



Abortion quality of care from the client perspective: a qualitative study in India and Kenya

Sarah E Baum^{1,*}, Rebecca Wilkins², Muthoni Wachira³, Deepesh Gupta⁴, Shamala Dupte⁵, Peter Ngugi⁶ and Shelly Makleff¹

¹Ibis Reproductive Health, 1736 Franklin Street, Suite 600, Oakland, CA 94612, USA

²International Planned Parenthood Federation, 4 Newhams Row, London SE1 3UZ, UK

³International Planned Parenthood Federation/Africa Regional Office, Lenana/Galana Road Junction, PO Box 30234, Nairobi, Kenya

⁴International Planned Parenthood Federation/South Asia Regional Office, 231 Okhla Industrial Estate, Phase-3, New Dehli-110020, India

⁵Family Planning Association of India, Nariman Point, Mumbai 400 021, India

⁶Family Health of Kenya, Mai Mahiu Road, Nairobi, Kenya

*Corresponding author. Ibis Reproductive Health, 1736 Franklin St, Suite 600, Oakland, CA 94612, USA. E-mail: sbaum@ibisreproductivehealth.org

Accepted on 28 May 2021

Abstract

Quality healthcare is a key part of people's right to health and dignity, yet access to high-quality care can be limited by legal, social and economic contexts. There is limited consensus on what domains constitute quality in abortion care and the opinions of people seeking abortion have little representation in current abortion quality measures. In this qualitative study, we conducted 45 interviews with abortion clients in Mumbai, India, and in Eldoret and Thika, Kenya, to assess experiences with abortion care, definitions of quality and priorities for high-quality abortion care. Among the many aspects of care that mattered to clients, the client–provider relationships emerged as essential. Clients prioritized being treated with kindness, respect and dignity; receiving information and counselling that was personalized to their individual situation and reassurance and support from their provider throughout the entire abortion process, including follow-up after the abortion. Many clients also noted the importance of skilled providers and appropriate care. There were similarities across the two country contexts, yet there were some differences in how clients defined high-quality care; therefore, specific political and cultural influences must be considered when implementing measurement and improving person-centred quality of care. These domains, particularly interpersonal interactions, should be prioritized in India and Kenya when health systems, facilities and providers design person-centred measures for quality in abortion care.

Keywords: Quality of care, doctor–patient relationship, satisfaction, abortion, qualitative research, reproductive health

Key messages

- Abortion clients in India and Kenya highlighted the importance of client–provider relationships in high-quality care.
- Key aspects of quality care identified by clients included kind, non-judgmental treatment, individualized information and interactive counselling, on-going communication for follow up, and skilled providers.
- Preferences and needs were similar in India and Kenya; however, subtle differences across themes suggest client priorities may be influenced by political and social contexts. These contexts should be considered when measuring quality.
- In order to improve quality of abortion care, providers and health systems should address aspects of structure, process and outcome from the client perspective, with a focus on evaluating interpersonal interactions.

Introduction

The World Health Organization (WHO) defines quality of care as ‘the extent to which health care services provided to individuals and patient populations improve desired health outcomes’ and identifies quality as a key part of women's right to health and dignity (World Health Organization, 2020). According to the Institute of Medicine and WHO framework, quality of care includes six components: safety, effectiveness, timeliness, efficiency, equitability and people-centredness (Institute of Medicine (US) Committee on Quality of Health Care in America, 2001). Access to high-quality care can be limited by legal, social and economic contexts. Studies suggest that low- and middle-income countries ‘struggle to consistently provide good quality of care’ and evidence demonstrates the need for legal and social accountability efforts to improve quality on a large scale (Kruk *et al.*, 2017). Importantly, women who are marginalized including those who are poor, minors under age 18 years, unmarried, sex

workers, or live in rural settings are more likely to experience challenges accessing high-quality care (Bearinger *et al.*, 2007; Izugbara *et al.*, 2017; Global Network for Sex Workers Project 2018; Peters *et al.*, 2008).

Quality of care has been defined more specifically for reproductive health services. In 1990, Judith Bruce developed a seminal framework that reflected a client-centred approach to family planning services (Bruce, 1990). The framework was recently updated to align with human rights-based care; key domains include choice of method, competent providers, privacy, information exchange, interpersonal interactions and ancillary services (Jain and Hardee, 2018). Sudhinaraset *et al.*, (2017) defined person centred care as ‘providing reproductive health care that is respectful of and responsive to individual women and their families’ preferences, needs and values, and ensuring that their values guide all clinical decisions’. Reproductive health quality frameworks and studies have focused on family planning (Bruce, 1990) and maternal care (Sudhinaraset *et al.*, 2017), and there is limited consensus on what domains constitute quality of care in abortion (Dennis *et al.*, 2017).

Abortion quality has primarily been framed and measured by providers or institutions. A recent literature review found 75 unique indicators to measure abortion quality at facilities around the globe (Dennis *et al.*, 2017). While the quantity of indicators demonstrated that quality of care is a priority in the monitoring of abortion services, the authors also highlighted the lack of standardization in the definition and measurement of abortion quality across contexts and systems. The most frequently used indicators measured aspects of infrastructure or technical competence from the perspective of the clinicians (Dennis *et al.*, 2017).

The perspective of clients has little representation in current abortion quality measures. Feedback is often solicited through client exit interviews with general questions such as ‘How satisfied were you’ and ‘Would you recommend this service to a friend’. Women report high satisfaction in abortion care almost universally, regardless of setting or other demographic characteristics (Darney *et al.*, 2018). In the few studies and reports that have sought a deeper understanding, abortion clients prioritized the technical skill and reputation of providers, comfort with providers, perception of confidentiality and respectfulness, choice in the abortion method, counselling for aftercare, quality of the physical environment and information received (Becker *et al.*, 2011; Marie Stopes International, 2019; Mossie Chekol *et al.*, 2016). Altshuler and Whaley (2018) synthesized findings from recent abortion quality studies using a person-centred framework with domains such as autonomy, respect and trust. They highlight that abortion care often lacks a client-centred approach and fails to address people’s concerns and fears. These findings begin to provide valuable insight into women’s preferences; however, more exploratory work is needed to understand how abortion clients perceive quality and what aspects of care are most important to them. This information is essential in order for facilities to design person-centred measures for quality in abortion care.

In this qualitative study, we aimed to assess women’s experiences with abortion care, their definition of quality and their priorities for high-quality services. The research

was conducted in Kenya and India in order to include client perspectives from two distinct cultural and legal settings.

Legal and care-seeking context in Kenya and India

In both Kenya and India, the abortion rate is similar, with 48 per 1,000 women of reproductive age in Kenya estimated in 2012 and 47 per 1,000 women of reproductive age in India estimated in 2015. Many women in both settings obtain abortions outside of the healthcare system; however, assessments of complications due to unsafe abortion suggest mortality and morbidities are more common in Kenya (Mohamed *et al.*, 2015; Singh *et al.*, 2018).

In Kenya, access to legal abortion is limited to cases where the life or health of the woman is at risk, where health is defined based on the WHO definition: ‘physical, mental, and social wellbeing’. Many people in Kenya face barriers to safe abortion services such as perceived stigma, cost, fear of unsafe procedures and uncertainty about the law (Hussain, 2012; Izugbara *et al.*, 2009; Jayaweera *et al.*, 2018; Marlow *et al.*, 2014). One study reported that women in Kenya defined safe care as services that are affordable, identified through social networks and kept secret, likely due to the legal restrictions and social stigma (Izugbara *et al.*, 2015). Abortion incidence is particularly high among young women aged 15–24 years in Kenya, who often face increased stigma or discrimination from communities and providers (Izugbara *et al.*, 2017; Mohamed *et al.*, 2015). In addition, providers are discouraged from offering safe abortion services due to confusion and fear about unclear guidelines from the Ministry of Health (Federation of Women Lawyers (FIDA KENYA), 2019).

In India, at the time of the study, abortions were legal up to 20 weeks gestation when provided by a registered medical practitioner and required approval from an additional provider at later gestations. There are barriers in India for minors who seek abortion care—they must obtain spousal, guardian or parental consent, and recent legislation considers all pregnant minors to be victims of rape and requires that providers report regardless of consent (Medical termination of pregnancy act, 1971; The protection of children from sexual offences act, 2012; Partners for Law in Development, 2018). Despite the legal framework, there is a shortage of health facilities offering abortion services and most abortions happen outside the formal healthcare system. Based on the most recent estimate in 2015, the majority of abortions are medication abortions (81%) (Singh *et al.*, 2018). People often prefer obtaining medication abortion through pharmacies given the convenience, affordability and anonymity (Srivastava *et al.*, 2019). Unmarried women in India, in particular, face delays in seeking abortion and experience higher rates of second trimester abortion, likely due to delayed recognition of pregnancy, lack of partner support and fear of disclosure (Jejeebhoy *et al.*, 2010).

Materials and methods

Between October and November 2017, we recruited abortion clients in Mumbai, India, and Eldoret and Thika, Kenya, to participate in a qualitative study about their perceptions of quality of care and their experiences seeking and obtaining

induced abortion services. We selected the geographic regions within each country based on locations with high incidence of abortion (Kenya) and the locations of health facilities that had high client flow (India and Kenya) and diverse client profiles (India and Kenya). In each country, we aimed to include multiple sites to expand the perspectives included in the data. We recruited participants primarily through health facilities affiliated with Family Health Options Kenya (FHOK) and Family Planning Association of India (FPAI). In Kenya, we also recruited through peer educators and additional private providers who worked in Eldoret or Thika.

We conducted semi-structured, in-depth interviews in both India and Kenya, and focus group discussions in India. The research team in Kenya expressed concerns about the acceptability of focus group discussions due to client fears of disclosing their abortion to others. Any distinctions in methodology between the two country contexts were based on extensive conversations with the local research teams regarding cultural norms, perceived acceptability, recruitment strategies and feasibility. Women were eligible for the study if they were over 18 years of age, spoke one of the study languages (Kiswahili, English, Hindi or Marathi) and had obtained an abortion in the 2 months prior to recruitment in India or past 6 months in Kenya. We aimed to include a range of ages, including young people less than 25 years old, as well as both married and unmarried women. In India, we anticipated challenges recruiting women who reported being unmarried given the stigma associated with abortion among unmarried women and fear of being turned away for services. The study was conducted in collaboration with the authors' institutes in India and Kenya.

During the recruitment period, service providers in both countries invited all eligible women to participate in the study at FPAI and FHOK health facility recruitment sites. Clients were recruited at follow-up visits or approached at the end of their procedure visit. In Kenya, peer educators already affiliated with the FHOK health facilities contacted women in their community who had disclosed a recent prior abortion to determine eligibility and invite them to participate. These women received abortion care at a range of sites including health facilities or chemists. We identified various private providers in the same region as the participating health facilities in Kenya who also recruited clients at follow-up visits.

We identified one or two interviewers per country who were knowledgeable about abortion provision in the local context, trained in qualitative interviewing and ethics, and did not provide patient care at the recruitment sites. They piloted the interview guide, discussed edits and adjustments with the research team and finalized the instruments. The focus group discussion guide was reviewed by the research team after the first group and revised for clarity and time management for the second group. Interview and focus group guides included open-ended questions addressing women's knowledge of and experiences with recent abortion care. Topics included experiences seeking services, expectations before receiving care, experienced or perceived stigma, cost of the procedure, preferred and obtained type of abortion and provider/staff treatment. At the end of each interview, after the participant had shared their experience and their reflections and reactions to their services, they were asked to identify three components of abortion care that they believed were most important. They responded to a translated version of the following question:

'If you had to describe in three words what makes a quality abortion service, what words would you use? Please mention anything that feels important to you, no matter how big or small.'

Interviews and focus group discussions took place in a private space at each clinic. For the interviews, women were given the choice to participate on the day of recruitment or schedule for an alternative day, and for focus group discussions, women were asked to return to the facility on a particular date. We experienced low attendance at the focus group discussions, despite potential participants expressing interest and agreeing to attend. We conducted focus group discussions if a minimum of four people attended. Women provided written consent immediately prior to data collection and all participants consented to be audio-recorded. Each participant received compensation for their transportation costs (~1000 KES in Kenya and INR 330 in India).

Local professionals transcribed audio recordings in the language in which they were conducted and then translated into English. We conducted thematic analysis with inductive techniques to identify patterns of priorities in quality of care among all women in the sample and between the two countries. Both our interview guide and codebook were informed by the abortion quality indicators identified by Dennis *et al.*, and by the person-centred care maternity health framework developed by Sudhinaraset *et al.*, (Dennis *et al.*, 2017; Sudhinaraset *et al.*, 2017). We created an initial codebook using a priori topics from the instruments and *in vivo* codes that emerged directly from the transcripts. Two members of the research team independently coded multiple transcripts and edited the codebook and then applied the revised codebook to two additional transcripts and finalized the list of codes after improving for clarity and collapsing related codes. The final codebook was applied to all transcripts using Dedoose 8.0 (Dedoose, SocioCultural Research Consultants Los Angeles, CA). We wrote summaries of key codes in order to identify patterns and analyse relevant themes. For the final question in the interview guide asking participants to identify the most important aspects of quality care, we categorized all responses from each participant. We assigned the coded responses to create a list of domains that fell into three elements of quality: structure, process (interpersonal or technical) and outcomes. This framework is based on the Donabedian model for the assessment of quality of care developed in 1966 (Donabedian, 1966), which remains relevant in measuring and improving quality across health sectors (Berwick and Fox, 2016). We separated 'process' to include technical (appropriate, evidence-based provision of care) and interpersonal (interactions with the providers) aspects of care in order to capture the distinct priorities in the two categories (Darney *et al.*, 2019). Within each element, we ranked the domains from most common to least common. We present illustrative quotes from the key themes that emerged and identify the participants by country and by age.

Results

Participant characteristics

A total of 45 women participated in this study. In Kenya, 24 women completed in-depth interviews, and in India, 10 women completed in-depth interviews and 11 participated in two focus group discussions. The mean age was 27 years

Table 1. Participant characteristics

	Total (n = 45)	Kenya (n = 24)	India (n = 21)
Age (years)			
Mean	26.9	26.9	27.0
18–24	16	9	7
25–35	27	13	14
≥36	2	2	0
Marital status			
Married	30	9	21
Unmarried	15	15	0
Education			
High school or less	28	9	19
College or above	15	14	1
Missing	2	1	1
Type of work			
Paid for work	19	13	6
No work outside the home	16	2	13
Student	10	9	1
Religion			
Christian	24	24	0
Hindu	18	0	18
Muslim	3	0	3
Number of children			
0	14	11	3
1–2	24	9	15
≥ 3	6	4	2
Missing	1	0	1
Number of prior abortions			
0	32	22	10
≥ 1	11	2	9
Missing	2	0	2
Type of facility			
FHOK or FPAI	38	17	21
Other private clinic	6	6	–
Chemist	1	1	–
Type of abortion ^a			
Medication	24	15	9
Surgical	21	9	12

^aParticipants self-reported type of abortion and did not specify type of surgical procedure.

(range in Kenya 18–46 years and range in India 19–35 years), and there were a total of 16 young people (age 18–24 years), with nine in Kenya and seven in India. One-third of women in Kenya identified as married, and the entire sample in India reported being married. Thirty women had one or more children (13 in Kenya and 17 in India), and 11 participants reported a prior abortion (two in Kenya and nine in India) [Table 1].

Thirty-eight women received services at a participating health facility, six obtained their abortion service from another private provider and one from a chemist. In Kenya, 15 women had a medication abortion and nine had a surgical procedure; in India, nine women had a medication abortion and 12 received a surgical procedure.

At the end of each interview, participants were asked to identify three aspects of abortion care that were most important for a high-quality service. The most common element was ‘process’ (identified 64 times by participants) with 47 mentions of ‘interpersonal’ aspects of care and 17 mentions of ‘technical’ aspects of care. The most commonly mentioned domains of interpersonal care included kind and caring providers, accurate information, supportive counselling and

Table 2. Categories of abortion care identified by clients as most important for high-quality care

	Total ^a	India	Kenya
Structure	31	16	15
Follow-up service provided	9	3	6
Appropriate equipment/quality meds available	6	3	3
Reasonable cost	6	2	4
Cleanliness/hygiene	5	4	1
Quick service	3	2	1
Clinic offers full scope of services	2	2	0
Process	64	28	36
Interpersonal	47	21	26
Kind and caring providers/staff	12	6	6
Accurate information/good explanations	9	6	3
Counseling (support decision/discuss problems)	9	2	7
Maintain secret/privacy	7	1	6
Women put at ease and made comfortable	4	2	2
Warm welcome (reception/first encounter)	3	2	1
Women given options for treatment	2	2	0
Contraception options discussed/provided	1	0	1
Technical	17	7	10
Procedure done well/accurate regimen	10	4	6
Certified, skilled, experienced provider	4	1	3
Not painful	3	2	1
Outcomes	13	4	9
No complications	5	1	4
Confirmed completion/100% complete	4	3	1
Maintains fertility	2	0	2
Woman does not die	2	0	2

^aData represent the number of participants who mentioned each category.

privacy. The ‘structural’ aspects of care were highlighted as important 31 times; this included provision of follow-up, appropriate equipment and quality medications and reasonable cost. The ‘outcomes’ of care were mentioned as important 13 times and included lack of complications and a complete abortion. The responses are categorized in

Four key themes emerged from the interviews in both Kenya and India as important aspects of high-quality abortion services: kind and caring providers; receiving accurate, clear information and counselling; technical competency in the delivery of services; and the opportunity to follow-up during or after the abortion. These priorities mirrored the most common responses in Table 2. Each of these themes is described in detail below.

Kind and caring clinicians and staff

Women in both India and Kenya found their interactions with clinicians and staff to be one of the most important aspects of good care. They wanted a provider—nurse, doctor or other clinical worker—who was ‘encouraging’, ‘supportive’, ‘concerned’, ‘reassuring’ and had a ‘heart for assisting people’. In some cases, being treated with kindness meant providers spoke politely and did not shout or scold—as one woman stated, ‘rudeness is the worst’ (Kenya, age 26).

Some clients feared the providers would be unkind; however, most were surprised by the warmth they experienced. This woman from India explained that her expectations were

influenced by her assumptions about how she believed female patients were treated generally:

I was [a] little scared because in some places doctors shout at the patients. But in this clinic, no one is like that. Everyone talked to me very politely and even the doctor also talked to me very well. As they all are ladies here, I was scared that they can shout at the patients but after coming here I noticed that they all are very good. (India, age 22)

Participants not only noticed kind (or unkind) care from the clinicians, but also from the ultrasonographers, the receptionists and other staff. This participant in India noted that her interactions with the receptionists could impact her confidence:

If [the receptionist] is not welcoming us or are not cooperative, then it is not good. Our confidence goes down if that treatment is not good or [if they] ask unwanted questions. [It will be good] if they are welcoming us, helping us to fill the form and card, if their attitude is helpful. (India, age 22)

The way the providers interacted with clients played a role in their ability to speak freely and their sense of confidentiality. This participant described how a clinician should read the room so the client feels at ease to share: 'If the patient is not comfortable to discuss her problem in front of her own people then you must know how to politely request the person to leave the room. If the patient is afraid to speak up then they must make the patient comfortable and ask her in a manner so that she speaks up' (India, age 19).

In addition to feeling more confident, at ease, and comfortable, another client explained that kind, caring providers would motivate her to return to the clinic: 'The way I was spoken to... [will make] me go back there' (Kenya, age 30).

Accurate, clear information and counselling

In addition to the kindness of clinicians and staff, women believed good services included receiving understandable information about what to expect during their abortion and open communication with the provider about their concerns and questions. The participants' priorities for information provision varied by country. Women from India tended to seek information about what they needed to do before and after the procedure. As one woman said, 'The nurses should guide us properly and give us full information on everything to be done' (KNAK FGD India, Focus Group ages 24–28). Another client explained that getting a description of the abortion process was essential to good care because it can give reassurance and helps mitigate fears.

If the procedure is explained properly then there will be less chances of her getting scared. Also if she is scared then the staff should be able to relax her. Any uncertainty [that] is there should be taken away. Even when she is [in the room for the procedure] she should be put [at] ease and not [be] confused. (India, age 22)

Multiple clients in India described specifically wanting to know how to take care of themselves after taking the pills

and what adverse events to look for, as described by this participant:

They must make the patient aware of what will happen after taking the tablet and when to call back and ask for help, if there is heavy bleeding then what to do. They must give information on how to cope with such issues... they must give detailed information on the food intake, whether we can eat non-vegetarian food or we must be kept on fluid and liquid food or any other specific food which is good at such times. (India, age 19)

Some women in India felt that in order to receive accurate explanations for their personal circumstances, they needed the providers to listen to their personal circumstances or concerns. One woman explained how her providers fulfilled this role: 'they listen to all pregnant ladies. They listen to their problems and then they give them the proper solution, and they also make them understand very well' (India, age 28).

Women from Kenya tended to emphasize the importance of being able to express their concerns and feel heard as part of their care. Many Kenyan participants wanted a provider that 'listen[ed] to what I am saying without cutting me short. [Because] some...doctors just want to fill in ...to complete your sentences while maybe that's not what you were saying' (Kenya, age 24). This was echoed by another participant who stated, 'when someone just gives you a platform to speak, I can call that quality' (Kenya, age 19). One participant highlighted the lack of questions or counselling she experienced when seeking services from a chemist and defined this as poor care:

He didn't even ask me anything. I just didn't like that, because he should at least have told me what that medicine does. The only thing he did was to give me medication then told me to wait for 8 hours. Then he left. (Kenya, age 21)

In addition to needing to voice their concerns or questions, some participants in Kenya also sought empathy and validation from their providers, as described by this participant.

To me, the best service, it starts when the doctor is able to listen to me, is able to understand me, is able to enter into my shoe like he will own the problem, and he will have [a] great attitude. (Kenya, age 26)

This validation was especially valuable given the shared concerns about dying as a result of unsafe abortion. Multiple Kenyan women described seeking reassurance from providers that the procedure would be safe, such as this participant who recalled abortion complications from herbal medicines among people in her community:

The doctor counselled me. He told me that I knew these things because I had witnessed many cases at home where people died during abortion. So he told me that it's not a must for one to die. There are many people who have aborted and they are okay afterwards. (Kenya, age 26)

Competent providers and appropriate care

Participants in India and Kenya felt that good-quality abortion services must include competent providers who performed the abortion well and could handle complications. Nearly half of the women interviewed in Kenya felt that only 'a qualified doctor' (Kenya, age 24) or a 'real doctor' (Kenya, age 34) who is 'professionally trained' (Kenya, age 32) should provide abortion services. Another woman echoed, 'The person assisting me, obviously I expected him to have knowledge about it' (Kenya, age 22). In India, one woman added, 'the procedure should be performed very well and without much pain' (India, age 30).

In addition to skilled providers, participants commonly talked about getting the 'necessary' examinations, the 'right' procedure and a 'successful' service. Participants also said that a provider who understood a client's individual situation could ensure she was given the most appropriate treatment. This woman believed she had a good doctor because 'he asked me in detail about my health, whether I had any operation before, or [if] I have [had] any problem.' (India, age 24) Another client added:

[A provider] has to listen to what you want then they should examine me properly so that they know what they are treating. When they are giving me treatment, they should be sure that the treatment will work. (Kenya, age 32).

The clients described high-quality care as receiving effective medications, not experiencing much pain, the procedure going as they were told it would, and no long being pregnant after the procedure. The belief that that they had competent providers and reliable medication helped clients feel that their procedure would be both safe and successful. One participant noted, 'She should not have any reaction. And if [it] does happen then the doctors and staff should be equipped to handle that. The patient should not have any trouble.' (India, age 22). Without these assurances, women raised concerns about poor services that would lead to complications and put their lives or their future fertility at risk.

Opportunity to follow up after the abortion

Participants highlighted the importance of both interpersonal and technical skills not only during the clinical encounter, but also during follow-up services as well. Clients defined follow-up services as a provider checking on their health during or after the abortion, the opportunity to confirm that the abortion was successful and/or treatment for complications or incomplete abortion when required. A participant in Kenya responded to a question about what a satisfactory service would entail by explaining, 'if you [do] get complications later, he [the provider] will help you out of it, so you end up having good body health' (Kenya, age 26).

Communication with the provider during or after the abortion often demonstrated to the client that the provider cared about their wellbeing and wanted to ensure their safety. This is exemplified by one participant who had a medication abortion in Kenya and reached out to the provider for follow up after taking the pills at home:

Then when I was going through the process, I called a doctor because I was having some serious pain in my stomach.

I called him then I heard his response. The doctor himself was concerned with the patient. I felt that was the best service I got. (Kenya, age 22)

Some clients received a call from the doctor after the procedure, and they tended to find this experience to be both unexpected and appreciated, as described by this woman.

I got the service beyond my expectations. After giving me that service, they called me here again for a check-up [about] whether I have any problem[s] or not. Sometimes, in case of some hospitals, it happens like after giving an abortion service they don't care if the patients suffer from any problems. But they called me here again to check-up my health condition, and again they gave me medicines. (India, age 28)

However, others did not receive a call and felt that it would have been useful. Beyond checking in on physical symptoms, the clients sought reassurance or confirmation that they were no longer pregnant. For this woman in India, the confirmation was the most important part of high-quality care. 'Ladies are mostly worried about whether they would have a complete abortion or not. They always want it [the pregnancy] to get cleared properly.' (India, age 35).

Discussion

Through this study, we gained a deeper understanding of how abortion clients in India and Kenya described high-quality care. There was overwhelming consensus among this group of clients from primarily clinic-based settings that providers' interpersonal skills are paramount to a good abortion experience. The women we interviewed desired service providers that treated them with respect and dignity and offered them personalized information and counselling that helped them feel prepared and reassured. The competency of clinicians to provide appropriate, effective care also emerged as a priority for some clients. These findings echo previous studies that identified the importance of interpersonal interactions and information provision in abortion quality, and associated these aspects of care with overall satisfaction (Elul, 2010; Ganatra *et al.*, 2010; Mossie Chekol *et al.*, 2016; Sudhinaraset *et al.*, 2018; Zamberlin *et al.*, 2012).

This study also contributes new and more detailed insights to our definition of quality abortion care from the client perspective. For example, clients discussed the importance of being able to ask questions or feel heard, suggesting that information exchange is necessary for high-quality abortion care, rather than just information provision. Participants also noted a good abortion experience can be influenced not only by interactions with the providers, but also by staff members they see throughout their process, such as the receptionist or ultrasonographer. In addition, the women in this study highlighted the value of follow-up care or interactions which made them feel safe and supported. While not all clients require follow-up care after abortion, this theme requires us to consider quality beyond the primary clinical interaction. In order to address client priorities in abortion quality of care, service providers, researchers and other stakeholders should centre client-provider relationships while also addressing their

needs and preferences throughout the structure, process and outcomes of the abortion experience.

While clients in Eldoret and Thika, Kenya, and Mumbai, India, shared similar priorities and preferences in many areas of abortion care, we identified some distinct perspectives between the two contexts. For example, there was consensus across the sample that high-quality care would include information provision and that this would lead to feeling reassured. However, the way in which women wanted the provider to engage during these interactions varied by country. Women in India tended to prioritize receiving comprehensive information to prepare them for the experience, while women in Kenya highlighted the need to be listened to and supported when they expressed their fears or questions. It was also Kenyan participants who focused more on the importance of skilled, competent providers and avoiding serious complications including death. These differences may derive from the legal and cultural environment in which the participants lived and sought services (Sudhinaraset *et al.*, 2018). In Kenya, abortion is legally restricted and women described common narratives in their community about unsafe abortion resulting in morbidity and mortality; indeed complications from unsafe abortion continue to be common (Ziraba *et al.*, 2015). In India, on the other hand, there is more clarity on the conditions in which abortion is legal, and high-quality medications for abortion are more widely available. The details of these differences are valuable when considering how frameworks and indicators for abortion quality can be flexible to suit specific political and cultural contexts. Such adaptability was demonstrated by Sudhinaraset *et al.*, when developing a multi-dimensional person-centred scale for family planning among clients in India and Kenya. The researchers similarly noted differences across contexts and modified items in the scale to reflect the values of women in each place (Sudhinaraset *et al.*, 2018). Future measurement tools for abortion quality must establish guidance on adaptation for diverse settings.

The person-centred care themes identified as important by individuals in this study align with domains in the reproductive health literature, including family planning and maternity quality of care frameworks. People who obtain abortion services, similar to contraception and maternity care clients, value competent providers, respect, non-discrimination, empathy, information exchange that is honest and clear, confidentiality and receiving services tailored to their individual needs (Holt *et al.*, 2017; Izugbara and Wekesah, 2018; Jain and Hardee, 2018; Paine *et al.*, 2000). Trust, which appears in the quality contraceptive counselling framework by Holt *et al.*, was not discussed explicitly by abortion clients in the current sample; however, we posit that being treated with kindness, feeling listened to, and receiving calls after the procedure to check on their status likely contributes to a sense of trust with their provider. Choice of methods, which appears in the Bruce/Jain framework, is not discussed directly by the abortion respondents, perhaps suggesting that choice was less available for abortion services as compared to contraceptive care, or that clients did not value it as much as other parts of their service experience. Our data suggest that various person-centred care domains already defined in reproductive health frameworks could apply to abortion clients, yet there are aspects of abortion care that may require special consideration. For example, the need for reassurance and information provision, particularly due to the social stigma or pervasive

negative narratives around abortion, as well as the option for communication with a provider throughout the entire abortion experience and not just during the initial clinical encounter, may be particularly important for abortion care. An abortion-specific framework, informed by evidence and client perspectives, will offer guidance for providing, evaluating, and improving abortion quality at the local, regional, and national levels.

Quality in abortion care is also necessarily unique because of the political landscape in many countries and the social norms that influence women's experiences seeking care. In a prior analysis of this same dataset, we found that stigma, limited knowledge, negative attitudes towards abortion, legal consequences and fears about safety and discrimination contribute to low expectations of abortion care. Social norms and stigma around abortion are exacerbated for young and unmarried women regardless of legal environment (Makleff *et al.*, 2019). It is possible that these contextual factors play a role in women's care-seeking behaviours and how they perceive quality. When women arrive to abortion care with low expectations, they may be more willing to accept poor care, think they deserve bad treatment or not have defined for themselves what high-quality services should include; this could impact the feedback they provide on their experience. We posit that this likely contributes to the overwhelmingly high satisfaction rates across all contexts for abortion (Darney *et al.*, 2018). New or updated evidence-based measures to assess client-centred abortion quality are needed in order to obtain meaningful feedback and identify areas for policy and programmatic improvements. In addition, facilities should consider providing easy-to-understand information and examples of the attributes of high-quality abortion to clients when they arrive for abortion services. This could disrupt the existing negative expectations of abortion care and give clients agency to assess their treatment based on the care they deserve.

We would like to highlight some of the limitations of this study. While the sample included a diverse sample in terms of socio-demographics including age, education, prior abortion and type of abortion, clients were recruited predominantly from clinics affiliated with a global non-governmental organization. Therefore, we are not able to comment on the perception of quality among unmarried women in India or among clients from a range of service-delivery models in each country. In particular, participants discussed fears of judgement and disrespect based on prior experiences in public sector facilities and pharmacies; future research should explore perspectives on quality among clients at these types of providers. In addition, clients were recruited by health care providers at the facilities where they received services and peer educators based on who had disclosed a recent abortion in their communities; this may have influenced who agreed to participate in the study. We hypothesize this would result in more participants who reported positive experiences. In an effort to encourage honest conversations during data collection, the interviewer was not affiliated with the service-providing organization and the consent form explicitly noted that their responses would be confidential and would not impact their care. Lastly, we did not recruit samples in each country to reach saturation on all themes for comparison across the two contexts. Therefore, we analysed the entire dataset and addressed patterns in each country where relevant.

There is a growing interest among abortion providers, researchers and policy makers around the globe to improve indicators of quality in abortion care. In order to accomplish this goal, we need to build consensus around the definition of high-quality abortion and prioritize the client perspective in designing and implementing indicators. The women in this study obtained abortion primarily from clinic-based providers and prioritized kind, non-judgmental treatment, individualized information and interactive counselling, ongoing communication for follow-up and skilled providers. These aspects of interpersonal care will not only be valuable to inform policies within clinic or hospital systems, but also can likely be applied across all models of abortion care such as pharmacy provision or abortion support outside of the formal health sector for medication abortion. This is particularly notable during the COVID-19 pandemic where women face additional barriers in accessing facility-based care and seek alternative routes to abortion care. The themes that emerged in this study may also be applicable to other stigmatized reproductive health issues. Future research should gather data from people who obtain abortion in diverse legal and social environments in order to determine whether the patterns seen here are similar in other contexts, models of care, social norms or legal environments. In addition, we can build on this work by exploring opportunities to inform clients at the start of their abortion visit about what it means to receive, and deserve, high-quality abortion care. It will be valuable to assess whether this type of intervention might improve clients' willingness and ability to provide honest and meaningful feedback that can be used to improve quality of care.

Data availability

The qualitative data underlying this article cannot be shared publicly due to the privacy of individuals that participated in the study. The data will be shared on reasonable request to the corresponding author.

Acknowledgements

We would like to thank Sofia Filippa for her support of coding and data analysis; James Newton for his contributions to the study design and interpretation of findings; Wilson Bunde, Usha Radhakrishnan, Mourice Barasa, Sangeeta Sonawane, Dr Trisha Bhagwan, Ashwini Bhoir, Dr Kalyani Kelkar, Sunanda Gawali, Preeti Sakat, Dr Kshama Todankar, Amita Dhanu, Dr Kalpana Apte, J.E. Mistry, Fred Kyalo, John Ngeera and the Management Team at FHOK for supporting survey design, recruitment and data collection. This work was supported by an anonymous donor.

Conflict of interest statement The authors declare that they have no conflict of interest.

References

- Altshuler A, Whaley NS. 2018. The patient perspective: perceptions of the quality of the abortion experience. *Current Opinion in Obstetrics and Gynecology* 30: 407–13.
- Bearinger LH, Sieving RE, Ferguson J, Sharma V. 2007. Global perspectives on the sexual and reproductive health of adolescents: patterns, prevention, and potential. *The Lancet* 369: 1220–31.
- Becker D, Díaz-Olavarieta C, Juárez C *et al.* 2011. Clients' perceptions of the quality of care in Mexico City's public-sector legal abortion program. *International Perspectives on Sexual and Reproductive Health* 37: 191–201.
- Berwick D, Fox DM. 2016. 'Evaluating the quality of medical care': Donabedian's classic article 50 years later. *The Milbank Quarterly* 94: 237–41.
- Bruce J. 1990. Fundamental elements of the quality of care: a simple framework. *Studies in Family Planning* 21: 61–91.
- Darney BG, Kapp N, Andersen K *et al.* 2019. Definitions, measurement and indicator selection for quality of care in abortion. *Contraception* 100: 354–9.
- Darney BG, Powell B, Andersen K *et al.* 2018. Quality of care and abortion: beyond safety. *BMJ Sexual and Reproductive Health* 44: 159–60.
- 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: 7–15.
- Donabedian A. 1966. Evaluating the quality of medical care. *The Milbank Memorial Fund Quarterly* 44: 166.
- Elul B. 2010. Assessments of the importance of provider characteristics for abortion care: data from Women in Rajasthan, India. *Health Care for Women International* 32: 72–95.
- Federation of Women Lawyers (FIDA KENYA). 2019. The status of safe abortion in Kenya.
- Ganatra B, Kalyanwala S, Elul B, Coyaji K, Tewari S. 2010. Understanding women's experiences with medical abortion: in-depth interviews with women in two Indian clinics. *Global Public Health* 5: 335–47.
- Holt K, Dehlendorf C, Langer A. 2017. Defining quality in contraceptive counseling to improve measurement of individuals' experiences and enable service delivery improvement. *Contraception* 96: 133–7.
- Hussain R. 2012. *Abortion and Unintended Pregnancy in Kenya (In Brief No. 2)*. New York, NY: Guttmacher Institute.
- Institute of Medicine (US) Committee on Quality of Health Care in America. 2001. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academies Press (US).
- Izugbara CO, Egesa C, Okelo R. 2015. 'High profile health facilities can add to your trouble': women, stigma and un/safe abortion in Kenya. *Social Science & Medicine* 141: 9–18.
- Izugbara CO, Egesa CP, Kabiru CW, Sidze EM. 2017. Providers, unmarried young women, and post-abortion care in Kenya: providers, unmarried young women, and post-abortion care in Kenya. *Studies in Family Planning* 48: 343–58.
- Izugbara CO, Otsola KJ, Ezech AC. 2009. Men, women, and abortion in Central Kenya: a study of lay narratives. *Medical Anthropology* 28: 397–425.
- Izugbara CO, Wekesah F. 2018. What does quality maternity care mean in a context of medical pluralism? Perspectives of women in Nigeria. *Health Policy and Planning* 33: 1–8.
- Jain AK, Hardee K. 2018. Revising the FP quality of care framework in the context of rights-based family planning: revising the FP quality of care framework in the context of rights-based family planning. *Studies in Family Planning* 49: 171–9.
- Jayaweera RT, Ngui FM, Hall KS, Gerds C. 2018. Women's experiences with unplanned pregnancy and abortion in Kenya: a qualitative study. *PLoS One* 13: e0191412.
- Jejeebhoy SJ, Kalyanwala S, Zavier AJE, Kumar R, Jha N. 2010. Experience seeking abortion among unmarried young women in Bihar and Jharkhand, India: delays and disadvantages. *Reproductive Health Matters* 18: 163–74.
- Kruk ME, Pate M, Mullan Z. 2017. Introducing the lancet global health commission on high-quality health systems in the SDG Era. *The Lancet Global Health* 5: e480–1.
- Makleff S, Wilkins R, Wachsmann H *et al.* 2019. Exploring stigma and social norms in women's abortion experiences and their expectations of care. *Sexual and Reproductive Health Matters* 27: 50–64.

- Marie Stopes International. 2019. *My Body, My Voice: Women's Views on Abortion Care 2019* London, UK: Marie Stopes International. <https://www.msichoice.org/media/3672/my-body-my-voice-womens-views-on-abortion-care.pdf>, accessed 25 February 2020.
- Marlow HM, Wamugi S, Yegon E *et al.* 2014. Women's perceptions about abortion in their communities: perspectives from western Kenya. *Reproductive Health Matters* 22: 149–58.
- Medical Termination of Pregnancy Act. 1971. <https://tcw.nic.in/Acts/MTP-Act-1971.pdf>, accessed 25 February 2020.
- Mohamed SF, Izugbara C, Moore AM *et al.* 2015. The estimated incidence of induced abortion in Kenya: a cross-sectional study. *BMC Pregnancy and Childbirth* 15: 185.
- Mossie Chekol B, Abera Abdi D, Andualem Adal T. 2016. Dimensions of patient satisfaction with comprehensive abortion care in Addis Ababa, Ethiopia. *Reproductive Health* 13: 144.
- NSWP. 2018. Sex workers' access to comprehensive sexual and reproductive health services. <https://tcw.nic.in/Acts/MTP-Act-1971.pdf>, accessed 25 February 2020.
- Paine K, Thorogood M, Wellings K. 2000. The impact of the quality of family planning services on safe and effective contraceptive use: a systematic literature review. *Human Fertility* 3: 186–93.
- Partners for Law in Development. 2018. Country assessment on human rights in the context of sexual health and reproductive health rights. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3348988, accessed 25 February 2020.
- Peters DH, Garg A, Bloom G *et al.* 2008. Poverty and access to health care in developing countries. *Annals of the New York Academy of Sciences* 1136: 161–71.
- The Protection of Children from Sexual Offences Act. 2012. https://legislative.gov.in/sites/default/files/The%20Protection%20of%20Children%20from%20Sexual%20Offences%20Act,%202012_0.pdf, accessed 25 February 2020.
- Singh S, Shekhar C, Acharya R *et al.* 2018. The incidence of abortion and unintended pregnancy in India, 2015. *The Lancet Global Health* 6: e111–20.
- Srivastava A, Saxena M, Percher J, Diamond-Smith N. 2019. Pathways to seeking medication abortion care: a qualitative research in Uttar Pradesh, India. *PLoS ONE* 14: e0216738.
- Sudhinaraset M, Afulani P, Diamond-Smith N *et al.* 2017. Advancing a conceptual model to improve maternal health quality: the person-centered care framework for reproductive health equity. *Gates Open Research* 1: 1.
- Sudhinaraset M, Afulani PA, Diamond-Smith N, Golub G, Srivastava A. 2018. Development of a person-centered family planning scale in India and Kenya: development of a person-centered family planning scale in India and Kenya. *Studies in Family Planning* 49: 237–58.
- World Health Organization. 2020. *What is Quality of Care and why is it important?* https://www.who.int/maternal_child_adolescent/topics/quality-of-care/definition/en/, accessed 25 February 2020.
- Zamberlin N, Romero M, Ramos S. 2012. Latin American women's experiences with medical abortion in settings where abortion is legally restricted. *Reproductive Health* 9: 34.
- Ziraba AK, Izugbara C, Levandowski BA *et al.* 2015. Unsafe abortion in Kenya: a cross-sectional study of abortion complication severity and associated factors. *BMC Pregnancy and Childbirth* 15: 34.