ADDRESSING ABORTION STIGMA THROUGH SERVICE DELIVERY

SUMMARY 3: STIGMA INTERVENTIONS

The following summary provides a definition of abortion stigma in brief; for a more thorough exploration, see the full white paper, Addressing Abortion Stigma Through Service Delivery. Just as there are different manifestations of abortion stigma occurring at distinct cultural levels, there are different types of interventions designed to address them. In this summary we explore intrapersonal, interpersonal and structural interventions.[i] Interpersonal and intrapersonal interventions aim to improve the experiences of the stigmatized or at address negative attitudes or stereotypes held by the non-stigmatized. These types of interventions generally fall under one of more of the following themes: counseling approaches, information-based education, skills-building education, or contact with affected groups. The second type of intervention we present addresses the structural levels of stigma, such as institutions, laws and policies, or the media.

Intrapersonal interventions seek to reduce the negative impacts that stigma can have on targeted individuals. For example, abortion counseling is one intrapersonal intervention that can provide healthcare information, emotional support, and empowerment to the stigmatized. Peer support, in the form of in-person, phone counseling or support groups, can also provide those affected by abortion stigma with a group of people with which to share experiences and design strategies for resilience. For professionals who are targeted by stigma, peer support might take the form of affinity groups or professional workshops and meetings. Though there is not a lot of research on the impact of intrapersonal interventions on the experiences of women who have abortions, one review of emotional care practices around other stigmatized issues suggested that best practices are likely to include: (1) establishing a supportive client-provider relationship, (2) assisting with decision-making, (3) offering supplemental sources of support, and (4) directly addressing stigma.[ii]

Another intervention type involves creating opportunities for "contact" between the stigmatized and non-stigmatized. The contact hypothesis suggests that interactions between majority (non-stigmatized) and minority (stigmatized) individuals can lead to reductions in prejudice between the groups.[iii] Whether in-person or extended (eg. through media), contact can be a powerful way to help the nonstigmatized increase their knowledge about the experience of stigma and comfort with a stigmatized individual. When a stigma is concealable, disclosure or "coming out" might be necessary to create knowledge about the divergent statuses or identities. This process, often done through storytelling, has been cited as a potentially potent tool for reducing negative attitudes toward women who have had abortions.

Educational interventions aim to provide the nonstigmatized with information and/or skills that are necessary to reduce stigma. Educational interventions can be particularly useful in health care settings where workshops build both knowledge and skill. Overall, educational interventions are intended to reduce myths and address stereotypes while increasing empathy and tolerance. However, educational interventions with the goal of reducing stigma have met with very mixed results.[iv] Though increased knowledge is often found post-intervention, lasting improvements in attitudes are rare.[v,vi]

Social marketing is one example of a structural-level intervention. Programmers use marketing techniques (along with others such as education or contact) to achieve behavioral and/or health-related goals at a mass level. In an evaluation of one anti-stigma social marketing campaign, Time to Change, researchers measured knowledge, attitudes, and intended behavior using validated and reliable scales on a sample of the target population. They found that social-marketing campaigns like Time to Change may have more success in influencing knowledge about stigmatized groups than in influencing attitudes and behaviors.[vii]

Another type of structural-level interventions is protest, an action that publicly calls attention to media, businesses, organizations, or individuals that promote discrimination, myths or sterotypes.[viii] Protest can also have a secondary impact on the stigmatized by replacing feelings of isolation and shame with feelings of solidarity and pride. Protest can provide temporary experiences of power, pride, visibility, and safety in numbers for individuals who ordinarily experience the powerlessness, shaming, invisibility, and vulnerability of stigma. There have been very few rigorous evaluations of the impact of protest strategies on reducing stigmatizing attitudes and beliefs, and protest can have unintended rebound effects, worsening prejudicial attitudes in the target group.[ix] Therefore, when selecting protest as a method, groups may want to consider where attitude transformation falls in their theory of change.

REFERENCES

[i] Brown, L., Macintyre, K., & Trujillo, L. (2003). Interventions to reduce HIV/AIDS stigma: What have we learned? *AIDS Education and Prevention, 15*(1), 49-69.

[ii] Upadhyay, U. D., Cockrill, K., & Freedman, L. R. (2010). Informing abortion counseling: An examination of evidence-based practices used in emotional care for other stigmatized and sensitive health issues. *Patient education and counseling, 81*(3), 415-421.

[iii] Allport, G. W. (1954). *The nature of prejudice*. Cambridge: Addison-Wesley Pub. Co.

[iv] Brown et al., 2003

[v] Brown, et al., 2003

[vi] Corrigan, P. W., Morris, S. B., Michaels, P. J., Rafacz, J.

[vii] D., & Rüsch, N. (2012). Challenging the public stigma of mental illness: A meta-analysis of outcome studies. *Psychiatric services, 63*(10), 963-973.

[vii] Evans-Lacko, S., London, J., Little, K., Henderson, C., & Thornicroft, G. (2010). Evaluation of a brief anti-stigma campaign in Cambridge: do short-term campaigns work? *BMC public health, 10*(1), 339.

[viii] Corrigan, P. W., River, L. P., Lundin, R. K., Penn, D. L., Uphoff-Wasowski, K., Campion, J., . . . Goldstein, H. (2001). Three strategies for changing attributions about severe mental illness. *Schizophrenia bulletin, 27*(2), 187.

[ix] P.W. Corrigan, et al., 2012

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