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ABORTION, STIGMA AND INTERSECTIONALITY

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Abstract

Abortions and abortion-related care (e.g., pregnancy testing, information access, post-abortion care) are essential healthcare. Stigma shapes abortion care access and experiences. Abortion stigma is linked to other reproductive stigmas, and is stratified across gender, race, class, and other axes. This stratification can heighten or exacerbate how stigma manifests, is experienced, or felt by abortion seekers and abortion providers. This chapter draws on two frameworks– intersectionality and Reproductive Justice– to examine how abortion stigma operates within matrices of oppression to shape abortion care at the micro, meso, and macro levels. After a short introduction to the concept of 'stigma', the chapter offers a detailed consideration of abortion stigma conceptualizations and their relevance for abortion care provision, and experiences of abortion care, policy, activism, and research. It demonstrates that an intersectional approach to abortion stigma at the micro, meso, and macro levels enables an understanding of the role of stigma in shaping and (re)producing forms of reproductive injustice for abortion care-seekers. It shows how abortion stigma has been resisted across these levels by a range of actors. The chapter concludes by underscoring the importance of understanding abortion stigma at multiple levels and call for more work on understanding and resisting structural and macro-level manifestations of stigma.

Keywords Abortion, stigma, intersectionality, reproductive health, reproductive justice

1. Introduction

Abortions and abortion-related care (e.g., pregnancy testing, information access, post-abortion care) are essential healthcare. Stigma shapes abortion access and experiences, including the outcomes of abortion care over time. Abortion stigma is linked to other reproductive and sexual stigmas (e.g., pregnancy and age, pre-marital sexual activity) and is stratified across social, political, economic, and temporal lines (Colen 1995, Harris and Wolfe 2014). This stratification means that abortion stigma is enacted and felt differently across these different axes. For some, it is heightened and exacerbated, while for others their

specific social, political, or economic privileges may protect or buffer them from these impacts. Stratification, thus, can affect the extent to which abortion or abortion care is stigmatized.

Understanding the multiple manifestations and implications of abortion stigma at different levels is critical in order to minimize its harm. This requires a conceptual framework that accounts for the micro (e.g., individual, interpersonal), meso (e.g., health facility, community), and macro (e.g., structures, governance) scales at which abortion stigma operates (Kumar, Hessini et al. 2009, Millar 2020). Diverse actors and work on abortion stigma function across these three levels and include research (Shellenberg 2010), advocacy and campaigns (e.g., Inroads*, Amplify Change†), and service provision (e.g., Ipas‡). Scholars have cautioned that over-interpretation or over-application of abortion stigma risks diluting the concept and can render invisible other forms of stigma, discrimination, and oppression (e.g., racism) (Kumar 2013). Thus, any interrogation of abortion stigma must acknowledge and incorporate these other factors in order to fully situate abortion stigma in its context.

This chapter interrogates the role of stigma in abortion care and how it is enacted at the micro, meso, and macro levels. Drawing on intersectionality (Crenshaw 1991, Hill Collins 2019) and Reproductive Justice (SisterSong , Ross and Solinger 2017) frameworks, it examines how stigma operates within matrices of oppression, shaping the conditions that surround peoples' abortion experiences. A brief review of the conceptual origins of stigma is followed by a detailed consideration of abortion stigma and its relevance for abortion care provision (including providers), experiences of care, policy, activism, and research. The chapter demonstrates that an intersectional approach to abortion stigma at the micro, meso, and macro levels enables an understanding of the role of stigma in shaping and (re)producing forms of reproductive injustice for abortion care-seekers. It considers how abortion stigma has been resisted by care-seekers and providers and conclude by underscoring the importance of understanding abortion stigma across these levels, calling for more work on understanding structural and macro-level manifestations of stigma.

2. Conceptualizing stigma

The academic conceptualization of stigma came to prominence with Goffman's germinal work, *Stigma* (1963) in which he argues that stigma is an attribute that is "deeply discrediting" and results in an individual being "tainted, discounted" from those around them. Attributes or "marks" of stigma were linked to stereotypes that, when used, could "other" a person. Stigma, a deeply complex issue, is "both a cause and a consequence of inequality" (Kumar 2013, p.e330). Goffman's work situated stigma within social interactions between stigmatized and non-stigmatized individuals. Stigma, in these interactions at the individual level, manifests as "enacted", "anticipated" or "internalized" (Earnshaw and Chaudoir 2009). Enacted stigma is the degree to which individuals have experienced discrimination, prejudice or shame from others, while anticipated stigma is the degree to which individuals expect social rejection or discriminatory behaviors or attitudes because of their "marks" (Earnshaw and Chaudoir 2009).

While some "marks" are visible (e.g., some physical disabilities), others may be concealed in an effort to avoid or cope with stigmatization. Goffman (1963) suggests that those with invisible stigmas are often in a state of worry, fearing discovery and the subsequent consequences. These efforts to hide or conceal

* https://www.makeinroads.org/

† https://amplifychange.org/

‡ https://www.ipas.org/

their "marks" can result in internalized stigma – stigma directed at the self *from* the self, unlike enacted or anticipated stigma which are directed *at* them from others (Earnshaw and Chaudoir 2009).

The emergence of the HIV/AIDS crisis and the role of stigma in shaping state, policy, community, and healthcare responses led to conceptual developments that departed from Goffman's more individualized approach to stigma (Link and Phelan 2001). Goffman's conceptualization of stigma as an "attribute" was also critiqued for failing to consider the role of power (Tyler 2018, Millar 2020), and understandings of power became increasingly salient in conceptualizations of stigma. Operating at multiple levels, power can impact how stigma is enacted, anticipated, and felt and can limit the impact of anti-stigma campaigns, policies or service provision (Parker and Aggleton 2003). The othering of individuals through labels connected to negative stereotypes (re)produces and enacts stigma when enabled by macro structures– i.e., social, economic, political, and colonial systems. It is the conferral of power and privilege onto non-stigmatized groups over stigmatized groups that makes stigma possible and underpins the reproduction of inequalities and oppression (Parker and Aggleton 2003)

Link and Phelan's work on HIV/AIDS linked stigma with social - specifically sexual - scripts, showing how these scripts create labels and define stigma within communities. Scripts are the socially sanctioned modes of behavior within a community. Where "acceptable" sex and sexuality have been defined in monogamous and heterosexual terms, the association of HIV/AIDS with queer sex, sex work, and racialized people disrupted normative sexual scripts and became a tool to other people living with HIV/AIDS, and label them as 'deviant' (Logie and Gibson 2013). This approach allows for interrogation of the role of structural stigma operating at the macro-level, which has informed and been operationalized through policy, legislation, and governance (Hatzenbuehler and Link 2014). The criminalization of HIV non-disclosure in Canada, for example, is structural stigma framed as "risk management". Such criminalization constructs people living with HIV/AIDS (PLWHA) as a "collective risk" that requires managing through surveillance and imprisonment; heightening the risk that PLWHA are exposed to and potentially deterring them from care-seeking (Gagnon and Vézina 2018). Understanding the structural factors that shape health and stigma are critical for tackling the persistence of health inequalities .

3. Abortion Stigma

Trajectories to abortion care are shaped by myriad intersecting factors operating concurrently at multiple scales (Coast, Norris et al. 2018). A pregnant person's access abortion care is shaped by how and when they recognize their pregnancy, the knowledge and information available to them about care options, the services (availability, accessibility, affordability, and acceptability), and the socio-cultural, legal, and political context. The normative environment shapes the acceptability of an abortion and of the care a person should receive. Such environments and care-seeking efforts are in part shaped by the family, friends, sexual partners, and other people that a pregnant person interacts with (Berro Pizzarossa and Nandagiri 2021, Strong 2022). Abortion stigma, thus, affects not just the abortion seeker but abortion providers, supporters, family members and other actors present and involved in care-seeking or care-provision. These trajectories to care at the micro, meso, and macro levels are shaped by abortion stigma.

The conceptualization and interrogation of abortion stigma is relatively recent. In response to the paucity of work conceptualizing abortion stigma, Kumar et al.'s (2009) review identified five levels within which abortion stigma is located: (i) framing discourses and mass culture; (ii) government / structural factors; (iii) organization / institutional influences; (iv) community factors; and (v) individual factors. The authors highlight how women who seek abortions are placed outside "acceptable" social and sexual scripts, due to

contravening prevailing norms around "womanhood", in which "female sexuality [is] solely for procreation, the inevitability of motherhood and [the] instinctual nurturance of the vulnerable" (p. 628).

Norris et al. (2011) extend this work to conceptualize abortion stigma as enacted through: (i) the construction of fetal personhood, (ii) legal restrictions and the role of stigma as a barrier to legal change, (iii) the view of abortions as unhealthy (and, by extension, unsafe), and (iv) anti-abortion language and discourse. These four elements point to individual, institutional, and discourses (e.g., the construction of fetal personhood) as drivers of abortion stigma.

Abortion stigma is linked to other reproductive and sexual stigmas (e.g., pregnancy and age, pre-marital sexual activity) which are also subject to discourses (e.g., the "right" number of children) and policies (e.g., incentivizing sterilization) shaping individual experiences. Abortion stigma can,, thus be understood as a social process that is experienced and reproduced at a range of scales and deeply rooted in power and the shaping - and reshaping - of categories of difference within power relations (Millar 2020).

Although abortion stigma is present across contexts, it is not enacted or experienced in a singular, universal manner (Kumar, Hessini et al. 2009) but is instead rooted in specific contextual environments. This broad conceptualization of abortion stigma reflects how it is framed and reproduced by social processes rooted in contexts and environments, and not just restricted to the individual or micro level.

Abortion stigma has found resonance with researchers, activists, and policymakers. Yet, scholars have cautioned against "conceptual inflation", where all negative experiences related to or surrounding abortion are framed as stigma. Defining all of these as stigma risks rendering invisible the gendered, racialized, classed, and ableist environments that people navigate, whilst also making abortion stigma too complex an issue to tackle (Kumar 2013).

4. Intersectionality, Reproductive Justice, and Abortion Stigma

"Intersectionality", conceptualized by Kimberley Crenshaw (1991), highlights how Black women's access to justice systems was made unequal due to their intersecting racialized and gendered experiences. Within health research, intersectionality has enabled understanding of how access to care, quality of care, and experiences of receiving and providing care are not uniform across a population; they require a non-additive approach to the interaction of different social stratifiers and their underpinning power structures (Larson, George et al. 2016).

People who seek abortions are not a homogenous group and their experiences of how abortion stigma is both felt and enacted is not uniform . Similarly, abortion providers are not "neutral" entities and care provision is shaped by stigma towards abortion, whether around fear of judgement, internalized stigma or worries of a "spoilt" identity (Martin, Hassinger et al. 2018). Their particular positions – whether as an abortion-seeker or a provider – within gendered, racialized, classed, and ableist systems shape their experiences of seeking, receiving and providing abortion care, and the kinds and strength of stigmas they contend with. Interrogating abortion stigma through intersectionality thus makes visible how power is intertwined with and shapes abortion care.

Understanding reproduction as "stratified" allows for an exploration of how stigmatizing labels and categories placed on people generate discrimination in their abortion trajectories. Stratified reproduction describes how social scripts of fertility, reproduction, notions of 'good' and 'bad' motherhood or

parenthood create a value hierarchy towards reproductive labor. These scripts categorize some people's reproduction as valued and supported, while the reproduction of others is devalued or denied, and these scripts are then (re)produced in policies and practice (Colen 1995, Harris and Wolfe 2014). For example, Black women's experiences of abortion are shaped by normative frames placed on their lives and reproduction, including pressure to avoid pregnancy and use long-acting reversible contraception, or to live up to community expectations to be "strong" (Brown, Plummer et al. 2022). The stigma that Black women experience when accessing abortions within the US are, therefore, different compared to other racialized groups due to the normative reproductive expectations placed on them by different actors and at different levels.

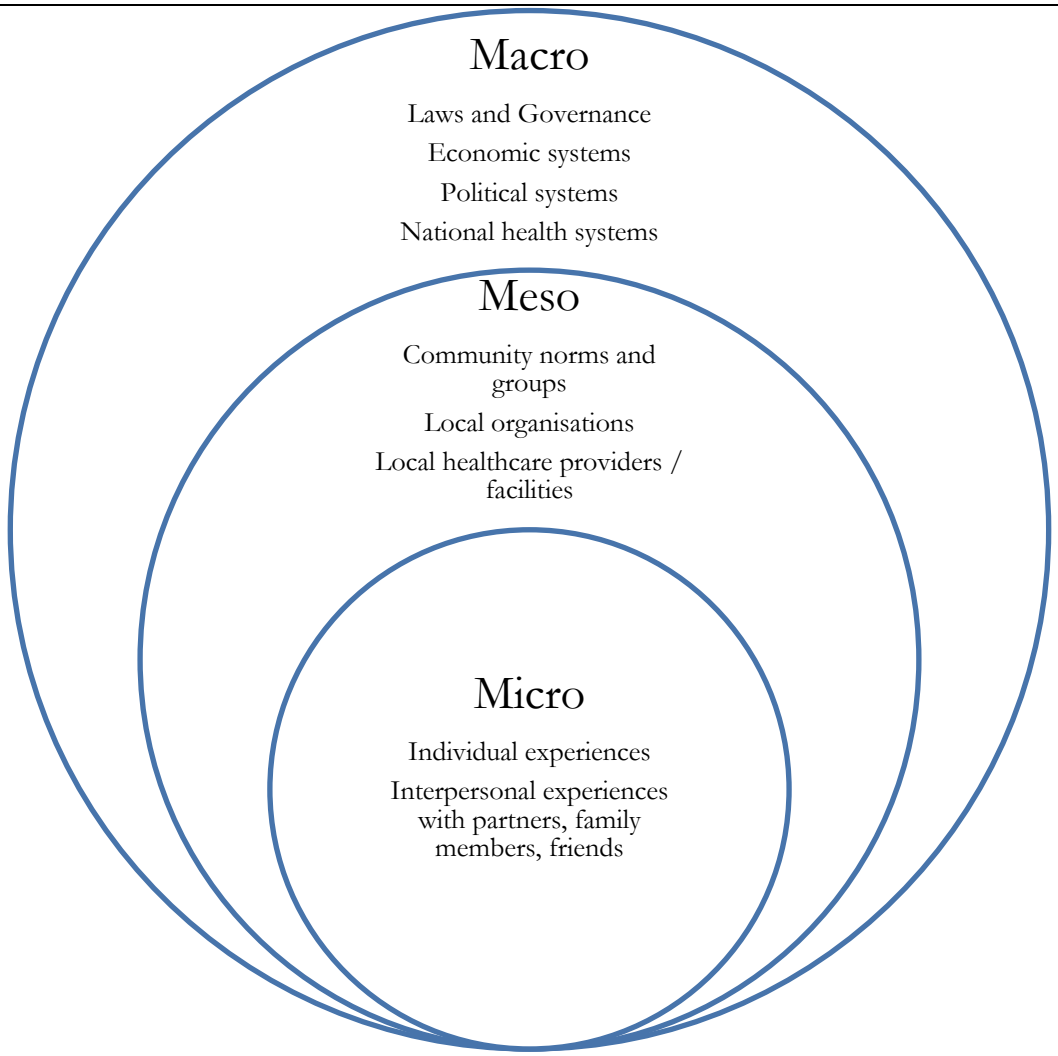
Policies – legal, health, employment – can exacerbate inequalities by either failing to consider intersectional experiences of oppression or by actively privileging particular groups. Abortion-related policies are embedded in historical, colonial, political and social structures which seek to control some peoples' reproduction, while encouraging others. These forms of structural violence shape the overall environment - or the conditions - that people navigate when making reproductive decisions (Nandagiri, Coast et al. 2020). Current abortion laws in many countries including Malawi and Zambia, for example, are built on colonial era penal codes that continue to restrict or criminalize abortions (Kangaude, Coast et al. 2020).

Interrogating these contexts surrounding reproductive decision-making and the assumption of "choice", Black feminists in the US conceptualized "Reproductive Justice": the right to have children, not have children, and parent children in safe and sustainable communities and environments (SisterSong , Ross 2017). Thus, grappling with the social, political, economic, and colonial structures that shape these environments and create the conditions under which people make reproductive decisions is essential for understanding and tackling abortion stigma as a cause and a consequence of reproductive injustice (Davis 2019).

To effectively contend with abortion stigma, it is crucial to consider how stigma manifests differently across locations (Cutler, Lundsberg et al. 2022). Understanding how reproduction can be stratified allows for an interrogation of the societal and cultural acceptability of abortion and the boundaries of abortion stigma (Cutler, Lundsberg et al. 2022). The following sections map evidence on abortion-care seeking at the micro, meso, and macro level to understand how an intersectional approach to abortion stigma, through the lens of stratified reproduction, allows researchers to make visible forms of reproductive injustice. The section then explores how abortion providers contend with abortion stigma.

Socio-ecological models are an important lens through which to understand how individual, community, and environmental factors interrelate to form health outcomes. In the context of this paper, we draw on the socio-ecological model as a means to understand how these three levels, which we term 'micro', 'meso', and 'macro', are dynamic and intersecting levels through which stigma is (re)produced (Kumar, Hessini et al. 2009).

Image 1: The socio-ecological model with macro-, meso-, and micro-level descriptions



These socio-ecological levels are embedded in one another (see image 1). The ***micro-level*** references personal and individual level experiences. This includes how a person views themselves, their individual and personal experiences, and their interpersonal interactions, most often with partners, family members, and friends. Micro-level experiences of stigma are embedded within the broader community context in which a person exists. This context forms the ***meso-level*** and includes community and group-based systems and structures. Community norms, for example around sex, shape the conditions which an individual navigates abortion-related care. At the meso-level are local health systems, providers, and local organizations, which impact the ways in which norms and values are enacted or resisted. Encompassing the meso-level at regional, national, or international levels, are ***macro-level*** factors. These are the broader systems and structures that create social, economic, political, legal, and cultural forms of governance. Macro-level factors include the broader discourse around abortion, including provision of services, how abortion is framed in policy (e.g., in health policy, in the educational curriculum, or through criminalization), and media discourse.

4.1 Abortion care-seekers: Micro-level abortion stigma

At the individual level, internalized abortion stigma - or 'self-stigma' - includes feelings of shame, guilt, and perception that it is necessary to maintain secrecy around an abortion . This includes people self-labelling themselves after receiving abortion care. Internalized abortion stigma can have negative consequences on future health outcomes, including psychological health. Higher perceptions of abortion

stigma among people who had either obtained or been turned away from abortion care in the USA led to higher odds of experiencing psychological distress in later years (Biggs, Brown et al. 2020).

A study of 17 women in the UK who sought abortions found that perceived negative social consequences and internalized 'blame' for needing an abortion led to non-disclosure and secrecy (Astbury-Ward, Parry et al. 2012). Internalized stigma can manifest in people reporting feeling 'selfish', guilty, and blaming oneself in the process of accessing abortion care (Hanschmidt, Linde et al. 2016). However, experiences of internalized stigma and the perceived need to maintain secrecy are not uniform among people seeking abortions. For unmarried women in Kenya, the fear that their abortion would lead to being labelled as someone to avoid marrying, as well as their own perceptions that abortion was sinful, contributed to their desire to maintain secrecy (Rehnstrom Loi, Lindgren et al. 2018).

Interpersonal interactions with friends, partners, and family members can help mitigate some of the experiences of internalized stigma in accessing an abortion. However, abortion stigma plays a critical role in shaping whether a person feels they are able to seek support of social networks. A study of 4,613 women who had abortions in the US found that 58% felt that they would need to keep their abortion a secret from friends and family, with Hispanic women reporting a greater need to keep their abortions a secret than other women (Shellenberg 2010). A systematic review of evidence on the economics of abortions reported that women who were unable to confide in their social networks were less likely to have the adequate financial resources to access an abortion (Moore, Poss et al. 2021). For women who have less access to financial resources, the ability to navigate stigma through selective disclosure and secrecy is undermined, meaning that they are more likely to be exposed to abortion stigma than people with greater access to finances or in contexts where abortions are low cost or free.

Alongside perceptions of the social consequences of obtaining an abortion, people seeking care also experience perceived and enacted stigma from abortion providers and the care environment itself. Perceptions and experiences of treatment when accessing care are not singular or homogenous among people seeking abortions. Young people interviewed in the US, who had an unintended pregnancy between ages 13 and 25, reported how their age shaped the duality of stigma: being young and pregnant meant they were subjected to stigma, whilst judgement for accessing an abortion was also enacting stigma (Moseson, Filippa et al. 2019). Among adolescents in India, the stigmatization of their pregnancy and their abortion decision intersected with their lack of access to finances and social support, and lead them to seek abortions in non-medical facilities to maintain privacy (Ganatra and Hirve 2002). A study among young people in the Democratic Republic of Congo found that experiences of sexual violence, pregnancy, and subsequent abortions intersect to generate significant stigma (Burtscher, Schulte-Hillen et al. 2020).

Abortions intersect with existing sexual taboos to heighten the experience of stigma, including norms around un/acceptable sex (Koster-Oyekan 1998). The intersection of adolescent pregnancy stigma and abortion stigma was a reason for adolescents in Ethiopia to keep their abortions secret (Kebede, Hilden et al. 2012). The duality of the stigma of being pregnant in circumstances that are socially stigmatized while also experiencing abortion stigma has been reported for people who are, for example, unmarried or more highly educated (Rossier 2007). Evidence in Malawi highlights how young people face greater stigma for pre- or extramarital pregnancies, as well as their abortions (Levandowski, Kalilani-Phiri et al. 2012).

People who have had a prior abortion may experience abortion stigma through the creation of a label – someone who has had an abortion – that intersects with abortion stigma for a subsequent abortion. In Uruguay, young women reported being more concerned about judgement when accessing abortion care

than older women, and women who had more than one abortion were three times as likely to report feeling judged as women that had not had a prior abortion (Makleff, Wilkins et al. 2019). Among women in Canada who had multiple abortion experiences, feelings of shame and internal stigma were part of their decisions to not seek care from the same provider, even when they had prior Positive abortion care experiences (LaRoche and Foster 2018).

4.2 Abortion care-seekers: Meso-level abortion stigma

Community-level stigma, including that of health facilities, is a critical space in which abortion stigma is enacted. Abortion stigma located in the community can have profound implications for the choice, experience, and quality of care available to a pregnant person. Experiences of stigma at health facilities can lead to people seeking care outside of facilities, through non-formal providers and self-management (Gerdts, Raifman et al. 2017).

Community level stigma towards people who have had an abortion shapes how and whether a person can seek support to access abortion care. A study of women in Angola found that norms around abortion meant social networks were more likely to support a person obtain medically necessary post-abortion care rather than seek an abortion (Blodgett, Weidert et al. 2018). Individual and community-level abortion stigma are interconnected. Negative views about abortion were significantly lower for people who knew someone who had an abortion in the US (Jones and Cox 2011). Yet, the ability to share an abortion with social networks is shaped in part by the identities of the person seeking an abortion, and the judgements and intersecting stigma they face. Thus, where community norms might be more accepting of abortions that are known by social networks, this can further marginalize groups who are less able to disclose their abortion, further compounding secrecy and stigma.

Abortion stigma located within communities is exacerbated by stratified notions of acceptable reproduction. In India, where normative notions of sexuality are linked to age, marital status, and gender, women's abortions are markers of "non procreative" sexual activity, particularly when they are perceived to be past "appropriate" age for childbearing (Nandagiri 2022). Even where quality of abortion care was considered to be good, people living with HIV in South Africa, reported being stigmatized for both being pregnant and having an abortion by members of their community due to their seropositive status (Orner, de Bruyn et al. 2011). Showing how stigmas are interlinked, a community-based study on HIV discrimination in Yemen reported that 62% of 613 young adults believed that women living with HIV should be forced to have an abortion (Badahdah 2016).

Racialized notions of womanhood and motherhood intersect with the acceptability of an abortion and the stigmatization of care seeking. A study with 23 self-identified Black women in the US highlighted how Black women felt that their community expectations for them to be "strong" and "take responsibility" for a pregnancy shaped norms around abortion (Brown, Plummer et al. 2022). These perceptions were explicitly tied to community norms in the US about Black women's reproduction. Communities and health facilities can enact gendered, racialized, classed, and ableist discrimination in ways that enable the enactment of abortion stigma. In Brazil, Black women seeking post-abortion care in public facilities faced greater difficulties accessing quality care than white women, including longer times waiting to be attended and being provided a bed (Freitas Goes, de Souza Menezes et al. 2021). In Indonesia, unmarried women seeking abortion experienced intersecting stigmas related to premarital sex and abortion and this shaped the quality of care that they received (Bennett 2001). Men's actions, for example in rejecting a

pregnancy or denying paternity (Burtscher, Schulte-Hillen et al. 2020), can exacerbate further the stigma experienced by a pregnant person and their subsequent abortion experience (Strong 2022).

4.3 Abortion care-seekers: Macro-level abortion stigma

Macro structures - social, political, economic, legal - and their temporality, are critical in the (re)production of abortion stigma. Representation of abortion in public spaces, including the media, can reinforce abortion stigma (Sisson and Kimport 2014). Legislation provides a legal script within which an abortion may be considered 'acceptable'. In many countries, colonial-era legislation frames contemporary abortion policy, practice and experiences (Kangaude, Coast et al. 2020). Prior to the 2022 Dobbs judgement and the overturning of *Roe v. Wade*, liberalization of abortion laws in the US was followed by the enacting of anti-abortion statutes that increased stigma for those seeking to access legal care (Joffe 2013). Frequently used legal exemptions for abortion - in the case of the pregnant person's health, fetal indication, or if the pregnancy is due to rape or incest - are weaponized to create scripts of acceptable and unacceptable abortions, of abortion as in need of regulation (De Zordo 2018). These are forms of reproductive governance (Morgan and Roberts 2012) which pit reproductive rights against moralizing discourses, and rely on mechanisms including stigma to mark reproductive bodies as desired or not, responsible or not.

Anti-abortion framing has attempted to (re)construct abortion as deviant, shameful, and that anti-abortion campaigns are seeking to protect women (Cullen and Korolczuk 2019). These framings are classed, racialized, and gendered, using fetal personhood to describe pregnant people as mothers prior to birth and creating shame and framing abortion as murder (Baird and Millar 2018). Anti-abortion framings frequently draw on essentialized notions of womanhood and motherhood that are rooted in heteronormativity (Graff and Korolczuk 2021), which stigmatizes queer, trans, and non-binary people seeking abortion care, and punishes any departure from these scripts, including by heterosexual women.

Abortions are located in ableist systems that create and perpetuate disability stigma. Anti-abortion groups operationalize disability rights to oppose abortions and add to their stigmatization. During the Zika epidemic in Brazil, anti-abortion groups instrumentalized disability rights to oppose expanding abortion care (Wenham, Abagaro et al. 2021). Rarely, however, is there recognition of the broader policy implications for supporting a person to decide whether to seek an abortion in case of fetal abnormality, and the types of services and social, educational, and economic structures necessary for those who choose not to have an abortion (Jesudason and Epstein 2011).

Health policy can reflect abortion stigma, as well define the markers of abortion stigma. In the USA, policies that prevent companionship in Northern California meant that people seeking abortions reported fewer mechanisms that mitigated feelings of stigma (Altshuler, Ojanen-Goldsmith et al. 2021). Health policies, such as in Uruguay, that mandate "reflection periods" of five days between consultation and being provided care stigmatize care seekers by framing them as untrustworthy and needing to reflect on the 'consequences' of their decision (Cárdenas, Labandera et al. 2018).

The impact of stigma within health policy impacts the capacity of a health system to provide abortion care. Lack of medical education for trainee doctors in Australia, through the omission of abortion within medical guidelines, led to a dearth of qualified care providers, resulting in less access to care for pregnant people (Baird 2015). In Ghana, abortion stigma led to the omission of abortion from national health policies prior to 2003, despite legislation in 1985, resulting in few facilities providing services except for post-abortion care (Lithur 2004).

Inadequate abortion care provision is not experienced equally by people seeking abortions and structural stigma shapes the experiences of care (Broussard 2020). In Ireland, structural stigma in the form of restrictive laws forced pregnant people to travel for their abortions, or self-manage care, generating feelings of shame and secrecy (Aiken, Johnson et al. 2018). Moreover, the capacity to access these services is explicitly tied to the ability to find, finance, and take time to obtain care. In Poland, the removal of abortion from public health provision combined with gestational limits to care resulted in classed differences in the ability to access care (Chełstowska 2011). The role of abortion stigma in shaping available care has differing impacts for those who can navigate commodified and / or difficult to access care and those who cannot.

5. Providers and abortion stigma

Abortion providers highlight the complex nature of abortion stigma; through being associated with abortions they are themselves recipients of stigma, while also being a critical population capable of enacting stigma. Historic representations of abortion providers - e.g., the 'illegal abortionist' - have persisted and perpetuated stigma, which has important, negative consequences for care seekers and providers (Joffe, Weitz et al. 2004). The notion of abortion as "dirty work", tainted by physical, social, and moral taboos, others abortion providers from other healthcare workers (Harris, Debbink et al. 2011). This external stigmatization of abortion providers is significant due to the threat and experience of violence from anti-abortion groups, including the murder of providers (Harris, Debbink et al. 2011).

Abortion providers can experience stigma within the workplace from colleagues not providing abortions, including questions or comments about the 'morality' of their work (Freeman and Coast 2019). Concerns around experiencing stigma by qualifying as an abortion provider has been critical in the low levels of trained staff in Australia, thus limiting the access to care for pregnant people (Baird 2015). Experiences of stigma among abortion providers can culminate in burnout and compassion fatigue (Martin, Debbink et al. 2014). Where abortion provision is already limited due to limited facilities and personnel, provider burnout can lead to an exacerbation of barriers to access. These access issues are experienced differently for people seeking abortions depending on their resources and means to navigate structural barriers to care, emphasizing how provider experiences of stigma intersect with existing access inequities.

Abortion providers can also be instrumental in the process of mitigating, as well as enacting, stigma on people seeking care. Community Health Intermediaries in India enacted stigma by treating women differently depending on whether they perceived them as having a 'good' or 'bad' abortion, and subverted other norms around abortion in order to provide care, either due to meeting acceptable thresholds of 'deserving' or because of interpersonal relationships that behoove them to offer care as an exception (Nandagiri 2019). A comparative study of abortion providers in Italy and Cataluña highlighted how providers operationalized classifications of more and less 'acceptable' abortions, and although they provided care, they framed abortions as a 'social problem' (De Zordo 2018). Within this, providers categorized young women in particular as lacking 'responsibility', highlighting how their stigmas were stratified by age (De Zordo 2018).

Providers are also susceptible to replicating community and structural abortion stigma . In Zimbabwe, providers drew on normative notions of abortions as 'evil' and 'socially unacceptable' by women who sought care (Chiweshe and Macleod 2017). Among providers in Senegal, normative values on women's sexuality and fertility often conflicts with women seeking abortions to navigate dual stigma for being pregnant, especially if they are young or unmarried (Suh 2018). In Burkina Faso, the selection of uterine

evacuation technology for post-abortion care is driven, in part, by motivations to mitigate abortion stigma (Ouedraogo and Juma 2020). Thus, the stigmatization of abortion care-seeking by providers can shape access to, and content of, care.

6. Resistances to abortion stigma: care-seekers and providers

Abortion stigma is a dynamic, social process (Millar 2020), one that is (re)constructed continually in response to changing social, economic, and political conditions. It is resisted by individuals, collectives, and communities, from the local to the transnational, with stigmatizing labels and framings challenged and normative attitudes shifted. How abortion stigma is challenged, by whom, and to what extent is shaped by a person or group's experiences of oppression. In this chapter, the authors use the broad micro-meso-macro levels, recognizing the blurriness of the boundaries between these levels, to structure the evidence relating to abortion resistance enacted by care-seekers and providers.

Among pregnant people in South Africa, the use of "everyday chatter" within informal social support networks in the abortion care waiting room provided a strategy to mitigate perceived shame within healthcare facilities (Mavuso and Macleod 2020). The use of sharing experiences across networks has similarly been found as a strategy to mitigate stigma (Izugbara, Egesa et al. 2015), while it might compound the stigma experienced by those unable to share their abortions. These strategies of discussion and sharing experiences have been operationalized by abortion activists to mitigate internalized stigma (Giovannelli, Mannarini et al. 2022).

As the experience of abortion stigma is not uniform, nor is its resistance. A study of 15 women in the UK found that women from different class backgrounds employed different strategies to mitigate the experience of stigma when accessing abortion care (Love 2021). To avoid internalizing abortion stigma, middle class women used classed social and cultural capital, whereas working class women used strategies previously developed to avoid class stigma (Love 2021). However, women in the UK also used normative and gendered notions of motherhood to resist abortion stigma, framing themselves as not ready to be a 'good mother' and, therefore, justifying their abortions (Hoggart 2017).

While sharing abortion experiences can help mitigate abortion stigma, it places the burden of resistance on individuals and limited evidence suggests mixed success. In a US survey of people who shared their abortion stories publicly, two thirds reported that they received support, while 60% also reported harassment and negative incidents after sharing (Woodruff, Schroeder et al. 2020). An individual-level intervention in the US that used digital narratives to reduce stigma found no significant differences between intervention and control groups, with results indicating that intersections of racialization and stigma were crucial in the different levels of felt stigma (Sackeim, Lee et al. 2022).

To mitigate perceived and enacted stigma during the process of accessing care at a facility, pregnant people may utilize abortion helplines and feminist collectives. Women in Poland, Brazil, and Nigeria used medical abortion helplines to avoid stigma from formal providers, which women heard about through shared abortion experiences (Baum, Ramirez et al. 2020). Among women in Great Britain who accessed medical abortions through online organizations, 30% cited concerns of stigma at facilities as a critical factor in their decision-making to access services online (Aiken, Johnson et al. 2018).

Abortion providers also resist abortion stigma. In-depth interviews with 14 medical professions associated with abortion in the US highlighted how creating a provider community and support from social networks was important, alongside the construction of a "hero" framing of abortion providers doing essential care work (O'Donnell, Weitz et al. 2011). Among nurses providing abortions for fetal indication in Canada, framing the work as gratifying and underscoring that they provide quality care helped them to navigate stigma within their clinical environments (Chiappetta-Swanson 2005).

Interventions to resist abortion stigma have also grappled with the role that abortion providers can have in shaping abortion experiences. Quality counselling and patient-centered practices are among the recommendations for providers to help mitigate stigma experienced by people seeking care (Upadhyay, Cockrill et al. 2010). Efforts to create positive framings of abortion, as well as remove notions of abortions as exceptional care, have helped to mitigate stigma (Purcell, Maxwell et al. 2020). These efforts, aimed to reduce experiences of abortion stigma for providers and people seeking abortions, continue to burden individuals with the solutions to their stigma, ignoring the broader meso and macro factors that generate and maintain stigma (Martin, Debbink et al. 2014).

Interventions designed to resist abortion stigma at the community-level are rare and have mixed effects (Cutler, Lundsberg et al. 2022). These efforts sought to utilize the sharing of abortion experiences within social networks to tackle community-level stigma. A book club pilot intervention in the US was able to improve positive feelings towards people who have had abortions as well as abortion providers, and the improvement was greater if someone within the book club discussed an abortion experience (Cockrill and Biggs 2018). However, the use of first-person abortion stories as a way of deconstructing abortion stigma at the community-level has mixed effects, particularly if it fails to consider intersecting racialized and classed prejudice and stigma (Cutler, Lundsberg et al. 2022). The spaces for, and participants in, resistance to abortion stigma are dynamic and evolving.

The limited evidence on strategies to mitigate abortion stigma at the community and structural level highlights how strategies have failed to incorporate stratified reproduction and intersectional stigma in their design. Within Australian advocacy and activism, efforts to tackle abortion stigma that focus solely on choice have consequentially (re)centered white, middle-class identities by not considering the racialized, classed, gendered, and ableist conditions under which people seek care (Baird and Millar 2018).

Within Polish and Irish pro-choice activism, efforts to de-stigmatize abortion included framing abortion bans as detrimental to health of women, while minimizing intersectional approaches to activism (Cullen and Korolczuk 2019). Operating within socially conservative and gendered environments and the emphasis of abortion as "safe, legal, and rare" reinforced abortion as exceptional and undesirable (Cullen and Korolczuk 2019). Pro-choice framings of abortion as "rare" have the potential to stigmatize people who have had multiple abortions.

7. Evidencing abortion stigma

Abortion stigma can also be located within the commodity chain of research and evidence. Who conducts the research, and the location and norms that they navigate in doing so, can lead to abortion evidence and researchers being stigmatized by academic communities (Chiweshe 2018). It is not uncommon, for

example, for IRB and other ethical review committees to ask specific questions on the sensitivity of abortion, thereby (re)producing normative views that abortion is different to other forms of healthcare. Abortion research stigma has been suggested as a potential reason for researchers to experience difficulty securing funding or encountering pressure to study "less controversial" topics (Norris, Bessett et al. 2011). The individualization of abortion stigma is also reflected in research, which frequently uses stigmatized people as the focus of interventions and evidence-generation (Littman, Zarcadoolas et al. 2009).

Scales have been developed to measure stigma at the individual, community, and provider levels. Yet, these scales are insufficient to capture the stratification of reproduction or intersecting layers of stigma (Cutler, Lundsberg et al. 2021). Scales for measuring stigma are frequently not rooted in theoretical conceptualization (Hanschmidt, Linde et al. 2016); the lack of an intersectional lens in current abortion stigma conceptualization exacerbates this tension between measurement and reality.

The Stigmatizing Attitudes, Beliefs, Actions Scale (SABAS) includes components that relate to the negative stereotyping (labelling) of a woman who seeks an abortion and how these correspond to exclusion and discrimination (Shellenberg, Hessini et al. 2014, Håkansson, Oguttu et al. 2018). It does not, however, account for how people are labelled and excluded differently. The Community Level Abortion Stigma Scale (CLASS) developed by Sorhaindo et al in Mexico (2016) incorporates whether a woman is 'good' or 'bad' because of her abortion but does not measure stratified differences in stigma.

Stigma measures designed within a specific context incorporate some questions that gather data on how stigma varies for different people seeking abortions. A measure developed in a study of abortion attitudes among university students in Ghana allowed for differences in attitudes towards married and unmarried women accessing care (Rominski, Darteh et al. 2017). The Scale to Measure Adolescent Sexual and Reproductive Health Stigma is divided into components on enacted stigma, internalized stigma, and stigmatizing lay attitudes (Hall, Manu et al. 2018). The survey acknowledges the specific intersection between adolescence, sexuality, and sexual and reproductive health - including abortion - though does not layer these across racialized, classed, or ableist systems of discrimination.

Measures of stigma among medical professionals emphasize the duality of abortion providers as people who both experience stigma and enact stigma in provision of abortion care. The Revised Abortion Providers Stigma Survey focuses on the experience of abortion providers and the causes and consequences of stigma they face for their work (Mosley, Martin et al. 2020). This includes the impact of stigma on disclosure, on feeling judged and discriminated, as well as internalized stigma. The scale does not incorporate measures that would capture how providers might themselves enact stigma in the process of giving care. The Values Clarification and Attitude Transformation (VCAT) measurement incorporates some questions relating to how providers' attitudes might themselves be stigmatizing - for example, whether providers or people working in abortion think abortions after the first trimester should be restricted (Turner, Pearson et al. 2018).

8. Conclusion and Future Directions

Abortion stigma is multidimensional and has negative consequences for both care seekers and providers. Interrogating abortion stigma through an intersectional lens complicates notions that abortion stigma is derived from deviations of scripted 'womanhood' (Kumar, Hessini et al. 2009). Socially scripted notions

of acceptable and unacceptable sexual and reproductive behaviors are stratified along racialized, classed, gendered, ableist, and ageist lines.

An intersectional lens allows greater examination of how abortion stigma is felt and enacted differently for disparate abortion seekers. Evidence shows how multiple stigmas can intersect and be unavoidable for people seeking abortions. In particular, people who disrupt social scripts around acceptable pregnancies - such as people who are young, unmarried, non-binary or trans, differently-abled, have low access to resources - are faced with dual stigma for becoming pregnant and then for seeking an abortion. For many people, navigating abortion stigma involves maintaining secrecy and disclosing to specific people - if any at all - for support (Nandagiri 2020). These strategies can carry specific burdens by internalizing abortion stigma, as well as limiting the support - financial, emotional, practical - that might be needed to access care. Abortion stigma, therefore, exacerbates existing obstacles that many groups face when seeking care.

Within health settings, interactions between people seeking abortions and providers are spaces through which stigma is unevenly enacted. Evidence indicates that abortion providers can help mitigate experiences of stigma. However, negative attitudes deployed selectively towards care-seekers, which can include objecting to providing care altogether (Freeman and Coast 2019), have a critical stigmatizing effect. These interactions outline the role of perceived and felt stigma in shaping access to abortion care, with some people self-managing their abortions in order to avoid what they have either heard or perceive to be stigmatizing experiences (Aiken, Johnson et al. 2018).

Micro, meso, and macro layers intersect to reproduce and shape abortion stigma. Individual-level and provider stigma are embedded within community-level stigma. Community-level stigma shapes the normative environment that pregnant people must navigate in the process of seeking care. Scripted norms around womanhood and motherhood generate specific expectations on how a person should respond to a pregnancy and the acceptability of an abortion. Community notions of stigma thus determine the conditions under which seeking particular care, from specific providers, is deemed acceptable, as well as the capacity for a person to share their abortion experiences.

Whilst providers might attempt to mitigate stigma through counselling and quality care practices, health policy frequently frames abortion seekers - and women specifically - as untrustworthy and uninformed about their bodies and requiring state “protection” (Doan and Schwarz 2020). This is exacerbated in treatment and policies designed to make women ‘reflect’ on abortions as ‘hard’ decisions. Thus, the place of care (hospital, clinic, or other facility) becomes a space where micro, meso, and macro levels of abortion stigma collide. The stigma experienced by abortion providers due to their work plays a dual role, alongside their ability to enact abortion stigma in the process of providing care.

These complex intersections within abortion stigma, and between abortion stigma and other axes of discrimination and oppression are critical. Examining abortion stigma through an intersectional lens offers insights into how resistance to abortion stigma is limited and constrained. The focus of resistance at the individual-level - interventions to reduce stigma and interventions using people who have had abortions to share their stories - has had mixed success. Without grappling with stratified reproduction within meso and macro abortion stigma, dismantling abortion stigma can in fact reinforce notions of the ‘good’ and ‘bad’ abortion and the ‘worthy’ and ‘unworthy’ individual (Freeman and Coast 2019). The lack of abortion stigma resistance at the macro level undermines attempts at the micro and meso level.

Research-evidence has grown since the first significant attempt to conceptualize abortion stigma (Kumar, Hessini et al. 2009). Though conceptualizations of abortion stigma have developed to incorporate greater nuance, there is little research on stigma that grapples specifically with how reproduction is stratified. Much of the current evidence is US-focused. Measures of abortion stigma have been developed to understand stigma at the micro and meso levels, yet few of these account for the variable abortion stigma experienced by different groups. The paucity of interventions and work grappling with providers as both experiencers and enactors of stigma is also reflected in research-evidence and the lack of measures to capture these. Research is a site of stigma for researchers and those they research, producing evidence that does not adequately account for the intersectional experiences of abortion stigma, and simultaneously a source of resistance by generating evidence for advocacy and activism.

Abortion stigma is indicative of the conditions under which women and pregnant people seek care. It is fundamental to acknowledge, however, that abortion stigma is not a singular experience that can be universalized. The interaction between abortion stigma and other axes of discrimination and oppression exacerbates experiences of reproductive injustice among people seeking care. An intersectional approach to understand stigma uncovers the complexities of whether a person seeks care, how and where they can obtain care, their experiences of obtaining abortion, and the consequences of that care. This provides depth and nuance to how reproductive injustice is (re)produced at the micro, meso, and macro levels, which is essential for researchers, providers, activists, advocates, and policymakers to incorporate into their pro-abortion work.

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