S., Thakwalakwa, C., Alfonso, W., & Jackson, A. (2020). Evaluation of mainstreaming youth-friendly health in private clinics in Malawi. *BMC Health Services Research*, *20*(1), 79. https://doi.org/10.1186/s12913-020-4937-9

Bernstein, A., & Jones, K. M. (2019). *The economic effect of abortion access: A review of evidence*. Institute for Women's Policy Research. Washington DC.

Beyeler, N., Liu, J., & Sieverding, M. (2015). A systematic review of the role of proprietary and patent medicine vendors in healthcare provision in Nigeria. *PLoS One*, *10*(1), e0117165. https://doi.org/10.1371/journal.pone.0117165

Biddlecom, A. E., Munthali, A., Singh, S., & Woog, V. (2007). Adolescents' views of and preferences for sexual and reproductive health services in Burkina Faso, Ghana, Malawi and Uganda. *African Journal of Reproductive Health*, *11*(3), 99–100. https://doi.org/10.2307/25549734

Birgisson, N. E., Zhao, Q., Secura, G. M., Madden, T., & Peipert, J. F. (2015). Preventing unintended pregnancy: The contraceptive CHOICE project in review. *Journal of Women's Health*, *24*(5), 349–353. https://doi.org/10.1089/jwh.2015.5191

Braeken, D., & Castellanos-Usigli, A. (2018). Sexual pleasure: The forgotten link in sexual and reproductive health and rights (Training Toolkit). www.gab-shw.org

Braeken, D., & Rondinelli, I. (2012). Sexual and reproductive health needs of young people: Matching needs with systems. *International Journal of Gynecology & Obstetrics*, *119*(Suppl. 1), S60–S63. https://doi.org/10.1016/j.ijgo.2012.03.019

Brandi, K., Woodhams, E., White, K. O., & Mehta, P. K. (2018). An exploration of perceived contraceptive coercion at the time of abortion. *Contraception*, *97*(4), 329–334. https://doi.org/10.1016/j.contraception.2017.12.009

Brieger, W. R., Delano, G. E., Lane, C. G., Oladepo, O., & Oyediran, K. A. (2001). West African youth initiative: Outcome of a reproductive health education program. *Journal of Adolescent Health*, *29*(6), 436–446. https://doi.org/10.1016/s1054-139x(01)00264-6

Brindis, C. D., Geierstanger, S. P., Wilcox, N., McCarter, V., & Hubbard, A. (2005). Evaluation of a peer provider reproductive health service model for adolescents. *Perspectives on Sexual and Reproductive Health*, *37*(2), 85–91. https://doi.org/10.1363/3708505

Campbell, A. (2004). State regulations of medical research with children and adolescents: An overview and analysis. In M. J. Field, & R. E. Behrman (Eds.),

Ethical conduct of clinical research involved children (pp. 93–112). National Academies Press.

Carlström, E. D., Hansson Olofsson, E., Olsson, L.-E., Nyman, J., & Koinberg, I.-L. (2017). The unannounced patient in the corridor: Trust, friction and person-centered care. *The International Journal of Health Planning and Management*, *32*(1), e1–e16. https://doi.org/10.1002/hpm.2313

Center for Reproductive Rights. (2020). The world's abortion laws. Retrieved December 10, 2020, from https://reproductiverights.org/worldabortionlaws

Center for Reproductive Rights and UNFPA. (2010). *Briefing paper: The right to contraceptive information and services for women and adolescents*. Center for Reproductive Rights and UNFPA. New York.

Chandra-Mouli, V., Svanemyr, J., Amin, A., Fogstad, H., Say, L., Girard, F., & Temmerman, M. (2015). Twenty years after international conference on population and development: Where are we with adolescent sexual and reproductive health and rights? *Journal of Adolescent Health*, *56*(1), S1–S6. https://doi.org/10.1016/j.jadohealth.2014.09.015

Coast, E., & Murray, S. F. (2016). "These things are dangerous": Understanding induced abortion trajectories in urban Zambia. *Social Science & Medicine*, *153*, 201–209. https://doi.org/10.1016/j.socscimed.2016.02.025

Coleman-Minahan, K., Jean Stevenson, A., Obront, E., & Hays, S. (2020). Adolescents obtaining abortion without parental consent: Their reasons and experiences of social support. *Perspectives on Sexual and Reproductive Health*, *52*(1), 15–22. https://doi.org/10.1363/psrh.12132

Cotter, S. Y., Sudhinaraset, M., Phillips, B., Seefeld, C. A., Mugwanga, Z., Golub, G., & Ikiugu, E. (2021). Person-centred care for abortion services in private facilities to improve women's experiences in Kenya. *Culture Health & Sexuality*, *23*(2), 224–239. https://doi.org/10.1080/13691058.2019.1701083

Darney, B. G., Kapp, N., Andersen, K., Baum, S. E., Blanchard, K., Gerdts, C., Montagu, D., Chakraborty, N. M., & Powell, B. (2019). Definitions, measurement and indicator selection for quality of care in abortion. *Contraception*, *100*(5), 354–359. https://doi.org/10.1016/j.contraception.2019.07.006

Darney, B. G., & Saavedra-Avendaño, B. (2018). Quality measurement is key to improving family planning services and outcomes for adolescents in low- and middle-income countries. *Journal of Adolescent Health*, *62*, 251–252. https://doi.org/10.1016/j.jadohealth.2017.12.006

Darroch, J. E., Woog, V., & Bankole, A. (2016). *Adding it up: Costs and benefits of meeting the contraceptive needs of adolescents*. Guttmacher Institute.

Dehlendorf, C., Fox, E., Sobel, L., & Borrero, S. (2016). Patient-centered contraceptive counseling: Evidence to inform practice. *Current Obstetrics and Gynecology Reports*, *5*(1), 55–63. https://doi.org/10.1007/s13669-016-0139-1

Dennis, A., Blanchard, K., & Bessenaar, T. (2017). Identifying indicators for quality abortion care: A systematic literature review. *Journal of Family Planning and Reproductive Health Care*, *43*(1), 7–15. https://doi.org/10.1136/jfprhc-2015-101427

Donnelly, K. Z., Dehlendorf, C., Reed, R., Agusti, D., & Thompson, R. (2019). Adapting the interpersonal quality in family planning care scale to assess patient perspectives on abortion care. *Journal of Patient-Reported Outcomes*, *3*(1), 3. https://doi.org/10.1186/s41687-018-0089-7

Dunsch, F., Evans, D. K., Macis, M., & Wang, Q. (2018). Bias in patient satisfaction surveys: A threat to measuring healthcare quality. *BMJ Global Health*, *3*(2), e000694. https://doi.org/10.1136/bmjgh-2017-000694

Federal Ministry of Health Ethiopia. (2013). *Technical and procedural guidelines for safe abortion services in Ethiopia*. Federal Ministry of Health.

Fikree, F. F., Abshiro, W. K., Mai, M. M., Hagos, K. L., & Asnake, M. (2017). Strengthening youth friendly health services through expanding method choice to include long-acting reversible contraceptives for Ethiopian youth. *African Journal of Reproductive Health*, *21*(3), 37–48. https://doi.org/10.29063/ajrh2017/v21i3.3

Gabarron, E., Fernandez-Luque, L., Armayones, M., & Lau, A. Y. (2013). Identifying measures used for assessing quality of youtube videos with patient health information: A review of current literature. *Interactive Journal of Medical Research*, *2*(1), e6. https://doi.org/10.2196/ijmr.2465

Gelaye, A. A., Taye, K. N., & Mekonen, T. (2014). Magnitude and risk factors of abortion among regular female students in Wolaita Sodo University, Ethiopia. *BMC Women's Health*, *14*(1), 50. https://doi.org/10.1186/1472-6874-14-50

Gonsalves, L., & Hindin, M. J. (2017). Pharmacy provision of sexual and reproductive health commodities to young people: A systematic literature review and synthesis of the evidence. *Contraception*, *95*(4), 339–363. https://doi.org/10.1016/j.contraception.2016.12.002

Han, L., Boniface, E. R., Han, L. Y., Albright, J., Doty, N., & Darney, B. G. (2020). The abortion web ecosystem: Cross-sectional analysis of trustworthiness and bias. *Journal of Medical Internet Research*, *22*(10), e20619. https://doi.org/10.2196/20619

Holt, K., Reed, R., Crear-Perry, J., Scott, C., Wulf, S., & Dehlendorf, C. (2020). Beyond same-day long-acting reversible contraceptive access: A person-centered framework for advancing high-quality, equitable contraceptive care. *American Journal of Obstetrics and Gynecology*, *222*(4), S878.e1–S878.e6. https://doi.org/10.1016/j.ajog.2019.11.1279

IOM. (2001). *Crossing the quality chasm*. National Academies Press.

Ivanski, C., & Kohut, T. (2017). Exploring definitions of sex positivity through thematic analysis. *The Canadian Journal of Human Sexuality*, *26*(3), 216–225. https://doi.org/10.3138/cjhs.2017-0017

Jerman, J., Frohwirth, L., Kavanaugh, M. L., & Blades, N. (2017). Barriers to abortion care and their consequences for patients traveling for services: Qualitative findings from two states. *Perspectives on Sexual and Reproductive Health*, *49*(2), 95–102. https://doi.org/10.1363/psrh.12024

Kapp, N., & Lohr, P. A. (2020). Modern methods to induce abortion: Safety, efficacy and choice. *Best Practice & Research Clinical Obstetrics & Gynaecology*, *63*, 37–44. https://doi.org/10.1016/j.bpobgyn.2019.11.008

Kim, C. R., & Free, C. (2008). Recent evaluations of the peer-led approach in adolescent sexual health education: A systematic review. *Perspectives on Sexual and Reproductive Health*, *40*(3), 144–151. https://doi.org/10.1363/4014408

Kruk, M. E., Gage, A. D., Arsenault, C., Jordan, K., Leslie, H. H., Roder-DeWan, S., Adeyi, O., Barker, P., Daelmans, B., Doubova, S. V., English, M., Elorrio, E. G., Guanais, F., Gureje, O., Hirschhorn, L. R., Jiang, L., Kelley, E., Lemango, E. T., Liljestrand, J. . . ., Pate, M. (2018). High-quality health systems in the Sustainable Development Goals era: Time for a revolution. *The Lancet Global Health*, *6*(11), e1196–e1252. https://doi.org/10.1016/s2214-109x(18)30386-3

Levandowski, B. A., Kalilani-Phiri, L., Kachale, F., Awah, P., Kangaude, G., & Mhango, C. (2012). Investigating social consequences of unwanted pregnancy and unsafe abortion in Malawi: The role of stigma. *International Journal of Gynecology & Obstetrics*, *118*(Suppl. 2), S167–S171. https://doi.org/10.1016/s0020-7292(12)60017-4

Makleff, S., Wilkins, R., Wachsmann, H., Gupta, D., Wachira, M., Bunde, W., Radhakrishnan, U., Cislaghi, B., & Baum, S. E. (2019). Exploring stigma and social norms in women's abortion experiences and their expectations of care. *Sexual and Reproductive Health Matters*, *27*(3), 50–64. https://doi.org/10.1080/26410397.2019.1661753

Matulich, M., Cansino, C., Culwell, K. R., & Creinin, M. D. (2014). Understanding women's desires for contraceptive counseling at the time of first-trimester surgical abortion. *Contraception*, *89*(1), 36–41. https://doi.org/10.1016/j.contraception.2013.09.013

Mazur, A., Brindis, C. D., & Decker, M. J. (2018). Assessing youth-friendly sexual and reproductive health services: A systematic review. *BMC Health Services Research*, *18*(1), 216. https://doi.org/10.1186/s12913-018-2982-4

McLemore, M. R., Desai, S., Freedman, L., James, E. A., & Taylor, D. (2014). Women know best—Findings from a thematic analysis of 5,214 surveys of abortion care experience. *Women's Health Issues*, *24*(6), 594–599. https://doi.org/10.1016/j.whi.2014.07.001

Millar, E. (2020). Abortion stigma as a social process. *Women's Studies International Forum*, *78*, 102328. https://doi.org/10.1016/j.wsif.2019.102328

Morgan, S., & Yoder, L. H. (2012). A concept analysis of person-centered care. *Journal of Holistic Nursing*, *30*(1), 6–15. https://doi.org/10.1177/0898010111412189

Munakampe, M. N., Zulu, J. M., & Michelo, C. (2018). Contraception and abortion knowledge, attitudes and practices among adolescents from low and middle-income countries: A systematic review. *BMC Health Services Research*, *18*(1), 909. https://doi.org/10.1186/s12913-018-3722-5

Ndwiga, C., Abuya, T., Mutemwa, R., Kimani, J. K., Colombini, M., Mayhew, S., Baird, A., Muia, R. W., Kivunaga, J., & Warren, C. E. (2014). Exploring experiences in peer mentoring as a strategy for capacity building in sexual reproductive health and HIV service integration in Kenya. *BMC Health Services Research*, *14*, 1. https://doi.org/10.1186/1472-6963-14-98

Nyblade, L., Stockton, M., Nyato, D., & Wamoyi, J. (2017). Perceived, anticipated and experienced stigma: Exploring manifestations and implications for young

people's sexual and reproductive health and access to care in North-Western Tanzania. *Culture Health & Sexuality*, *19*(10), 1092–1107. https://doi.org/10.1080/13691058.2017.1293844

Rehnström Loi, U., Gemzell-Danielsson, K., Faxelid, E., & Klingberg-Allvin, M. (2015). Health care providers' perceptions of and attitudes towards induced abortions in sub-Saharan Africa and Southeast Asia: A systematic literature review of qualitative and quantitative data. *BMC Public Health*, *15*(1), 1–13. https://doi.org/10.1186/s12889-015-1502-2

Rubashkin, N., Warnock, R., & Diamond-Smith, N. (2018). A systematic review of person-centered care interventions to improve quality of facility-based delivery. Advance online publication. https://doi.org/10.1186/s12978-018-0588-2

Salam, R. A., Faqqah, A., Sajjad, N., Lassi, Z. S., Das, J. K., Kaufman, M., & Bhutta, Z. A. (2016). Improving adolescent sexual and reproductive health: A systematic review of potential interventions. *Journal of Adolescent Health*, *59*(4), S11–S28. https://doi.org/10.1016/j.jadohealth.2016.05.022

Senderowicz, L. (2019). "I was obligated to accept": A qualitative exploration of contraceptive coercion. *Social Science & Medicine*, *239*, 112531. https://doi.org/10.1016/j.socscimed.2019.112531

Simkin, P. (1996). The experience of maternity in a woman's life. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, *25*(3), 247–252. https://doi.org/10.1111/j.1552-6909.1996.tb02432.x

Singh, S., Remez, L., Sedgh, G., Kwok, L., & Onda, T. (2018). *Abortion worldwide 2017: Uneven progress and unequal access*. Guttmacher Institute New York.

Solo, J., & Festin, M. (2019). Provider bias in family planning services: A review of its meaning and manifestations. *Global Health Science and Practice*, *7*(3), 371–385. https://doi.org/10.9745/ghsp-d-19-00130

Sudhinaraset, M., Afulani, P., Diamond-Smith, N., Bhattacharyya, S., Donnay, F., & Montagu, D. (2017). Advancing a conceptual model to improve maternal health quality: The person-centered care framework for reproductive health equity. *Gates Open Research*, *1*(1), 1–14. https://doi.org/10.12688/gatesopenres.12756.1

Sully, E. A., Atuyambe, L., Bukenya, J., Whitehead, H. S., Blades, N., & Bankole, A. (2018). Estimating abortion incidence among adolescents and differences in postabortion care by age: A cross-sectional study of postabortion care patients in Uganda. *Contraception*, *98*(6), 510–516. https://doi.org/10.1016/j.contraception.2018.07.135

Swica, Y., Raghavan, S., Bracken, H., Dabash, R., & Winikoff, B. (2011). Review of the literature on patient satisfaction with early medical abortion using mifepristone and misoprostol. *Expert Review of Obstetrics & Gynecology*, *6*(4), 451–468. https://doi.org/10.1586/eog.11.37

Thomas, D. R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation*, *27*(2), 237–246. https://doi.org/10.1177/1098214005283748

United Nations. (1981). *Secretary-general's report to the general assembly*. A/36/215.

United Nations. (2003). *Youth world report*. Author.

Vahdat, H. L., L'Engle, K. L., Plourde, K. F., Magaria, L., & Olawo, A. (2013). There are some questions you may not ask in a clinic: Providing contraception information to young people in Kenya using SMS. *International Journal of Gynecology & Obstetrics*, *123*(Suppl. 1), e2–e6. https://doi.org/10.1016/j.ijgo.2013.07.009

van Reeuwijk, M., & Nahar, P. (2013). The importance of a positive approach to sexuality in sexual health programmes for unmarried adolescents in Bangladesh. *Reproductive Health Matters*, *21*(41), 69–77. https://doi.org/10.1016/s0968-8080(13)41694-4

VERBI Software. (2019). MAXQDA 2018. Berlin, Germany: VERBI Software. Available from maxqda.com.

Warenius, L. U., Faxelid, E. A., Chishimba, P. N., Musandu, J. O., Ong'any, A. A., & Nissen, E. B. M. (2006). Nurse-midwives' attitudes towards adolescent sexual and reproductive health needs in Kenya and Zambia. *Reproductive Health Matters*, *14*(27), 119–128. https://doi.org/10.1016/s0968-8080(06)27242-2

WHO/RHR & CCP. (2018). *Family planning: A global handbook for providers*. World Health Organization Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP), Knowledge for Health Project. Baltimore and Geneva.

Woog, V., Singh, S., Browne, A., & Philbin, J. (2015). *Adolescent women's need for and use of sexual and reproductive health services in developing countries* (pp. 1–63). Guttmacher Institute.

World Health Organization. (2014). *Ensuring human rights in the provision of contraceptive information and services*. Author.

World Health Organization. (2018a). *Medical management of abortion*. Author.

World Health Organization. (2018b). *WHO recommendations on adolescent sexual and reproductive health and rights*. https://apps.who.int/iris/bitstream/handle/10665/275374/9789241514606-eng.pdf?ua=1

World Health Organization. (2020). Adolescent pregnancy. Retrieved May 13, 2020, from https://www.who.int/en/news-room/fact-sheets/detail/adolescent-pregnancy

Zuurmond, M. A., Geary, R. S., & Ross, D. A. (2012). The effectiveness of youth centers in increasing use of sexual and reproductive health services: A systematic review. *Studies in Family Planning*, *43*(4), 239–254. https://doi.org/10.1111/j.1728-4465.2012.00324.x

Author Biographies

Laura E. Jacobson is a PhD student at the OHSU-PSU School of Public Health and research consultant with Ibis Reproductive Health. Her work focuses on the health system and policy elements of improving quality of care, particularly, in maternity and abortion services. Laura holds a Master of Public Health and Certificate in Global Health from the University of Wisconsin-Madison School of Medicine and Public Health.

Ana Maria Ramirez manages quantitative and qualitative research projects as a Project Manager at Ibis Reproductive Health. Her work focuses on expanding access to safe abortion and reproductive health care services including abortion-related stigma experienced by providers and abortion clients, the measurement of abortion quality of care, and the development of mHealth interventions to increase access to abortion and reproductive health information. Ana holds a Master of Public Health from Columbia University.

Chiara Bercu manages research projects in Latin America and sub-Saharan Africa as a Project Manager at Ibis Reproductive Health. Her current work focuses on understanding the role of abortion stigma amongst providers and women, and developing improved metrics for quality of care of abortion services. Chiara holds a Master of Public Administration in International Development from Columbia University's School of International and Public Affairs.

Anna Katz is a research assistant at Ibis Reproductive Health. She supports a variety of studies focused on access to contraception and abortion globally including measurement of abortion complications, quality of care, contraceptive use and preferences, and abortion stigma. Anna holds a Bachelor of Arts in Global Health and African and African American Studies from Duke University.

Caitlin Gerdts is an epidemiologist and serves as the Vice President for Research at Ibis Reproductive Health. Her past and current research includes clinical and epidemiologic studies to measure the prevalence of informal sector abortion, document women's experiences with medication abortion self-management, explore strategies (including mobile technologies) to improve access to safe abortion, analyze women's experiences traveling for abortion in Europe, measure abortion-related mortality, and understand the consequences of abortion denial. Caitlin's methodologic expertise is in study design and implementation, impact evaluation, and causal inference methods; she has authored and co-authored over 20 peer-reviewed publications.

Sarah E. Baum is an Associate at Ibis Reproductive Health where she leads a portfolio of social science research addressing access to safe abortion and reproductive health care. As an expert in qualitative methods, she has published and presented on work assessing abortion-related stigma and quality care among providers and women, evaluating use of medication abortion in legally restrictive countries through various modes of service delivery, and documenting the impact of restrictive abortion and family planning laws. Sarah holds a Master of Public Health in Reproductive and Family Health from Columbia University's Mailman School.