

“It's not a seven-headed beast”: Abortion experience among women who received support from helplines for medication abortion in restrictive settings

Sarah E Baum*^a

Ana Maria Ramirez ^a

Sara Larrea^b

Sofia Filippa ^a

Ijeoma Egwuatu^c

Justyna Wydrzynska^d

Magdalena Piasecka^d

Sybil Nmezi^c

Kinga Jelinska^b

Affiliations:

- a. Ibis Reproductive Health, Oakland, CA, USA*
- b. Women Help Women, Amsterdam, the Netherlands*
- c. Generation Initiative for Youth and Women Network, Lagos, Nigeria*
- d. Kobiety w Sieci, Przasnysz, Poland*

Abstract

There are a growing number of abortion helplines where counsellors provide person-centered medication abortion services in legally restrictive settings. Few researchers have explored the perceptions and experiences of the people who obtain support from these helplines. Between April and August 2017, we conducted 30 interviews with women who had a medication abortion with support from helpline counsellors in Poland, Brazil, or Nigeria. Before seeking care with the helpline, women often heard negative stories about abortion and faced enacted stigma from the formal health care sector, or chose not to seek services from their doctors due to fear of stigmatizing treatment. Conversely, during their care with the helpline counsellors, women received clear information in a timely manner, and were treated with kindness, compassion, respect, and without judgment. Many women gained knowledge and understanding of medication abortion, and some gained a sense of community among those who experienced abortion. Helpline models can provide high-quality, person-centered abortion care to people seeking abortions in legally

restrictive contexts. Evidence from these service-delivery models could help improve service within the formal health care systems and expand access to high-quality, safe abortion by redefining what it means to provide care.

Keywords: abortion; medication abortion; abortion hotline; quality of care; stigma

Background

People around the globe deserve access to high-quality abortion care (Jelinska and Yanow, 2018). However, pervasive legal restrictions on abortion limit access to safe abortion and restrict reproductive rights. It is widely accepted that restrictive abortion laws do not limit the number of people who seek and obtain abortions (Sedgh et al., 2016). Yet, those who want to end their pregnancy in these settings often face difficulty accessing reliable information and experience a limited availability of quality, affordable providers, among other barriers (Footman, Keenan, et al., 2018; Gerdtz et al., 2015; Lavelanet, Johnson, & Ganatra, 2019; Zamberlin, Romero, & Ramos, 2012).

Social stigma can exacerbate these legal, financial, logistical, and informational barriers. Abortion stigma is the shared understanding that abortion is morally wrong or socially unacceptable (Cockrill et al., 2013). While stigma can exist in any context, it is likely more pervasive in legally restrictive settings. It can manifest as fears about judgment from family or community members, experiences of exclusion or discrimination, and negative attitudes about oneself (Cockrill and Nack, 2013; Shellenberg et al., 2011). In addition to impacting the type of information that people access, stigma can lead to delays in care seeking, fears of interacting with formal health care systems, low expectations of abortion care, use of unsafe methods in order to keep the abortion a secret, or delay of treatment for complications—if they occur—due

to concerns about discrimination or even criminalization (Araújo et al., 2018; Coleman-Minahan, Stevenson, Obront, & Hays, 2019; Constant, Kluge, Harries, & Grossman, 2019).

In restrictive legal contexts, people who need abortions are increasingly relying on the use of safe, effective, World Health Organization (WHO)-recommended medications for abortion (mifepristone and misoprostol, or misoprostol alone) (Jelinska and Yanow, 2018). In many countries, however, people seeking medication abortion outside of the formal health care system access pills from a pharmacy or other drug seller, often without a prescription. While local access to medications outside the formal healthcare system is critically important, it can leave people without accurate information about how to take the medications, what to expect, and where to seek help if they need it (Footman, Scott, et al., 2018; Hendrickson et al., 2016; Weaver, Schiavon, Collado, Küng, & Darney, 2020). In order to leverage the availability of medication abortion and counteract these challenges, advocates and clinicians in restrictive settings around the world have established programs and services to deliver medical and emotional support, and information to people who are managing an abortion with medications. A growing number of abortion hotline counsellors or online telehealth counsellors (together we will call these helplines) provide these services in restrictive and low-resource settings. These groups are most often grassroots organizations made up of non-clinician volunteers or community members who are trained in evidence-based protocols and person-centered models of support, accompanying people through each step of managing their abortion (Erdman, Jelinska, & Yanow, 2018). The helpline counsellors aim to provide accurate information on medication regimens, dosage, what to expect, warning signs, and where to obtain trusted care if adverse events occur. Recent studies assessing these models of care in Argentina, Indonesia, Ireland, Peru, and along the Thai-Burma border contribute to a growing body of evidence that the use of

medication abortion outside the formal health care system is safe and effective when people have access to accurate information and support systems (Aiken, Digol, Trussell, & Gomperts, 2017; Foster, Arnott, & Hobstetter, 2017; Gerds and Hudaya, 2016; Grossman et al., 2018; Zurbriggen, Keefe-Oates, & Gerds, 2018). Helpline support for medication abortion in restrictive settings has the potential to increase use of safe methods, which would decrease morbidities from unsafe methods and therefore reduce burdens on health care services that treat these complications (Grimes et al., 2006; Vlassoff, Walker, Shearer, Newlands, & Singh, 2009). Few researchers have explored the perceptions and experiences of people who obtain support from helpline counsellors, particularly regarding how they assess the quality of their care.

The WHO defines quality of care as the provision of services that are safe, timely, efficient, effective, equitable, and patient-centered (*Quality of care: a process for making strategic choices in health systems*, 2006). While person-centered abortion care is a relatively new area of study, there are reproductive health frameworks that provide a foundation in understanding the domains. In a framework of maternal person-centered care published by Sudhinaraset et al., the authors identify key aspects of care, such as trust, support, autonomy, dignity and respect (Sudhinaraset et al., 2017). Altshuler and Whaley used this framework to assess findings from studies published in 2017-2018 addressing client experience in abortion care. The authors conclude that many service providers around the globe lack person-centered care (Altshuler and Whaley, 2018). It is important to identify how these concepts contribute to a definition of high-quality abortion care and which aspects are most prioritized by people who access services. Quality—and especially interpersonal aspects of quality—apply not only to provision of care in clinic settings, but also to provision of medication abortion in care models like helplines and pharmacies.

In this qualitative study, we partnered with staff and counsellors at three helplines in Poland, Brazil, and Nigeria that provide their services to women living in legally restrictive settings, in order to gain a deeper understanding from women who sought support for medication abortion. We explored women's expectations and experiences with the service they received, the role of stigma and their perceptions of quality care, and how their knowledge and attitudes toward medication abortion shifted in the process.

Methods

Between April and August 2017, we conducted 30 interviews with women who had a medication abortion with support from a participating helpline in Poland, Brazil, or Nigeria. Women had to be 18 years or older and speak English, Polish, or Portuguese to participate in the study. We identified one or two interviewers at each site; each interviewer participated in a training on qualitative research methods, including use of the interview guide and probing, as well as ethical principles. Each interviewer was affiliated with the helpline where they conducted interviews but did not act as the main counsellor for any of the participants that they interviewed.

We developed an interview guide in partnership with study staff from all three helplines. The topics included perception of abortion and knowledge of medication abortion prior to contacting the helpline, experience seeking general medical care in their community, abortion attempts prior to contacting the helpline, acceptability of the helpline service, perception of quality of care, and shifts in their beliefs on abortion following their experience.

In Nigeria, we partnered with the Ms. Rosy hotline, which is part of Generation Initiative for Women and Youth Network (GIWYN), a non-profit organization that advocates for women's human rights. Ms. Rosy hotline is a toll-free line providing information about reproductive health, including evidence-based protocols about the use of mifepristone and misoprostol, or misoprostol alone, for abortion. The helpline is run by trained community health workers and counsellors. In Poland, we partnered with Kobiety w Sieci, a non-profit organization that operates a telephone hotline as well as a moderated internet forum for people seeking information about safe abortion methods, including safe self-managed medication abortion and emotional support throughout the process. The hotline and the online forum are run by a group of trained lay health workers. In Brazil, we interviewed women who were supported by Women Help Women's (WHW) online service. WHW is an international feminist non-profit organization that provides access to and information about medication abortion through a telehealth service and engages in global advocacy for self-managed abortion. A team of expert counsellors answers questions and accompanies women through email before, during, and after the procedure in Portuguese and five other languages.

At each helpline, women were recruited by study staff via telephone or email. Women who were eligible and interested provided contact information, were given an identification number, and scheduled a telephone interview at a convenient time. The interviewer completed an informed consent immediately prior to the interview; all interviews in Nigeria were conducted in English, in Poland were conducted in Polish, and in Brazil were conducted in Portuguese. Interviews were audio-recorded and lasted between 20-60 minutes. Participants received the local equivalent of approximately 12 Euros (approximately 40

BRL, 50 PLN, 3860 NGN) in exchange for their participation. This study was approved by Allendale Investigational Review Board (Old Lyme, CT, USA).

We transcribed interviews in the language in which they were conducted and then translated the interviews to English, if applicable. The research team developed an initial codebook and two researchers applied the codes independently to two transcripts. After the team met to discuss discrepancies and gaps, we collapsed and clarified code definitions and again two researchers applied the new codebook to two additional transcripts. The research team came to consensus on inconsistencies, revised the codes, and then applied the final list of codes to all transcripts with two researchers each coding half of the dataset. We conducted a content analysis of emerging patterns and themes among the entire sample, as well as differences based on country of recruitment. We present findings with illustrative quotes, which are identified by country and age of the participant.

Results

Participant characteristics

The mean age among the 30 participants was 31 years old with a range from 18 to 44 years. The majority of participants were married (n=13), were currently paid for work (n=17), and had one or more children (n=16). Participants were early in pregnancy with the majority under twelve weeks gestation (n=26), two were over 12 weeks gestation, and the gestational age of two participants was unknown at the time of their interview.

[Table 1 insert here]

Obtaining information about medication abortion

Prior to seeking abortion care, some women knew that abortion pills existed, but most had very little or no knowledge about medication abortion safety or how to obtain pills. Some participants had heard about surgical procedures, but found out about medication abortion directly from the helpline counsellor or by searching online after they were pregnant. For example, this Polish woman explained,

I did not know anything at all. When I was thinking about getting an abortion, I was thinking about curettage, about surgical abortion. I didn't have any idea about a pill. Only when I searched the internet I started to read and I learned that there is such an option. *(Poland, 25 years old)*

Women obtained information about the method and where to access pills from various sources, including: internet searches, family and friends, or acquaintances who worked in the medical field. One participant from Brazil said:

I needed [an abortion], then I went and researched it, how I could get it and ... there I found out that there are a lot of people who sell it through the Internet, a lot of people that even promise to deliver it directly to you, right? Through a 'motoboy', or asking for a deposit and shipping it... a lot, a lot of people. I found a lot of people who deliver the pills. *(Brazil, 40 years old)*

A woman in Nigeria described strategies for what to say when purchasing the pills, which she learned at a seminar hosted by a non-governmental organization near her home.

They said that it's a miracle drug, without you going to the clinic, you can terminate a pregnancy by yourself. Do you get me? Though it may be that you want to buy it for grand mum who needs it for further cure because I learned it could also be used for some other things, cures like arthritis or something. *(Nigeria, 42 years old)*

Perceptions of safety and effectiveness

The participants were asked to consider what fears or expectations they had of medication abortion and a number of women mentioned having safety concerns once they learned about the method. In some cases, these fears included infertility and death; consequences that were often

derived from misinformation or hearsay reiterated by friends, or an overwhelming negative narrative surrounding abortion in their community. A Brazilian participant reported “I had heard that people who took it had a very hard time and that...you could hemorrhage and even die” (*Brazil, 39 years old*). A woman in Poland echoed the same and cited the role of stigma:

I heard it is very dangerous. Ends with bleeding, sometimes death. Later, often you cannot get pregnant. This is a very invasive undertaking. These are the common opinions that were often heard in the media during the black protest¹. This is a taboo topic so no one talks about it. The woman is condemned. Usually, in the context of abortion, it is extremely negative. (*Poland, 28 years old*)

Yet not all stories shared by others were negative. A Nigerian woman heard from a friend that medication abortion would be a “stress free” and reliable experience, giving this woman the misperception that abortion is always easy for everyone.

I heard it from [a friend] and they were of the view that the pills make it kind of stress free. It was a stress-free method of removing an unwanted fetus. (*Nigeria, 22 years old*)

There were others who specifically noted concerns about the quality of medications they might get online or from drug sellers. For example, a 25-year-old Polish woman was afraid to order medications from an “unknown source,” but said that confirmation from other women who had experience with the drug would help her feel more confident.

In some cases, participants discussed concerns about other methods for abortion including surgical procedures or herbs. In these cases, concerns about safety included fear of potential legal consequences. Two Brazilian women were worried about this and the financial burden if they went to an unknown provider. One had heard of a clandestine provider who encountered legal

¹The Black Protest was a series of mass street demonstrations in Poland in 2016, to oppose proposal for further legislative restrictions of abortion. https://en.wikipedia.org/wiki/Abortion_in_Poland#Black_Protest

trouble in the past, leaving her uneasy to seek services from him for fear of police involvement.

The other woman had a general distrust of seeking an abortion from a provider in a clinic.

Oh, the clinic is extremely expensive and you're never going to be sure that [the] doctor is really one, right? That he really is prepared and everything...the clinic would only really be the last resort. (*Brazil, 24 years old*)

Regardless of the methods that women heard about, many described feeling uncertain about the safety and effectiveness of the methods and those providing them.

Seeking or avoiding care in formal health care systems

Among our sample, ten women inquired or sought abortion services from a formal sector provider at some point during their pregnancy, while 20 others considered it but decided against it. A few women in each country described inquiring about or seeking care at their primary provider or a public facility and facing rejection, judgment, or denial of services. Sometimes these reactions were from trusted clinicians who they had known for years leading up to the encounter. Unsupportive providers in Brazil responded with words such as “Please do not talk to me about it because I am against it. I’m completely against it!” (*Brazil, 40 years old*) or “Don’t even think about abortion!” (*Brazil, 22 years old*). Similarly, a Polish woman said that when she brought up the subject, the provider became defensive. “She told me that it was forbidden, illegal. I have no right to demand such things from her. I cannot give her exact words.” (*Poland, 27 years old*).

In other cases, women did receive pregnancy-related services and were stigmatized or humiliated by the provider. For example, this woman described how she was spoken to at her ultrasound.

‘Your mates are coming here to do scanning to keep children and you are coming here to do scanning for abortion.’ Though I was insulted, [it] is my right to keep it if I want to keep it. I felt bad for what she said. (*Nigeria, 35 years old*)

A few women encountered understanding and supportive medical providers, but among participants in our studies, even supportive medical providers only offered referrals, not abortion services. In Brazil, one participant’s doctor told her about Women Help Women and provided her with a referral for an ultrasound (*Brazil, 35 years old*). A Polish woman said that as soon as she confirmed the pregnancy, she received supportive, trustworthy advice as well as aftercare. Interestingly, she reported that her provider explained the reason for not providing a prescription for the pills was because of her own fears.

I asked [my doctor] if she would help me get rid of it. She said that she cannot give a prescription because she is afraid, but she had heard about Women Help Women and Women on Web and I could order a kit on such sites. She said that it is safe and that she is available by phone if something happens, and that’s how it was. (*Poland, 25 years old*)

Many women chose not to talk to their formal sector providers about their abortion at all due to fear of rejection, judgment, or that they would “see you as a killer” (*Nigeria, 35 years old*). One woman explained how she assessed the risk of communicating with a doctor.

I was afraid that the doctor would quarrel that this cannot be done. I felt restricted. I did not want to talk to anyone from outside about it. I figured that I’m not sure whether this doctor will help me, and maybe would raise a stink so I let go of this idea. (*Poland, 24 years old*)

Another woman in Brazil chose not to speak to any medical providers because she had heard they might try and dissuade her from getting the procedure by inciting fear that the medications could kill her or cause her to lose her uterus. These concerns emerged most often in the interviews with women in Brazil who spoke about concerns of judgment, bad treatment, or the possibility of being criminalized or legally prosecuted.

Women in all three countries spoke about trying other abortion methods before accessing care with the helpline. Some described attempting to terminate with tea, herbs, or drinking copious amounts of alcohol. A woman in Brazil explained,

I took some teas of... there are several teas that they say, that makes the period faster. I started taking it before when my period did not come and I did not know about the pregnancy, and then I continued taking it. (*Brazil, 24 years old*).

In Nigeria, a woman talked about taking traditional medicine and “strong alcohol,” which ultimately caused vomiting for several days but did not cause an abortion. Other women described the process of attempting to obtain abortion pills from pharmacies or drug sellers or other methods, but ultimately did not use them. Participants described various reasons as to why they did not self-manage on their own: ultimately deciding that “such experiments on my body did not seem right to me,” that the hotline would be safer than “going to the quacks,” or even that they were concerned they might pay informal sellers for pills who would take their money but not deliver.

Finding and receiving support from the helplines

Most women in Brazil and Poland found out about the helplines from searching online using terms such as “pharmacological abortion” (*Poland, 33 years old*) and “how to do an abortion” (*Brazil, 22 years old*) and clicking on websites or news articles. A number of women, particularly in Nigeria, learned about the helpline from information or materials that were disseminated prior to becoming pregnant. One woman received the phone number from a friend, who said that “I could call the helpline when I have any issue concerning my body,” while another had obtained a flyer:

Yes, [the flyer] was very handy because I was not even very sure of where I kept it. I didn't think about it after I collected it [that] day they gave it me, but I remembered it when I was kind of at the cross road, thinking of how to go about it, where to go, I stumbled on that flyer, and then felt I can call this and see if they can be of any assistance to me. (*Nigeria, 33 years old*)

Women determined that the helpline and their staff were trustworthy primarily by hearing or reading about other women's experiences. For example, a woman in Brazil contacted another woman via WhatsApp and "asked if it was safe, if she had gotten help, and she said yes, she had settled it and thought she considered it safe" (*Brazil, 44 years old*). Another woman in Poland initially did not trust that she would get the pills from the helpline, but felt more confident after reading on the forum about the experiences of other women who had used the services.

Although the helpline models in each country are slightly different, and the counsellors use or combine different media for communication, all participants reported feeling well informed about the abortion process. Universally, women felt they received clear information in a timely manner — either via email, on the online platform, or over the phone. Women described the information they received as "clear," "detailed," "above and beyond" what they expected, "all the information I needed to make my decisions," and "invaluable" to their abortion experience overall. One Brazilian woman spoke about the ongoing communication she received from the helpline counsellor that made her feel confident.

They sent several emails asking how the abortion was, if I had had pain, how I was feeling...they were very attentive, they sent me a lot of emails and I always replied. It was very good, they are very competent. I wasn't afraid that anything might go wrong precisely because they were always following up. (*Brazil, 22 years old*)

Generally women felt that counsellors were "very available" to answer any of their questions when they needed them. In one case, a Brazilian woman said that she had to wait longer than she

would have liked for an email response. However, she said that overall she received the information she needed on time. These experiences were in stark contrast to even general health care experiences with medical providers in the formal sector; particularly in Brazil and Poland, where many women felt that they had not previously received all the details of their care or complete answers to their questions. A few Polish women spoke harshly about their formal system medical providers being uninterested and unwilling to explain their services or take the time to talk to them.

In addition to detailed information and timely responses to their questions, women also reported being treated with kindness, compassion, respect, and without judgment. Women in all three countries said they felt personally connected to their counsellors, like speaking to an older sister, or a friend. A few mentioned that counsellors created a sense of closeness by using endearing terms like “dear” to refer to women who called in; one woman in Brazil noted that she had not anticipated feeling her counsellor’s concern over email communication. A Polish woman was surprised that she could receive “so much understanding and support and willingness to help” from someone she did not know (*Poland, 27 years old*). She said the level of this care was something that even family members are not always able to provide.

Women spoke in diverse ways about the benefits of the virtual platforms through which they received care. Several women reported that telephone or online communication with counsellors increased their sense of confidentiality and made it easier to communicate freely about a taboo topic, as exemplified by this woman in Poland.

It’s easier, it’s not face to face. And with doctors you can’t always tell them. You want to say something, but can’t think of the right words. Whether on the forums or on the phone, it is easier to express your thoughts, your feelings, or your doubts. (*Poland, 25 years old*)

When speaking about the online forum in Poland, participants described a sense of community and connection and the comfort that came from knowing they were not alone or unique in their circumstance. For one woman, “reading stories of people that went through it and experienced this before calmed me down a lot. I had a faith that it can happen and I can get out of this unwanted pregnancy” (*Poland, unknown age*). Similar to how women described their relationships with their counsellors, they also described support, friendship, and confidence among other women on the forum. A woman explained that the forum provided her more support than the formal health care system, and though her interaction with the helpline was all digital, she still felt “held by the hand and stroked in the head” (*Poland, 33 years old*). Some women frequented the forum after their abortion, and one woman appreciated that she could start providing support to newer members.

Changes in knowledge and attitude after abortion

In each interview, women were asked whether they believed that their knowledge, beliefs, or attitudes toward abortion had shifted after their experience. Many women spoke about how their knowledge and understanding of medication abortion changed. They learned for the first time about mifepristone and misoprostol, the regimens, and options for abortion in the second trimester. This woman in Brazil highlighted:

That it is the safest procedure, in fact it is the WHO protocol. That. Ah yes! And that the combination of these two drugs makes the procedure 99% effective. Until then I only knew of the...of...misoprostol. I was not aware of mifepristone.
(*Brazil, 44 years old*)

Some women described how this new information helped to dispel myths or shift their understanding of the safety risks of medication abortion. A woman in Poland stated:

I had heard a lot around that the medicines are awful for your organism, that they cause harm, while actually, as it turned out, they provoke no harm; they help. There was a big change in regards to my concerns before taking the medicines, they are not that bad, and they actually help. (*Poland, 24 years old*)

In addition to safety and effectiveness, some women highlighted why they preferred medication abortion, such as this woman in Nigeria who explained her surprise that she could have an abortion at home.

I never knew one could stay in the comfort of your house. I think I really never knew about all that before, all my mind was that abortion must be done in the hospital or you start to use all those local concoctions that you don't even know what the future holds. (*Nigeria, 29 years old*)

A few participants considered how their knowledge might be useful in the future for themselves or their loved ones.

Interestingly, women who reported changes in their knowledge often spoke about feeling surprised by the option to use medication abortion safely and recognizing shifts in their expectations of abortion as a traumatic or difficult process. "It's a simple procedure, it's not a seven-headed beast; it's possible for anyone who wants to do it."(*Brazil, 39 years old*). A woman in Poland echoed:

It was quite easy to solve this problem. I would never have expected that the solution is at our fingertips. And it can be so simple. It seemed to me that it would require me a lot of gymnastics, including traveling to another country, to get a huge sum of money that I did not have at that moment. And it turned out to be a lot simpler than I thought. (*Poland, 27 years old*)

Women reported a range of attitudes toward abortion prior to their recent pregnancy, although most reported support for abortion access. One woman in Nigeria did have a change in her beliefs and no longer considered abortion a sin as she had before. Others felt that their experience had made their convictions stronger. A few women reflected on abortion as a right for all women. For example, this woman in Brazil explained,

Learning that it is a human right made me feel really empowered in my decision. It relieved my feelings of guilt... and it took away the air of shadiness and criminality that it can invoke. *(Brazil, 39 years old)*.

Another woman in Nigeria spoke about how her views on bodily autonomy and women's empowerment shifted after her interaction with the helpline counsellors. She feels more strongly about shifting social norms in her community.

I actually learned that every woman have her right, her body right. Whether you want, you want the child to live or not, it all depends on the woman and no other person has the right to decide for her...people actually think that women they are, are second class people. From this interaction with [the helpline], I've been able to believe and have that it's time for women to wake up and start believing in themselves. *(Nigeria, 22 years old)*

A woman in Poland agreed that men should not be the ones to decide about abortion access. She expressed frustration at the required secrecy around abortion in the restrictive setting.

What annoys me is that we are doing it in hiding that we have to get these [pills] 'illegally.' I started to look at what is going on here in Poland, these old men decide what I can do and what I can't do. I'm even more convinced that if someone needs help, then they should be made aware and informed that something like this exists. *(Poland, 42 years old)*

Women, particularly in Poland, who obtained support through an online forum, described shifts in their understanding that there were "other women like me" and that abortion was more common than they realized. For example, multiple women shared this woman's experience when she described, "[my feelings about abortion] have not changed. Same feelings and thoughts as I had before, I have now. I realized there are a lot of people, women, who think like me." *(Poland, 35 years old)*

Discussion

Through this study, we gain insight into the experiences of women who obtain support from medication abortion helplines in restrictive legal settings. Women across the three country contexts — Nigeria, Brazil, and Poland — spoke about their experiences with person-centered, quality care provided by the helplines. Participants described compassionate, kind counsellors who took the time to explain the abortion process and answer their questions. They reported establishing meaningful connections with helpline staff, and among participants in Poland, also connecting with a network of other people seeking abortion through the online forum. These interpersonal aspects of care can be also be defined as dignity, trust, support, and effective communication, which align with existing frameworks and measurements in other fields of reproductive health, like the Person-Centered Care Framework for Reproductive Health Equity (Sudhinaraset, et al., 2017) and the Interpersonal Quality in Family Planning scale developed for family planning and adopted for abortion provision in clinics (Dehlendorf, Henderson, Vittinghoff, Steinauer, & Hessler, 2018; Donnelly, Dehlendorf, Reed, Agusti, & Thompson, 2019). While frameworks and measurement of person-centered quality of care are still lacking for abortion provision (Darney et al., 2018; Dennis, Blanchard, & Bessenaar, 2017), and most especially for out-of-clinic provision such as the helplines models, findings from this study demonstrate that helplines not only fulfill many of the existing ways person-centered quality of care are measured or conceptualized, but they also provide new components of care, like community building.

The experiences described by women who received support from helpline staff were in sharp contrast to the poor-quality treatment they described in the formal health care system, either with their current pregnancy or prior interactions. In some cases, participants described ways in which hospital or clinic providers perpetuated abortion stigma, for example, trying to

convince women to keep a pregnancy, or refusing to provide information, resources, or referrals. In other cases, women explained that they intentionally avoided seeking care within formal health systems due to fears of judgment or denial of services—a finding that highlights high levels of perceived stigma, and is consistent with a recent systematic review that sought to understand why women chose informal sector abortion providers and found that one of the main reasons cited was fear of unwilling or stigmatizing providers (Chemlal and Russo, 2019). The articles included in the systematic review describe contexts where abortion was legal; yet it is reasonable to assume that the levels of stigma increase and unwillingness of providers is more prevalent in legally-restrictive settings, such as those in the present study. The inability of formal sector service-providers to meet the needs of people who seek abortion in this study demonstrates a failure of public health systems to guarantee reproductive rights for all people. Public health experts often focus on improvements to the formal health care system to increase access to abortion services, however we posit that staff at grassroots organizations rooted in feminist principles, such as the helplines, are providing critical, and sometimes lifesaving, services that formal health care systems in restrictive legal environments have not. Further, the findings suggest the staff at the helplines in Nigeria, Brazil, and Poland, Brazil are providing compassionate, comprehensive, and high quality person-centered abortion care.

Our analysis of the interviews also adds to the growing body of literature documenting the manifestations of stigma in people's experiences with abortion care-seeking. Participants in the study often learned about abortion through stories, myths, or rumors from others in their social networks. In all three countries, women described an overwhelmingly negative narrative around abortion within their communities, which could be a reflection of prevalent poor-quality care, unsafe abortion, and/or the silencing of positive abortion narratives. As a result, women tended

to approach abortion with fears about their own safety and future fertility, misinformation about the availability and dangers of medication abortion, and low expectations of how they would be treated. This misinformation about safety and low expectations of quality of care are consistent with other studies in both legally restrictive and non-restrictive contexts where there is silence around people's abortion experiences and women are exposed to negative narratives and descriptions of abortion through their social networks, providers, and communities at large (Coast, Norris, Moore, & Freeman, 2018; DePiñeres et al., 2017; Hajri, Raifman, Gerdt, Baum, & Foster, 2015b; Hossain et al., 2016; Marlow et al., 2014; Puri, Vohra, Gerdt, & Foster, 2015). Yet, while negative social norms and stigma around abortion can be perpetuated in people's social networks, trusted community members can also help people connect with others who have experienced abortion, which may reduce isolation and even provide a sense of agency (Jelinska and Yanow, 2018). Researchers and organizations that implement interventions to combat abortion stigma through the use of social networks have thus far focused on abortion providers and people with abortion histories (Belfrage, Ortíz Ramírez, & Sorhaindo, 2019; Debbink et al., 2016; Littman, Zarcadoolas, & Jacobs, 2009). However, we suggest that social support networks have value for those both seeking and experiencing abortions. Further research to document models of care that provide social support networks, such as the qualitative study by Zurbriggen et al., with a helpline in Argentina (Zurbriggen, et al., 2018) is needed.

The experiences of the helpline callers in this study challenge common presumptions about the formal health system being the desired, paradigmatic locus of all abortion care. It has profound implications for advocacy and policy making around abortion access, and medication abortion in particular. While advocates across the globe must continue to demand quality and affordable abortion care as part of the formal health care system's sexual and reproductive services, we know that these

systems are falling short based on reports of stigma, poor quality of care, and discrimination (DePineres et al., 2017; Hajri, Raifman, Gerdtts, Baum, & Foster, 2015a; Harries, Gerdtts, Momberg, & Greene Foster, 2015; Hossain, et al., 2016; Puri, et al., 2015). It is these experiences, and the advent of abortion pills, that led to community organizing to support people needing abortion through helplines. The professionals working in alternative, de-medicalized, safe models of care provide services which, despite being acceptable to their users, are still underused globally or even contested. Helpline staff in restrictive settings, often in sharp contrast to the formal systems of care, provide person-centered and reliable care, based on the evidence and in accordance to the newest WHO protocols (*Medical management of abortion*, 2018). They can be seen as harm-reduction interventions, strongly grounded in human rights standards and feminist ethos (Erdman, et al., 2018). Relevant research questions should identify how to integrate lessons learned and best practices from these novel approaches to revitalize and improve formal health care systems.

The main limitation to this study is that the sample was self-selected, and it is possible that people with negative experiences and perceptions chose not to participate in this study. Although interviewers were trained and were not the main service providers to anyone they interviewed, it is still possible that participants may have felt the need to withhold some of the negative feedback from their experiences. However, the main strength of our study is that it begins to fill a gap in the scientific literature about what we understand about people's experiences accessing safe abortion care outside of formal health care systems with helplines in restrictive contexts. Helpline counsellors are offering high quality, person-centered abortion care. Even in restrictive settings, their goals are not just to fill service-delivery gaps left by the formal system, but to provide holistic person-centered care. This model prioritizes not only safety, in terms of effectiveness, but safety understood also as person-centered interpersonal measures such as

support, kindness, solidarity, autonomy, criminalization prevention, and empowerment. More evidence on the quality of services and models of care from helplines is needed, as lessons from these service-delivery models could help improve service within the formal health care systems and expand access to good quality, safe abortion by redefining what it means to provide care.

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Table 1. Participant characteristics

	Total (n=30)	Brazil (n=10)	Nigeria (n=10)	Poland (n=10)
Age (years)				
Mean	30.9	31.9	31.4	29.3
18-25	9	3	2	4
26-35	10	2	4	4
36+	9	5	3	1
Missing	2	0	1	1
Relationship status				
Single	8	3	3	2
Married	13	2	6	5
Partnered	9	5	1	3
Paid for work				
Student	4	2	2	0
Number of children				
0	13	5	4	4
1-2	11	4	1	6
3+	5	0	5	0
Missing	1	1	0	0
Gestational age (weeks)				
≤7	17	6	7	4
8-12	9	4	1	4
13+	2	0	1	1
Missing	2	0	1	1