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Quality of care from the perspective of people obtaining abortion: a qualitative study in four countries

Sarah E Baum ,[1] Laura Jacobson,[1,2] Ana Maria Ramirez,[1] Anna Katz,[1,3] Belen Grosso,[4] Chiara Bercu,[1] Erin Pearson,[5] Ewenat Gebrehanna,[6] Nirali M Chakraborty,[7] Osasuyi Dirisu,[8] Rezwana Chowdhury,[9] Ruth Zurbriggen,[4] Sofia Filippa,[1] Tanzila Tabassum,[10] Caitlin Gerdts[1]

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For numbered affiliations see end of article.

Correspondence to
Dr Sarah E Baum;
sbaum@ibisreproductivehealth.org

ABSTRACT

Objective This qualitative study aimed to identify person-centred domains that would contribute to the definition and measurement of abortion quality of care based on the perceptions, experiences and priorities of people seeking abortion.

Methods We conducted interviews with people seeking abortion aged 15–41 who obtained care in Argentina, Bangladesh, Ethiopia or Nigeria. Participants were recruited from hospitals, clinics, pharmacies, call centres and accompaniment models. We conducted thematic analysis and quantified key domains of quality identified by the participants.

Results We identified six themes that contributed to high-quality abortion care from the clients' perspective, with particular focus on interpersonal dynamics. These themes emerged as participants described their abortion experience, reflected on their interactions with providers and defined good and bad care. The six themes included (1) kindness and respect, (2) information exchange, (3) emotional support, (4) attentive care throughout the process, (5) privacy and confidentiality and (6) prepared for and able to cope with pain.

Conclusions People seeking abortion across multiple country contexts and among various care models have confirmed the importance of interpersonal care in quality. These findings provide guidance on six priority areas which could be used to sharpen the definition of abortion quality, improve measurement, and design interventions to improve quality.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ We conducted interviews with a large qualitative study (n=98).
⇒ The study included diverse perspectives from participants in four countries who received abortion care and support from a range of service-delivery models.
⇒ The study did not include perspective on quality of abortion care from people who wanted abortion but did not get one, people in their second trimester or those who self-managed their abortion after obtaining pills from a pharmacist.

INTRODUCTION

Abortion care is an essential component of comprehensive sexual and reproductive healthcare and access to abortion is considered a human right.[1] Globally, there are an estimated 39 induced abortions per 1000 women of reproductive age which are obtained in facility and out-of-facility settings.[2] The safety and availability of abortion has improved, especially in high-income countries,[2] yet the quality of abortion services varies widely.[3 4] Given the potential implications of poor quality on health outcomes such as abortion complications or abortion-related deaths, as well as future healthcare seeking behaviour due to lack of trust, lack of privacy or fear of negative interactions,[5] measuring and improving quality of care is an essential part of ensuring access to safe and effective services.[6]

Quality of care is defined by the WHO as 'degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with evidence-based professional knowledge'.[7] The WHO quality of care framework includes safety, effectiveness, timeliness, efficiency, equitability, integrated and people-centredness.[8] Person-centred care refers to services and support that are responsive to the needs, values and preferences of individuals seeking care.[9–11] Person-centred care domains focus on interpersonal interactions with providers, counsellors and staff such as effective communication, dignity and respect, shared decision-making, trust and emotional support.[12–14] These interpersonal aspects of care, most of which fall in the 'process' domain (as opposed to 'structure' or 'outcomes') defined by Donabedian in

his components to evaluating quality of care,[15] are often poorly defined and rarely measured.[6 16]

In abortion care specifically, systematic and scoping reviews have found that a wide range of abortion quality metrics are used globally; however, there are no standardised measures for patient experience and respectful care.[17–19] Survey questions about 'satisfaction' alone are not sufficient for measuring quality from the individual's perspective, not only because they tend to reflect expectations rather than experiences,[20 21] but also because abortion clients tend to rate care as highly satisfying.[3] This lack of variation in reported satisfaction may be related to a number of factors including a combination of overwhelming relief, low expectations, stigma, lack of context for assessing quality or social desirability bias effect.[3 22–24] Despite these challenges, measurement of patient experience remains important because it has been associated with health outcomes[16 25] and is widely viewed as essential to realising high-quality care.[21]

Recent studies have used interpersonal care domains and person-centred care frameworks from other areas of reproductive health to assess abortion client experience with more nuance. One qualitative study among clients in Kenya found that patients described positive experiences when they received respectful, competent care and clear communication throughout the abortion process. These experiences contributed to feelings of autonomy. The researchers also highlighted the importance of social support outside of the clinic, especially in reducing feelings of stigma.[5] Researchers also developed and validated a measure of person-centred abortion care in Kenya which included two subscales: 'Respectful and Supportive Care' and 'Communication and Autonomy'.[19] Another qualitative study in the USA highlighted the need for abortion-specific interpersonal quality measures and the potential for these instruments to influence both provider behaviour and client confidence in deserving high-quality care.[26] We aim to expand on this work by establishing shared definitions and priorities for abortion quality of care from the perspective of people obtaining abortion care in low-income and middle-income countries across a range of legal and social settings as well as building evidence beyond clinic-based abortion provision.

Given the current focus on access to medication abortion—both mifepristone and misoprostol—across the globe, it is increasingly useful to define and evaluate quality throughout diverse models of abortion care both in facility and out-of-facility settings. These include telehealth and hotline models where people receive virtual information and support, pharmacy or drug sellers where people obtain pills and information, as well as hospitals and clinics. Provision of abortion care outside of health facilities is largely missing from the literature around abortion quality, however quality of care domains—particularly domains related to information provision and interpersonal dynamics—are applicable. Understanding client perspectives across these models can contribute to the development of a global standard for measuring abortion quality, which has the potential to more clearly identify areas for improvement, monitor changes over time, and ultimately increase availability of person-centred abortion care.

In order to gain a deeper understanding of the aspects of quality care that are important to people obtaining abortion, we conducted a phenomenological qualitative study in four countries: Argentina, Bangladesh, Ethiopia and Nigeria. We included a range of service-delivery models to ensure representation from public and private facilities, call centres, hotline support and drug sellers. In this analysis, we aimed to identify similarities in client perceptions, experiences and priorities across the sample that would contribute to the development and expansion of person-centred domains in the definition and measurement of abortion quality of care.

Country contexts

The four low-income and middle-income countries where this study was conducted represent a range of abortion laws and social norms related to abortion access, knowledge and availability. Nigeria's abortion law is highly restrictive, availing legal services only to save the life of the pregnant person.[27] Despite the restrictions, unwanted pregnancy and abortion remain common, likely due in part to unmet need for contraception.[28] There is widespread availability of medication abortion, especially misoprostol, from drug sellers who often provide inadequate information; however, one study found that most people were able to effectively self-manage their abortion with pills from the drug sellers.[29] Unsafe abortion remains a concern in Nigeria and is most common among young, uneducated, rural and poor women.[30] Argentina, at the time of data collection, also had highly restrictive abortion laws similar to Nigeria, with additional exceptions for rape and the health of the pregnant person.[31] Despite limited access to clinic-based services and ongoing opposition to abortion across the country, often due to religious reasons,[32] a strong feminist movement in Argentina influenced expansion of legal and social abortion rights, ultimately leading to the legalisation of abortion with no clausal restrictions up to 14 weeks' gestation in January 2021.[33–35] Ethiopia has a more moderate law, passed in 2005, permitting abortion without gestational limits for the life and health of the pregnant person, in cases of rape/incest, fetal impairment and other exceptions related to age and ability to care for a child.[36] People's knowledge of the law and how to access a safe abortion remains limited[37 38] and religiosity may impact provider's willingness to perform abortions.[39] Bangladesh's law states that induced abortion after pregnancy is confirmed as illegal except to save a person's life, however people can access menstrual regulation (MR) defined as regulation of the menstrual cycle when menstruation has been absent for a short duration. MR is offered in Bangladesh with medications (up to 9 weeks' gestation) or by manual vacuum aspiration (up to 12 week's gestation).[40] For the purposes of this paper, when this service is discussed with

other countries, all services will be referred to as 'abortion' generally. MR services are supposed to be free in the public sector, however, as of 2014, fewer than half of the facilities that could provide MR offered the service and women lacked information about the availability of the service.[41 42] A large proportion of abortions in Bangladesh happen outside of facilities,[43] and one study documented inadequate information about dosage and regimen from pharmacists and drug sellers.[44]

METHODS

Between December 2018 and March 2019, we conducted in-depth interviews with people aged 15–41 who had an abortion at participating sites in Argentina, Bangladesh, Ethiopia and Nigeria. These countries were selected as part of a formative study for the Abortion Service Quality Initiative which aimed to develop and test universal abortion quality indicators.[45] The Initiative sought to conduct research in countries that had diverse legal and social abortion settings, and where we could build or strengthen relationships with a range of service-delivery models for this study and future indicator testing. We predetermined our sample size, seeking to enrol approximately 25 people in each of the four countries. We identified recruitment sites to ensure participants represented perspectives from both in facility and out-of-facility settings; we aimed to recruit in at least two different care settings in each country. These sites included facilities (public and non-governmental organisation clinics), call centres affiliated with a health facility, accompaniment groups, safe abortion hotlines and proprietary patent medical vendors (PPMVs). Depending on the country, facilities offered legal abortion services in the clinic or provided pills for people to take at home, and affiliated call centres offered referrals to facilities or information about how to take pills. Accompaniment groups and safe abortion hotlines provided support and information throughout the abortion process with a feminist-based philosophy, either in person or virtually. PPMVs, a type of community drug retail outlet that often operates out of the drug seller's home, offered medications and information about a range of healthcare needs including abortion. An example pathway of care for people at each recruitment site is displayed in figure 1.

A qualitative researcher in each country managed recruitment and conducted data collection. US-based and local research teams hosted in-person training for recruitment site staff to provide information on the research objectives and study methodology as well as ethical guidelines. Trained staff were responsible for describing the study to abortion clients and inviting them to participate. Depending on the recruitment site, clients were invited at different points in their abortion process: immediately following the initial visit/contact, during follow-up care or contacting them via telephone after their abortion. People seeking abortion were eligible for the interviews if they were at least 15 years old (Bangladesh, Ethiopia, Argentina) or 16 years old (Nigeria), spoke a study

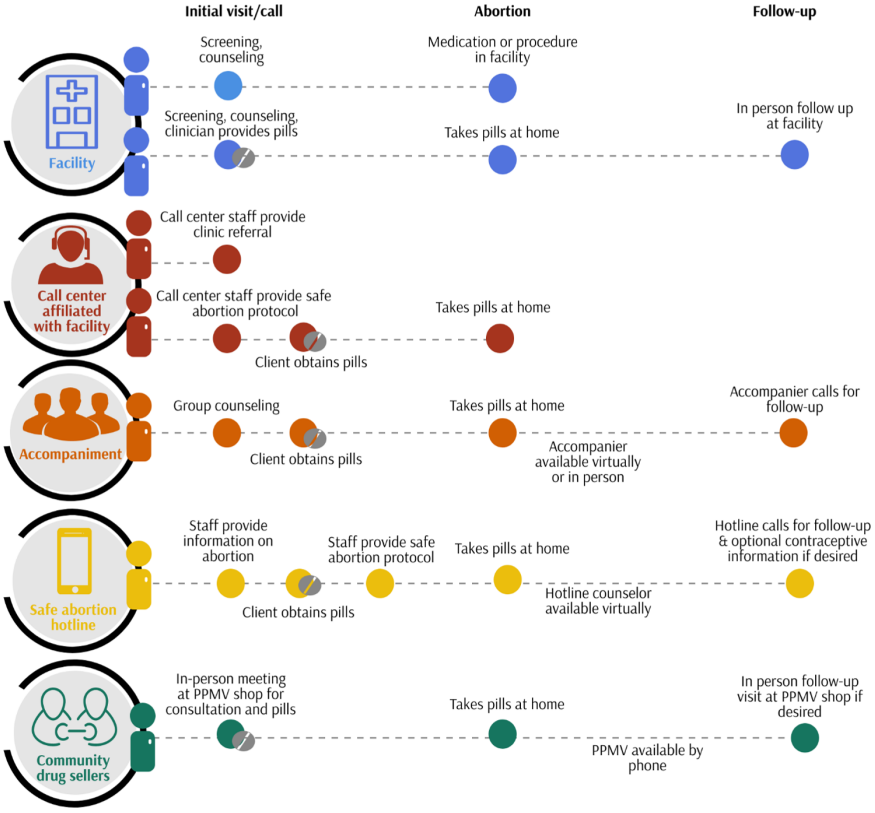

Figure 1 Example pathways of care, by service-delivery type. PPMV, proprietary patent medical vendor.

language (Amharic, Bengali, English, Pidgin English, Spanish, Tigrinya, Yoruba) and had an abortion in the previous 3 months (Bangladesh, Ethiopia, Nigeria) or 6 months (Argentina).

We developed a semi-structured interview guide (see online supplemental appendix 1) based on quality of care and person-centred care frameworks,[9 16 45] as well as input from experts in the field, research partners and local study teams. The guide included open-ended questions for participants to share their abortion experience, reflect on the care they received and identify priorities in high-quality care. We designed the instrument to ask about all aspects of quality, while probing specifically on person-centred themes and interpersonal dynamics, such as communication, privacy, preparedness and support, to gain a deeper understanding of their reflections on interactions with providers. At the end of each interview, participants were asked, 'If you had to describe the three most important parts of the best abortion care, what three parts would you say? Please mention the parts that feel most important to you, no matter how big or small'. Interviewers encouraged respondents to reply with three distinct aspects of care, however some responded with fewer than three. The interview guide in each country varied slightly to align with local researchers and study recruitment team recommendations based on the cultural, legal and service delivery context.

The lead qualitative researcher in each country piloted the instrument and adjusted questions for clarity and understandability in all study languages. The interviewing teams included one to three researchers who were trained in qualitative interviewing techniques, ethics and study objectives. These researchers conducted interviews in a private space at the abortion facility or recruitment site's office space, or over the telephone. All interviews were audio recorded with the participants' permission and lasted between 30 and 90 min. Clients provided verbal or written informed consent, depending on the country of recruitment (verbal in Argentina, Ethiopia and Nigeria; written in Bangladesh) and were provided the equivalent of US$3–10 for their time and travel. The amount and format (ie, cash, mobile money) of compensation in each country was based on recommendations from local partners.

We transcribed interviews in the language in which they were conducted. We analysed the data in English and Spanish, therefore we had all transcripts in other languages professionally translated to English. The research team deductively developed an initial codebook based on the instruments and key domains identified in the Akachi and Kruk quality of care framework,[16] Dennis *et al* abortion quality indicators[17] and Sudhinaraset *et al*'s Person-Centred Care Framework for Reproductive Equity.[9] Pairs of researchers coded two transcripts from each country then met to discuss discrepancies, collapse codes and add new codes based on emergent themes. The entire research team then honed the definition of codes in the revised codebook for consistent application to the transcripts. The remaining transcripts were divided among four members of the research team and were coded using the revised codebook. Approximately 20% of the data set was coded separately by two researchers to ensure reliability among coders. Coding was completed using MAXQDA 2018 qualitative analysis software (VERBI Software, 2017). Routine team meetings were held throughout the coding process and when new themes emerged that were not reflected in the codebook, a code was added and then applied across all the interviews. We conducted deductive thematic analysis of quality-of-care themes among the entire sample, with a focus on interpersonal quality. Once key quality themes were identified, the research team created a matrix in Excel to compare and contrast patterns across countries, as well as diagrams to explore visually how themes were interconnected.[46]

In order to analyse responses to the question on the three most important aspects of care, we categorised each response using a list of 39 quality of care domains which were organised in 12 key categories (see online supplemental appendix 2). We developed the list by combining and collapsing domains that were pulled from multiple sources: Akachi and Kruk's domains of quality-of-care measurement,[16] the Person-Centred Care Framework for Reproductive Health Equity,[9] the Interpersonal Quality of Family Planning scale[47] and qualitative findings from a similar study in India and Kenya.[48] Two researchers split the sample and categorised responses and together reviewed their application of the domains. The research team met to refine definitions, collapse domains and add new domains where necessary. The categorisation was adjusted based on these changes. Then all responses were categorised by a second researcher and any differences with the original coding was reviewed and reconciled.

Patient and public involvement

The design and implementation of this study was informed by abortion clients in similar prior studies conducted in India and Kenya,[48] South Africa and Ghana. Preliminary findings from these qualitative studies informed study instruments, sampling and data analysis. Abortion clients were not involved in the recruitment or dissemination of the study.

RESULTS

Participant characteristics

We conducted 98 interviews across four countries, with a similar number of participants in each country. The participant characteristics are presented in table 1. Participants ranged in age from 16 to 41, with a mean age of 26. The sample in Argentina was slightly older while the majority of adolescents (age 16–19) participated in Bangladesh and Nigeria. Approximately 42% of the sample reported being married, with nearly all women in Bangladesh reporting being married, about one-third in Ethiopia and Nigeria and none of the participants in Argentina. Among all participants, 27% reported at least

Table 1 Participant characteristics

	Total sample (n=98)	Argentina (n=24)	Bangladesh (n=26)	Ethiopia (n=23)	Nigeria (n=25)
Age (years)					
Mean	26	30	25	24	25
Range	16–41	20–41	16–40	19–38	16–41
Relationship status					
Married	42%	0%	96%	30%	36%
Unmarried	58%	100%	4%	70%	64%
Prior abortion	27%	25%	27%	17%	36%
Children (one or more)	54%	38%	81%	48%	48%
Gestational age (weeks)					
<9	66%	38%	81%	57%	88%
9–12	19%	38%	19%	13%	8%
13+	13%	25%	0%	30%	0%
Unknown	3%	8%	0%	0%	4%
Abortion type					
Medication abortion	60%	50%	46%	87%	60%
Surgical abortion	40%	50%	54%	13%	40%
Recruitment site					
Facility-affiliated	72%	50%	100%	100%	40%
Clinic/hospital	45%	50%	38%	48%	40%
Call centre	28%	0%	62%	52%	0%
Hotline or accompaniment models	22%	50%	0%	0%	40%
Community medicine vendors (PPMVs)	5%	0%	0%	0%	20%

PPMVs, proprietary patent medical vendors.

one prior abortion, ranging from 17% in Ethiopia to 36% in Nigeria. Over half of the sample (54%) had one or more children, ranging from 38% in Argentina to 81% in Bangladesh.

Most participants were in their first trimester of pregnancy with 66% self-reporting less than 9 weeks' gestation, 17% between 9 and 12 weeks and 13% beyond 12 weeks. Sixty per cent of the participants had a medication abortion and 40% had surgical abortion (manual vacuum aspiration or other in-clinic procedure). This also differed by country, with most women in Ethiopia (87%) obtaining medication abortion, 60% in Nigeria, 50% in Argentina and 46% in Bangladesh. We recruited 72% of the sample from facilities (clinics or hospitals) or call centres affiliated with facilities, 22% from hotlines or accompaniment models and 5% from community drug sellers called PPMVs (table 1).

We identified six themes that contributed to high-quality abortion care from the clients' perspective, with particular focus on interpersonal dynamics. These themes emerged as participants described their abortion experience, reflected on their interactions with providers and defined good and bad care. Each of the six themes is defined and explained below: (1) kindness and respect, (2) information exchange, (3) emotional support, (4) attentive care throughout the process, (5) privacy and confidentiality and (6) prepared for and able to cope with pain.

Kindness and respect

One of the most consistent descriptions of positive interpersonal interactions or quality care was providers and staff who were warm, caring, kind and friendly. Some participants described kindness in the way they were spoken to and others in the demeanour or attitudes of the providers and staff. One participant in Ethiopia explained,

> The qualified staff serve you with respect and good manner. I am telling you the truth. They are kind and show good facial expression. I got the service for free but staffs showed me respect. This indicates you can depend on the service. (30 years old, Ethiopia, recruited from call centre)

Another Ethiopian woman who had a clinic-based medication abortion procedure and stayed overnight described the kindness of the staff in response to her own fears or concerns.

> I received a very good service. I was stressed. On that day (her admission day) when the other women were leaving, I thought I am staying behind alone. I stayed overnight. All the doctors and the nurses were nice. I was afraid when I stayed alone. I even cried. But the nurses were with me all the time. (19 years old, Ethiopia, recruited from call centre)

In many cases, participants were surprised by the respect they found in providers or counsellors because of negative interactions during prior medical care, abortion experiences or stories from others. This woman in Bangladesh highlighted the clinician's demeanour as compared with other venues in which she had sought care.

> The behavior of those who are working there is really wonderful. In general, in other places, they often become angry with patients, telling them to sit here like this or wait there like that. They say many (bad) things like that. But in this place, I have never experienced any kind of unpleasantness like that. (26 years old, Bangladesh, recruited from call centre)

In fact, it was common for participants to discuss respect and kindness by describing a *lack* of discrimination, judgement or anger such as the experience of these two women:

> I think good care has to do with the people; when they don't judge you. When they give you all the privacy you need, when they give you all the love you need, without someone coming to judge you for anything or [forming] a bad opinion about you. I think, that's what good care is all about. (17 years old, Nigeria, recruited from hotline)

> They were divine. I think with a certain respect…I had, maybe I came a little afraid of that [judgement]. I felt they were going to think "this girl nearly 40-year-old and never learned to take care of herself". You come with that fear, they will judge me and challenge me. And no. Quite the opposite. At no time did I feel … mistreatment or prejudice, no. (38 years old, Argentina, recruited from facility)

For another woman in Argentina, the non-judgemental care she received from the accompaniment group not only represented good quality, but also made her want to offer her support to the organisation.

> I feel like that, that is, for me they are geniuses, that is why I tell you, I do not belong to any of these organizations, but I told them, like, that they can count on me for whatever they want, like, I am at your disposal, and that…I mean, that tells you everything. (33 years old, Argentina, recruited from accompaniment group)

Information exchange

Participants described wanting clear and honest explanations, accurate information and step-by-step instructions in order to anticipate what would happen to them throughout the abortion process. Information was valued from a range of providers and staff throughout an abortion visit or call, as explained by this health facility client in Ethiopia.

> When you go inside, you first go to registration desk. You get information there. Second when you meet the doctors, they do ultrasound and give advice. Finally, they tell the place where you take medication and advise you on that. These three things are very important and these are basic thing to get information. When you reach to decision, you will not be afraid. (30 years old, Ethiopia, recruited from call centre)

As this participant noted, many women explained that trusted, honest information made them feel less fearful and more prepared, even giving them, 'confidence' and 'courage'. In Nigeria, participants tended to focus on seeking information that provided reassurance about the procedure's safety and expected side effects, such as this client,

> The practitioner attempts to calm your nerves explaining that there is no need to be unduly frightened. Usually this assurance from the health care giver makes one relaxed and less frightened. (39 years old, Nigeria, recruited from facility)

Clients not only wanted instruction, but bidirectional communication where the counsellor or provider listened to their individual needs and questions, 'I was pleased… [the nurse] listened to my story and was very understanding. She understood that I needed the financial help'. (24 years old, Ethiopia, recruited from call centre) Similarly, this woman in Argentina explained 'I was alone and they listened to me, and for me that was really important because at that moment I unburdened myself'. (22 years old, Argentina, recruited from accompaniment group)

In some cases, clients defined quality by describing what was missing in an interaction, such as this Bangladeshi woman who highlighted a negative experience with her provider(s) and how it prevented her from voicing all of her concerns,

> They weren't answering any of my questions properly. They were very—what can I say—there was a lot of attitude. And because of that, I also did not attempt to say anything to her because I was nervous. You know how sometimes people can behave in a really rough fashion? It was like that, you see? (35 years old, Bangladesh, recruited from a call centre)

Most people received information during private sessions, however both recruitment sites in Argentina (accompaniment model and facility-based care) offered group counselling sessions. Some clients reported feeling nervous at first, but nearly all saw the value in meeting other people who were living through the same situation.

> I had a lot of anger and a lot of pain with me. Go through this again? I had been judging myself a lot, let it happen again. Well, I met people in the same workshop who had already been there on other occasions. I felt like good, it can happen to you again. (35 years old, Argentina, recruited from accompaniment group)

These sessions were valuable to the participants because they normalised abortion and gave space for people to listen to other questions in the group.

Emotional support

Many clients across models of care and legal settings felt that quality care included emotional support. For example, one woman in Argentina who did not feel comfortable telling her family, described the support she received and how alone she might have felt without the support of the accompanier. She believed that despite individual circumstances, nearly everyone would value being heard and supported as part of their care,

> I also felt accompanied, I felt that even if it was not going to be alone, since I could not tell my family, I knew that there was someone there that if I said "I have a problem", they would be there…I think that this service is good, because it's more than just the pills or… I feel that [providers] really support people, because someone might have many different needs but it doesn't matter who they are, they always need someone to listen to them, for me that's very important. (22 years old, Argentina, recruited from accompaniment group)

In some cases, it was the combination of empathy along with information and kindness that made clients feel safe and supported, such as this woman:

> It was like every time I talked to someone [at the clinic] it was like I felt even safer, because they explained everything so naturally and like they understood it and were in favor of it, and it was like they're not going to do anything to hurt me here, they're not going to judge me… I felt super safe, really safe. (20 years old, Argentina, recruited from facility)

This participant highlighted the value of providers that supported clients to recognise that abortion is normal and acceptable, as was echoed by clients in each country especially among those who obtained care through a hotline or an accompaniment group. This woman in Nigeria was asked about the best part of her care experience and stated, 'It was when she told me that I shouldn't feel bad about [the abortion], it is normal, it happens. That was the most comforting'. (16 years old, Nigeria, recruited from safe abortion hotline)

Participants identified the importance of emotional support not only if they had positive experiences as part of their abortion, but also, particularly in Ethiopia and Bangladesh, when they described situations where they did not receive emotional support. For example, one participant in Ethiopia explained how staff repeatedly asked her reason for abortion as if they did not believe her:

> The uncomfortable thing was the hospital staff don't act nicely when you say you want abortion and you also have to go through so many investigations… they were repeatedly asking why I was getting an abortion (19 years old, Ethiopia, recruited from facility)

Similarly, a participant in Bangladesh said that she was humiliated while checking into the health facility when she was scolded by someone working there, 'Why do you come to us with all this bad news? Try to come to us with some good news' (40 years old, Bangladesh, recruited from facility). She reported that she was forced to accept some form of contraception before the providers agreed to give her the MR services. An Ethiopian client described how this unsupportive, stigmatising behaviour led her to seek services elsewhere.

> I came here…hoping they will understand my problem. However, they did not give me the service right away. They said they will not provide me the service, advised me not to abort, and sent me home. They told me I am killing a human being for the wrong reason, saying this is going to pass and I will be ok… but I didn't listen and went to another facility to get the care. I was disappointed and frustrated. (27 years old, Ethiopia, recruited from facility)

In some cases, clients in Ethiopia or Bangladesh offered justification for the unsupportive care or described this type of interaction as neutral or positive. They made comments such as 'all they said was for my sake and I felt happy for that' or that the provider acted 'like a father would act' or 'out of concern'. In addition to justifying poor treatment, occasionally clients felt they had no choice in how they were treated because they were dependent on the providers for care.

Attentive care throughout the process

Participants felt they received attentive care when providers and counsellors 'were always available', 'were aware of us' and checked in after the abortion. For facility-based clients, attentive care could involve ongoing support during an individual's stay at the clinic or hospital (sometimes overnight). These two Ethiopian clients both had second trimester abortions and wanted to feel that nurses and doctors were available to take care of pain, discomfort or administering medications in a timely and caring manner,

> A good service is if they are checking up on you whenever you are in pain and when you tell them you are in pain they would be understanding and would treat your pain. (20 years old, Ethiopia, recruited from facility)

> Despite the huge patient flow here they don't forget to give you the medication at the right time. For instance, I was supposed to take a medication at 12 pm and the nurse came and gave it to me. She was checking up on me regularly so I liked it. Despite being busy she takes care of everyone and comes regularly. (22 years old, Ethiopia, recruited from facility)

Some other facility clients reflected on how their providers were often busy and managing high volumes, and yet were still able to offer punctual, efficient services.

Women who obtained care through hotlines, accompaniment groups or call centres focused on attentive care through ongoing virtual communication; specifically being able to reach their provider or counsellor during off-hours or on weekends.

> Whatever questions I had, I did ask them, but the questions did not all come into my head at the same time, and I could not find out the answers to all my questions at one go. So, whenever something occurred to me, I just called them. In general, the care that they provided was good. They said to me, 'This service of ours is open twenty-four hours a day'. (23 years old, Bangladesh, recruited from call centre)

> Even within the process, I called her at 6 in the morning, when I was expelling the placenta and she attended to me, gave me a couple of guidelines and after… everything that happened to me, too… the next day she also came back to me. call, wrote to me, if it was… excellent in… at all times. (33 years old, Argentina, recruited from accompaniment group)

These proactive follow-up contacts by counsellors made clients feel cared and protected as described by this hotline client:

> I think they called me after days, 4 days or one week interval, they were like, 'are you okay? Hope you are fine now? How are you feeling'…this and that. It was a good one. At least they care, they didn't just give me the services and relax, they still called on me to know how I'm feeling. (23 years old, Nigeria, recruited from safe abortion hotline)

Privacy and confidentiality

Most clients wanted providers to keep confidential their personal information and decision to have an abortion. Participants reported that they often assumed the providers were protecting their privacy, 'this is a personal matter, isn't it? This is a personal matter for each individual concerned. And besides, everybody is paying for this service. So why should they not keep it private?' (25 years old, Bangladesh, recruited from call centre). However, some women preferred to be reassured explicitly, for example, wanting a provider or counsellor to let them know when they were writing down identifying information or confirming that they would not share their decision with a family member.

Participants described that many people who disclose their abortion can face social backlash in their families, social circles and religious communities. Social consequences included exclusion and isolation, judgement and gossip or insults. In part due to such fears of social stigma, many participants, especially in restrictive settings, felt that their abortion should remain a secret. As one Nigerian participant noted when asked about quality care, 'privacy is like number one' (Nigeria). Participants often limited disclosure to just their husbands, partners, or close friends, or kept their abortion entirely to themselves.

For some participants, privacy also referred to the physical space of the clinic or hospital. Clients noticed and commented on the desire for private rooms, not being identified as an abortion patient, covering their body during care and minimal staff present during the abortion. One Bangladeshi participant commented on the extra staff in the room,

> Well, as I told you, Apa (Apa means sister, and is a respectful way of referring to the interviewer, nurse, or provider), there were a lot of people there. A lot of them were watching the woman who had had an MR just before me. There were ten or fifteen people there. But I got a little upset when I saw all of them. I said to the Apa, "Apa, I actually don't want to have it done in front of all these people. (32 years old, Bangladesh, recruited from facility)

For virtual services, such as hotline and accompaniment models, women spoke about how the remote interactions helped protect their privacy while seeking abortion care. This woman in Nigeria valued the anonymity of a phone call, as well as the fact that she did not have to share personal information with the hotline counsellor.

> I just believe it is privacy because, we did not have anything or. It's just no on facial interview we are just on phone. They don't know me and I don't know them even tomorrow if I should pass them, I should just greet them on the way or they greet me. They can't even know that they are the one. (23 years old, Nigeria, recruited from safe abortion hotline)

Prepared and supported to cope with pain

Women described a range of experiences with pain related to their abortion, from excruciating to non-existent. Similarly, there were a range of experiences with receiving pain management. Some facilities offered anaesthesia and pain medications, while others provided pain medication or alternative techniques such as hot water bottles. Distraction seemed to be a successful support provided by clinic staff to help bring attention away from pain during an in-clinic procedure. For example, this client in Ethiopia who shared how two nurses, 'were talking to me and making me laugh while the abortion was being done. They made me forget

the pain' (24 years old, Ethiopia, recruited from call centre). Another client in Bangladesh expanded on that,

> Does the pain actually reduce? If the focus had been there, then I could have been ambushed by all kinds of worries. Those worries were a little less keen. They were talking about so many things that I didn't have the chance to think about those worries. (22 years old, Bangladesh, recruited from facility)

Participants at the health facility in Argentina also described having the option to choose a song to play during their abortion which helped distract them from the pain. For people who had medication abortions at home, they were often instructed to obtain pain medications or use home remedies. A participant in Argentina describes how they were instructed to gather all of the things that would help generate a comfortable environment prior to beginning the process, 'I did everything [the accompanier] told me, I had everything ready, the hot water bag, the ibuprofen, the thermometer, the [antinausea medication]' (30 years old, Argentina, recruited from accompaniment group).

Regardless of the pain people experienced, there were two areas of pain management that stood out for quality care. First, women wanted to know what to anticipate and sought information to assuage their fears related to pain. 'She prepared my mind very good, because she explain to me and told me the side effect everything' (20 years old, Nigeria, recruited from PPMVs). Counselling related to pain was often important because of the prior negative experience or stories passed around social networks about high levels of pain during abortion. This information could help women feel confident in their own pain management, choose their preferred abortion type, feel prepared for the process, and monitor for possible complications.

Second, they wanted to trust their pain would be managed and that providers would be responsive to their pain. For some this included pain management that was affordable or free, for others it was important that it was timely—no matter what time of the day or night they needed support, and for others it was step-by-step explanations while obtaining pain management.

> Can I myself tolerate pain or not? How much pain is involved? For example, I cannot tolerate pain. As far as I can recall, I screamed a lot. But there are many places where, if you scream, they get annoyed with you. I saw that they were really not very annoyed with me. And I would say that three things are important. (16 years old, Bangladesh, recruited from facility)

As noted by this Bangladeshi participant, clients across multiple countries found the kind responses from providers about their pain to be unexpected.

Ranking quality of care domains, comparisons across countries

All participants provided at least one response to the question 'what are the three most important parts of the best abortion care' at the end of each interview. The domains identified in their responses are summarised in figure 2. The most common responses were in the domain of **client-provider interactions**, which included mention of any of the following areas of care: privacy and confidentiality, dignity and respect, trust, confidence, kindness, warm welcome, support or other interactions with providers. The other commonly mentioned domains were **information provision**, which included explaining of risks and benefits, explaining the steps in the abortion process, considering client circumstances when giving information, listening to what mattered to the client, opportunity to ask questions and good counselling; **infrastructure**, which included basic infrastructure, facility cleanliness and comfort and availability of follow-up services; and **outcomes** which included complete abortion, medical safety, lack of death or severe complications.

While client-provider interactions were ranked in the top three priority areas in all four countries, there were some notable differences in rankings. In Argentina, client-provider interactions were mentioned twice as often as any other domain, although information provision and infrastructure were important to Argentinean clients as well. Clients in Nigeria and Bangladesh commonly mentioned abortion outcomes and complications, which was much less common among women in Argentina and Ethiopia. Bangladesh was also the only country where information provision was mentioned more often than aspects of client-provider interactions. Ethiopian clients also put an emphasis on information provision. In Ethiopia, Bangladesh and Nigeria, providers' technical competence was in the top four priorities, while it was much lower among participants in Argentina.

DISCUSSION

The utility and importance of documenting patient experience and outcomes in healthcare broadly, and in maternity and reproductive health specifically, has been well established.[6 17 19 25 47 49] Yet there are not standard client-centred measures for abortion care, and many providers or healthcare systems defer to common, simple questions of satisfaction to assess client experience.[3 18] Our project set out to conduct formative work and offer a novel conceptualisation of person-centred abortion care derived from the experiences of people obtaining abortions. We sought to include experiences both in facility and out-of-facility settings in four low-income and middle-income countries. Analysis from interviews across these country contexts identified six priority areas: kindness and respect, exchange of information, emotional support, attentiveness, privacy and confidentiality and preparedness for and ability to cope with pain.

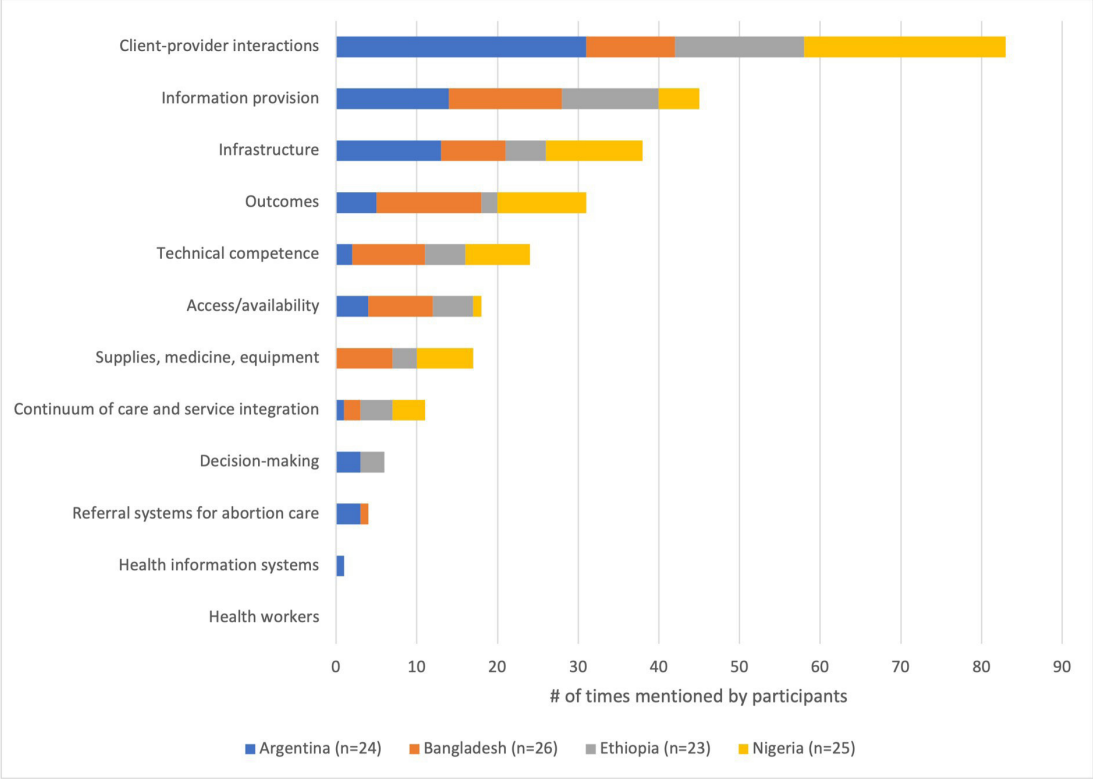

Figure 2 Most important quality of care domains identified by abortion clients, by country. Participants were invited to share the three most important parts high-quality abortion care at the end of their interview. All mentions were categorised by domains presented in online supplemental appendix 2, summed by country and ranked in order of frequency.

Our findings centre first-hand abortion client experiences from a broader scope of social and legal settings, and a wider range of models of care, than published to date.[4 5 19 26 48] Our findings align with prior studies on several client priorities: supportive care, clear and customised communication, privacy and respect/dignity. The similarities across contexts suggest that these domains may be nearly universal in their importance to people seeking abortion. Our analysis highlights two additional domains that contribute to how clients think about abortion quality: pain management and attentiveness of staff and providers. For both medication and surgical abortions, participants sought information to feel prepared for potential pain and reassurance related to their fears, as well as trustworthy management of their pain. They also looked for attentive staff and providers who could efficiently respond to their needs—either in person or virtually—and checked in both during and after the abortion process. Across these themes we see the common thread of client-provider interactions or interpersonal quality. When these client-provider interactions were positive, participants noticed how they felt held, comfortable and confident of their safety. This has not been consistently measured to date, and a standard measure of quality that centres client priorities and can be used globally has great potential. Our formative research from multiple contexts has demonstrated that some facets of abortion quality are universal, while others appear context specific.[50–52] A standard suite of client-centred indicators should be created to capture the universal aspects, while allowing for contextually-based additions.

Despite decades of guidance on measuring quality of care in medicine, and consistent messaging around the assessments of 'process',[15] it remains difficult to develop clear and actionable indicators to measure client experience. In fact, most cross-national or national quality measurement sets do not address client experience or satisfaction.[6] This likely contributes to the extensive list of abortion-related quality measures in the literature, as well as the gaps in these lists.[17 18] In the medical field broadly, innovations in measurement of client experience include the use of standard measures that lend themselves towards comparisons,[6 53] moving away from broad satisfaction questions and towards more targeted measures of person-centred domains[5 26 49] and seeking feedback about both positive and negative experiences.[54] The stigma and social norms that surround abortion in most contexts play a role in feedback on quality, as demonstrated in our data set when participants justified or rationalised poor treatment by a provider. In order to combat this, it may also be necessary to inquire about quality at particular moments in abortion care (eg, front desk, ultrasound, follow-up), invite clients to provide feedback through private or anonymous mechanisms when possible, and even preemptively inform abortion clients of their right to high-quality care.

The domains identified in this formative qualitative work are necessary and actionable to create new and

strengthen existing quality of care frameworks and metrics specific for abortion. Existing mechanisms to measure respectful maternity and contraceptive care developed for lower-income and middle-income countries have recently incorporated human rights and person-centred care.[9 49] While these frameworks informed the current study and have been adapted to measure abortion quality, it was important to gather data specifically from abortion clients to elucidate unique aspects of the abortion experience compared with other reproductive health services. Our findings were used to develop client-focused indicators for the Abortion Care Quality (ACQ) Tool,[45 55] a global standard for measuring quality of abortion services, which has been tested in three low-income and middle-income countries. This metric fills a gap in standardised abortion quality measurement, and explicitly identifies indicators applicable across a range of service delivery models including clinics, hotlines and pharmacies. The domains from the current study also offer a roadmap for which areas of interpersonal care to focus on in measurement of abortion quality through advocacy efforts, updates to international medical guidelines and clinic-specific or program-specific assessment.

Research and evidence on quality measurement has historically focused on formal health systems,[6] yet most abortions in the world happen outside of hospital or clinical settings. The WHO has recognised the benefits of task-shifting in abortion provision, thereby expanding the types of people considered providers of safe abortion such as lay health workers.[56 57] Each model of care that supports a person through any part of their abortion can and should be held to high standards of quality. The client-centred domains that emerged in this analysis helps to prioritise which aspects of interpersonal care should be included in quality measurement, such as feeling respected and supported by providers, feeling attended to and feeling prepared for pain. These domains are applicable to abortion care regardless of the type of provider or abortion type and therefore should play a central role in expanding abortion quality indicators beyond safety and effectiveness.

This study has several limitations. Our recruitment sites included a small set of community drug sellers but largely did not include pharmacies, therefore the perspective of people who self-managed their abortion alone after obtaining pills from a pharmacist is missing. However, many participants talked about interactions at pharmacies during their interviews, as obtaining pills was a part of their process. In addition, we interviewed participants up to 6 months after their abortion and those who had a larger gap may have had a harder time recalling some details of their interactions. However, we do not hypothesise this systematically impacted the findings. Lastly, there were limitations to comparing the sample by priority group, for example, not all countries had recruitment sites both in and outside of facilities, and we had few second trimester clients. Future studies should consider quality from the client perspective across gestations as quality is likely perceived and received differently later in pregnancy.

CONCLUSION

This large qualitative study across multiple country contexts has confirmed the importance of interpersonal care in quality from the perspective of abortion clients. We have provided guidance on six priority areas from people obtaining abortion which could be used to sharpen the definition of abortion quality, improve measurement and even design interventions to improve quality. Ultimately, measurement of abortion quality informed by client experience will contribute to increased access to person-centred, rights-based abortion care, which will lead to better health outcomes and well-being.

Author affiliations
[1]Ibis Reproductive Health, Oakland, California, USA
[2]OHSU-PSU School of Public Health, Portland, Oregon, USA
[3]University of California Berkeley School of Law, Berkeley, California, USA
[4]Colectiva Feminista La Revuelta, Neuquen, Argentina
[5]IPAS, Chapel Hill, North Carolina, USA
[6]School of Public Health, St Paul's Hospital Millennium Medical College, Addis Ababa, Ethiopia
[7]Metrics for Management, Oakland, California, USA
[8]Policy Innovation Centre, Abuja, Nigeria
[9]Ipas Bangladesh, Dhaka, Bangladesh
[10]Department of Anthropology, Dhaka University, Dhaka, Bangladesh

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Contributors SEB: guarantor, conceptualisation, supervision, funding acquisition, methodology, analysis, writing—original draft. LJ: analysis, writing—original draft. AMR: project administration, analysis, writing—review and editing. AK: project administration, analysis, writing—review and editing. BG: project administration, investigation, writing—review and editing. CB: project administration, analysis, writing—review and editing. EP: conceptualisation, funding acquisition, writing—review and editing. EG: project administration, investigation, writing—review and editing. NMC: conceptualisation, funding acquisition, writing—review and editing. OD: project administration, investigation, writing—review and editing. RC: project administration, investigation, writing—review and editing. RZ: project administration, investigation, writing—review and editing. SF: project administration, analysis, writing—review and editing. TT: project administration, investigation, writing—review and editing. CG: conceptualisation, funding acquisition, writing—review and editing.

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ORCID iD

Sarah E Baum http://orcid.org/0000-0002-5805-1084

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