The *Dobbs vs Jackson Women's Health Organization* Supreme Court decision in 2022 changed the landscape of reproductive healthcare in the US. As the authors of these Viewpoints explain, there are wide-ranging impacts on the US healthcare workforce and society. Workforce impacts include: (1) a lack of clarity on exceptions to state bans (e.g., health of the pregnant person), which leaves clinical providers in legal and ethical binds when determining which services they can provide, (2) major concerns for privacy of providers, and (3) loss of providers and clinics in restrictive states, affecting both current practice and medical education. Societal impacts are highest on those most vulnerable, such as minoritized racial/ethnic groups, low-income individuals, and individuals living in states with existing disparities in maternal health and poverty rates. Mental health outcomes are critical both for the workforce and broader society, and the authors note the pressing need for robust research on the impacts of *Dobbs*. This Comment expands on these important viewpoints to present implications and strategies for the workforce elsewhere.

Dobbs has emboldened some countries to enact restrictive policies, both for abortion and for other human rights issues. Anti-abortion activists in Kenya, Nigeria, and India have cited *Dobbs* as support for their cause,[1] and Uganda's constitutional court cited *Dobbs* to uphold anti-LGBTQ+ laws that allow for life imprisonment and the death penalty.[2] However, these countries diverge from overall global trends. More than 60 countries have liberalized their abortion policies in the past 30 years.[3] In March 2024, France guaranteed the right to abortion in its constitution,[4] thereby protecting abortion from political uncertainty, and policy-makers explicitly mentioned *Dobbs* as part of the rationale.

Long before *Dobbs*, US policies such as the Helms Amendment (1973) and the Mexico City Policy (1984) restricted access to abortion-related services and information.[5] Helms prohibits the use of US foreign assistance funds to pay for abortion as a method of family planning; in practice, it is implemented as a complete ban on abortion-related services and information. The Mexico City Policy (1984) - also known as the global gag rule - prohibits non-US NGOs from using their own resources to advocate or refer for abortion.The gag rule goes into or out of effect with changes in the political affiliation of the US president. Although the *Dobbs* decision has no legal bearing on these policies, key aspects of the gag rule mirror post-*Dobbs* US state policies that threaten jail time and significant fines for abortion providers and those that support them. Research on the gag rule suggests that impacts include reduction of numbers of NGO-facilitated training and shortage of abortion providers,[6] and early reports[7] suggest similar results of *Dobbs* in the US. Reductions in the number of both facilities and individuals who can provide care mean fewer abortion providers and fewer providers of related services, such as maternity and contraception care. Organizations that provide or support abortion-related care must navigate, and to the extent possible, insulate themselves from shifting US policies that now include the global gag rule, *Dobbs*, and any other future changes.

The abortion workforce is diverse and includes multiple types of clinical and non-clinical professionals. Pharmacists, for example, play a critical role in the availability and delivery of medication abortion, especially in contexts with highly restrictive abortion laws. Activists - people who take intentional action to effect change - are essential in a wide range of contexts: operating telephone hotlines or transnational

telemedicine services; providing information, referrals, and funding for abortion; and accompanying abortion care-seekers. This diverse ecosystem enables abortion care-seeking in formal and informal ways, both in the US and elsewhere. Formal abortion care includes the provision of procedural or medication abortion by a qualified provider in a healthcare setting or via telehealth. Informal practices include self-managed abortion[8], a medically safe practice that involves the use of misoprostol alone or the mifepristone-misoprostol combination; in the US, self-managed abortion has increased substantially following *Dobbs*.[9] With roughly half of US states now banning or dramatically restricting abortion, one way that the US workforce could address access challenges is to further develop this "constellation of actors" approach to abortion access and care by expanding the abortion workforce.

Along with restrictions on providing accurate information about abortion, the workforce must also face the growing challenge of mis- and dis-information about abortion. US-based anti-abortion groups provide support for facilities that give inaccurate information to convince people not to obtain abortions in El Salvador, the Philippines, Mexico, and other settings.[10] In the US, these facilities are called crisis pregnancy centers (CPCs), and research has shown that CPCs are associated with adverse health impacts, as they provide medically inaccurate information and delay access to legitimate medical care.[11] The proliferation of these types of facilities also contributes to abortion stigma for both abortion seekers and providers. While CPCs receive some private donations, they also receive government funding (both state and federal). Removing US government funding for these organizations would be an important step forward for improving access to abortion services and information.

Mounting pressures on the workforce are likely to exacerbate provider burnout and moral injury[12] and may result in fewer providers choosing careers in healthcare or specializing in abortion-related care. Workforce researchers call this a pipeline problem. Without an adequate supply of trained providers in the pipeline, workforce shortages will be exacerbated. This increases barriers to accessing not only abortion but the full scope of reproductive health services (e.g. management of miscarriage, ectopic pregnancy, routine pregnancy care).

There is no single solution for the complex issues facing the abortion workforce globally. Rather, a set of strategies are needed to address shifting challenges. Providers and support staff need context-specific guidance about what services and information they are allowed to provide within their country, state, and institution. In addition, medical education programs should explicitly address abortion care and more fully integrate it into training; successful models of this already exist and could be replicated or expanded. Finally, it is important to recognize that restricting abortion has far-reaching effects that expand into other aspects of healthcare and society, and that the fallout from the Dobbs decision is likely to persist for years to come.

References

1. The Global Impact of the Dobbs Decision on Abortion Laws, Policies, Legislation, Narratives, and Movements: Findings from Colombia, India, Kenya, and Nigeria [Internet]. Fos Feminista; 2024 Jan. Available from: https://fosfeminista.org/wp-content/uploads/2024/01/Dobbs-Full-Report_2024.pdf
2. McShane J. Uganda cited Dobbs to back an anti-LGBTQ crackdown. Americans should be worried too. Mother Jones [Internet]. [cited 2024 Apr 11]; Available from: https://www.motherjones.com/politics/2024/04/uganda-dobbs-lgbtq-court-law-dobbs-usa-abortion-rights/
3. Center for Reproductive Rights [Internet]. [cited 2024 Apr 11]. The World's Abortion Laws. Available from: https://reproductiverights.org/maps/worlds-abortion-laws/
4. Kumar A. Activism for Abortion Rights and Access Is Global: What the United States Can Learn from the Rest of the World. J Health Polit Policy Law. 2023 Aug 1;48(4):593–602.
5. France makes abortion a constitutional right on International Women's Day. Al Jazeera [Internet]. [cited 2024 Apr 11]; Available from: https://www.aljazeera.com/news/2024/3/8/france-makes-abortion-a-constitutional-right-on-international-womens-day
6. Maistrellis E, Juma K, Khanal A, Kimemia G, McGovern T, Midy AC, et al. Beyond abortion: impacts of the expanded global gag rule in Kenya, Madagascar and Nepal. BMJ Glob Health. 2022 Jul;7(7):e008752.
7. Research and Action Institute [Internet]. [cited 2024 Apr 11]. Training Location Preferences of U.S. Medical School Graduates Post Dobbs v. Jackson Women's Health. Available from: https://www.aamcresearchinstitute.org/our-work/data-snapshot/training-location-preferences-us-medical-school-graduates-post-dobbs-v-jackson-women-s-health
8. Berro Pizzarossa L, Nandagiri R. Self-managed abortion: a constellation of actors, a cacophony of laws? Sex Reprod Health Matters. 29(1):1899764.
9. Aiken ARA, Wells ES, Gomperts R, Scott JG. Provision of Medications for Self-Managed Abortion Before and After the Dobbs v Jackson Women's Health Organization Decision. JAMA [Internet]. 2024 Mar 25 [cited 2024 Apr 11]; Available from: https://doi.org/10.1001/jama.2024.4266
10. Radhakrishnan A. The Decision Heard Around the World: The Global Impact of Dobbs v. Jackson Women's Health Organization. [cited 2024 Apr 11]; Available from: https://www.americanbar.org/groups/diversity/women/publications/perspectives/2023/april/the-decision-heard-around-world-global-impact-dobbs-v-jackson-womens-health-organization/
11. Montoya MN, Judge-Golden C, Swartz JJ. The Problems with Crisis Pregnancy Centers: Reviewing the Literature and Identifying New Directions for Future Research. Int J Womens Health. 2022 Jun 8;14:757–63.
12. Sabbath EL, McKetchnie SM, Arora KS, Buchbinder M. US Obstetrician-Gynecologists' Perceived Impacts of Post–Dobbs v Jackson State Abortion Bans. JAMA Netw Open. 2024 Jan 17;7(1):e2352109.