ABORTION STIGMA IN BRIEF:

HOW CAN WE MEASURE ABORTION STIGMA?

Abortion stigma is a major barrier to adequate reproductive health care for women and a primary challenge for service delivery providers to address. Developing adequate measures of how abortion stigma manifests is a priority step for advocates who seek design and evaluate strategies for combatting abortion. Measures of abortion stigma are relatively new in the field of stigma measurement, but they can help provide a baseline understanding of the prevalence of stigma and how it varies by geographic and cultural context. In this brief we summarize our review of evidence-based tools designed to measure stigma across a range health topics. Additional information about abortion stigma, stigma measurement and interventions can be found in our white paper: Addressing Abortion Stigma Through Service Delivery.

Stigma manifests at different cultural levels including in media, policies, institutions, communities and within individuals. There are no standard protocols for exactly how to measure stigma at different levels, however the most common measurement tools are scales and indexes, which are administered to individuals in survey form. These tools can help us understand individual experiences of stigma as well as attitudes and behaviors toward the stigmatized among community members and health care providers.

To develop a measurement scale, researchers begin with qualitative data that help them understand and conceptualize the variable being measured. Then, the data is analyzed and the findings are used to develop a conceptual model. From that model, the researchers develop a set of items, or multiple-choice questions. They typically begin with many items and then work to find those that are most valid and reliable.

Scales that measure individual-level stigma –the experience of stigma by individuals– are usually designed to measure the following within the stigmatized: internalized stigma, or negative feelings toward oneself; enacted stigma, or actual discriminatory behaviors or negative interactions; felt stigma, or perceptions of negative attitudes and concerns about stigmatizing behaviors from others; and stigma management, or behaviors that individuals use to manage stigma. Cockrill et al.'s Individual Level Abortion Stigma Scale (ILASS) was the first published scale to measure the stigma of having an abortion. The scale is designed to investigate how women experience individual-level abortion stigma in the United States.[i] The researchers found that among women who have abortions, abortion stigma manifests as worries about judgment, isolation, self-judgment, and perceptions of community condemnation. They also found that Catholic and Protestant women experience higher levels of stigma than non-religious women, and that women with stronger religious beliefs experience higher levels of self-judgment and anticipate greater community condemnation than somewhat religious women. Researchers also found differences in experiences of abortion stigma across race, age, education, and motherhood status.

Scales that measure community-level stigma –the social norms, prejudicial attitudes, and negative behaviors toward abortion that exist in communities– aim to measure the attitudes, beliefs, and behaviors of the non-stigmatized. The Stigmatizing Attitudes, Beliefs, and Actions Scale (SABAS) was developed to measure community-level stigma based on populations in Ghana and Zambia.[ii] The scale captures negative stereotypes about people associated with abortion, discrimination and exclusion of women who have had abortions, and fear of contagion from contact with someone who has had an abortion. The researchers plan to use the scale to measure community attitudes in various contexts as well as community-level interventions, though it has not yet been tested outside of Ghana and Zambia. Scales that measure institutional-level stigma –practices employed by institutions that marginalize stigmatized individuals or experiences– usually measure the attitudes and behaviors of workers who come in contact with stigmatized individuals.

When looking at stigma within structures such as the media, law, and policy, however, we use a different set of methodologies. One methodology, probability sampling, could be a study in which every English-language newspaper in the US had the same random chance of being included in a study. An example of theory-based coding, another methodology, would be a study that analyzed legislation based on codes derived from a particular theory. Researchers using qualitative content coding might review relevant laws, create codes to reflect the themes found in the documents, code the documents, and then interpret the data. Researchers using focus groups might bring together groups of colleagues in a certain field to facilitate a discussion on a particular topic and analyze the transcripts afterwards. A study that used categorical analysis would separate data into clear categories to analyze each separate category as a group. Finally, narrative analysis uses text as the unit of

analysis to discern meaning, such as examining court cases to search for manifestations of abortion stigma.

Measurement is crucial to designing, implementing, and evaluating interventions that aim to reduce the negative effects of abortion stigma. As the field of abortion stigma measurement is relatively new, there are not yet enough valid and reliable measures. Another key issue is that researchers do not use the same measure across stigmas or across interventions, making comparison of the data challenging. These issues make measurement a primary limitation to the production of high quality research on stigma interventions.

REFERENCES

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