



A pivotal position

Stigma and its impact on U.S. abortion providers — Lori Freedman’s book reveals the complexities.

By Jennifer Colletti

Few of us would sign up for a job that would pose risks to our personal safety and our family’s safety, threaten to stifle or derail our career, cause our community to ostracize us, and cause us to continually face judgment and stereotyping from people we see every day. Yet

that is exactly what many—if not most—health-care providers sign up for when they decide to deliver abortion care in the United States. And it’s the same for providers in many countries around the world.

Abortion provider stigma traces a complex history

Earliest U.S. settlements – 1800s

Abortion was legal before “quickening,” which occurs around the fifth month of pregnancy when the sensation of fetal movement begins. Abortion was openly advertised and commonly performed by physicians and other providers.

Mid-to-late 1800s

States began passing laws to make abortion illegal. By 1910, all but one state had outlawed abortion except in cases where necessary to save a woman’s life. Only physicians could provide the procedure. Despite its illegality, the number of women seeking abortion didn’t decrease — even into the next century.

1920s – 1930s

Abortion rates rose because women faced a tough economy and needed to keep working (pregnant women were frequently fired). Depression-era abortion providers were fairly visible and tolerated by law enforcement.

When abortion is stigmatized in a society, the tentacles of social disapproval reach everyone—from the individual woman receiving the service and her family and community, all the way up to hospital administrators and lawmakers. Within this complex web of influences, abortion providers wage a daily battle to provide safe abortion care to women.

“Providers are not all on their own,” explains Anu Kumar, Ipas executive vice president. “They’ve got to relate to the health system, the legal system and the educational system, and they’ve got their bosses and their family. So it’s not so simple. When you walk into the provider’s office, you’re not getting just that person, you’re getting the institution behind that person.”

Of course, abortion providers experience stigma in drastically different ways depending on the particulars of their country and community. For example, in Uruguay abortion providers are often viewed as accomplices to murder due to deep-seated Catholic opposition to the procedure. On the other hand, communities in Zambia tend to respect the professional judgment of abortion providers but severely disapprove of women who get abortions. And provider experiences differ vastly even within the United States: Some physicians who work in more progressive urban settings face less discrimination and fewer social effects of stigma than their counterparts working in conservative rural communities.

The costs for providers

Given the complicated history of U.S. abortion politics, Americans often assume that physicians who provide abortion believe it’s morally acceptable and have the guts to go through with it, while those who do not are morally opposed and/or intimidated by society’s stigma. But in truth, who provides abortion in the United States often has little to do with moral or political resolve. For her book *Willing and Unable: Doctors’ Constraints in Abortion Care*, author and University of California, San Francisco researcher Lori Freedman interviewed physicians practicing obstetrics and gynecology nationwide and found many providers who were willing to perform abortions but unable to overcome the structural barriers that abortion stigma and U.S. politics create.

“While several of these physicians would have liked to continue to perform abortions after residency and even took steps toward it, they found that there would be significant professional and social costs in doing so—costs that they were not willing to bear,” Freedman writes. Professional obstacles cited by physicians included workplaces with an anti-abortion climate; the surprisingly widespread “no-abortion policies” that quietly exist in many private practices, HMOs, and hospitals across the country; the risk of being pigeonholed as just an abortion provider; and the risk of being ostracized by the local medical community and patient population. On a more personal level, some

1940s – 1950s

Law enforcement stopped tolerating illegal abortion providers and began arresting them, which inhibited new providers from stepping up to fill the openings.

1973

Women regained the right to abortion in all states thanks to the Supreme Court’s *Roe v. Wade* ruling. However, abortion providers continued to experience stigma.

1976

Outpatient abortion services expanded rapidly despite the fact that no guidelines or standards for abortion care had been created by major medical bodies. Abortion rights advocates point to this as proof the medical community did not consider the procedure legitimate from the outset.

physicians worried that providing abortions would cause their families to suffer discrimination and even danger.

In addition, many providers are stigmatized by the very patients who come to them for abortions. Physicians who staff specialized abortion clinics report disheartening interactions with patients who ask “How do you do this on a regular basis?” or “Isn’t this really hard for you?” Even though these patients are willing to have abortions, they have absorbed society’s beliefs about abortion providers and convey that to their doctors.

Specialized clinics: Separate but not equal

Separation is a hallmark of any stigmatized practice, and the fact that 93 percent of abortions are now performed at specialized clinics is no accident. Years of abortion prohibitions, threats and a professional medical culture that refuses to treat abortion inclusively has caused “multilevel, institutionalized buck-passing that marginalizes abortion practice,” Freedman writes.

While specialized abortion clinics are often able to cultivate a more positive environment for women in need of services, their complete separation from all other health-care facilities only serves to further stigmatize abortion. Separate clinics perpetuate the idea that abortion is not a “normal” part of women’s reproductive health care. And now that abortion practice is firmly established as a very separate type of patient care, there

are professional incentives for providers to stick with the model.

“If you’re going to do something that’s highly stigmatized in our culture, it’s not surprising that many people would like to do it in a setting where it’s not stigmatized, in a setting where everyone feels it’s normal and good, rather than in a setting where everyone is questioning what you’re doing,” Freedman tells *Because*.

The separation of abortion services from mainstream health care here in the United States is mirrored in many countries abroad thanks to U.S. foreign aid policy that strictly prohibits funding to any organization that provides abortion services.

“The assessments of the impact of the global gag rule and the Helms Amendment show that these policies have led to the isolation and separation of abortion, effectively delinking it from reproductive health and family planning,” explains Leila Hessini, Ipas director of community access. (See “One woman’s story and the role of institutionalized stigma in Ghana” on page 6.)

Solution: Add more settings and more providers

To reduce the marginalization of abortion care in the United States and abroad, one solution is obvious: “If you simply diffuse abortion provision across many more sites and many more providers and many more contexts, then the clinics aren’t so targetable and aren’t so focused

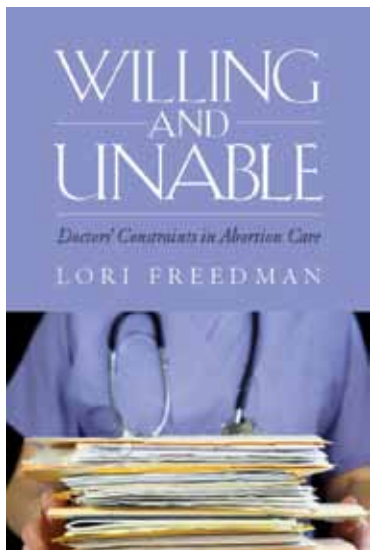


1980s – 1990s

By now the abortion decision was no longer between only a patient and her physician; powerful players such as the physician’s employer, malpractice insurers, hospital administrators, activists and lawmakers were all actively regulating to protect or obstruct the procedure.

on by protestors and people who want to perpetuate violence,” Freedman tells *Because*.

“If there are more providers in more places,” Kumar agrees, “it will become more routine and less specialized.”



In addition to expanding the settings where abortion is provided, diversifying the types of providers performing abortion is also key. In the United States, only physicians are permitted to perform first-trimester aspiration abortions—except in a few states which have granted limited rights for some nurse practitioners, physician assistants and certified nurse midwives to perform the procedure.

“The diversification of this provider pool is so critical,” Kumar stresses. And many countries in which Ipas works are already doing this. “Ethiopia, Nepal, Ghana and South Africa all permit primary care providers like midwives to perform abortion services,” she points out.

Researchers and advocates are working to make this a reality in the United States as well. The Primary Care Initiative (PCI)—a project of the University of California, San Francisco’s research group Advancing New Standards in Reproductive Health (ANSIRH)—is in the middle of a training and evaluation project for certified nurse midwives, physician assistants and nurse practitioners that seeks to prove the safety and effectiveness of allowing these types of providers to perform abortions, with the ultimate goal of affecting policy changes.

“With our study we’re looking to normalize abortion within women’s primary care and within reproductive health care, and so part of that is training more clinicians and health-care workers and teams of workers in providing safe abortion,” says PCI’s Principal Investigator Diana Taylor. Many states now allow providers such as nurses and midwives to administer medical abortion pills, and this “is certainly normalizing the experience” for this abortion method, she adds.

In the early 1990s, abortion rights advocates worried about an increasing shortage of abortion providers zeroed in on what seemed like an obvious cause: a

1993

Dr. David Gunn of Pensacola, Florida was fatally shot during a protest. He was the first in many fatal attacks by abortion-rights opponents.

1995

The Accreditation Council for Graduate Medical Education approved requisite abortion training for all residency programs, excepting only residents or hospitals that claimed moral or religious objections.

1992 – 1996

The number of abortion providers dropped by 14 percent.

1996 – 2000

The number of abortion providers dropped by 11 percent.

gaping lack of routine abortion training in OB-GYN residency programs. The number of residency programs that offer abortion training grew from 12 percent in 1991 to 51 percent by the mid-2000s; yet the service remained as separate and marginalized as ever.

“Now we know that training is only one part of it,” Freedman explains. Researchers realized that training does nothing to address the myriad obstacles to abortion provision that willing physicians encounter once they enter the workforce.

Support for providers = support for women’s reproductive rights

The complex tapestry of abortion stigma and its negative influences on providers, patients and society at large won’t unravel easily. But supporting abortion providers could be a critical first step.

“If we can do something about the stigma that providers feel and that they perpetuate, we have a hope of changing the very complicated picture of stigma,” Kumar says.

“Providers are in a really pivotal position, and how we as a system and a society treat them translates into how we treat women,” she explains. “So if we really hope to change how women experience abortion and to save women’s lives with safe abortion services, then we also really need to change the way we treat providers who perform these services.”

Stigma limits availability of U.S. abortion providers

While abortion is one of the most common procedures performed in America today, service providers are highly concentrated in urban areas and specialized clinics:

- 93 percent of abortions are performed in specialized abortion clinics.
- 69 percent of metropolitan counties and 97 percent of nonmetropolitan counties have no abortion provider.
- 87 percent of all U.S. counties do not have an abortion provider.
- Only 52 percent of all OB-GYNs who intended to provide abortions before their residencies actually did so after completion of their training.
- In 2008, just 22 percent of OB-GYNs nationwide had performed an abortion in the previous year.

Sources: Guttmacher Institute’s August 2011 “Facts on Induced Abortion in the United States” and Willing and Unable: Doctor’s Constraints in Abortion Care by Lori Freedman.

2000 – 2008

Roughly half of all residency programs include routine abortion training. In spite of this, the number of abortion providers dropped by another 2 percent. In 2008, there were 1,793 abortion providers in the United States, and 93 percent of abortion procedures occurred in specialized abortion clinics.

Freestanding abortion clinics reported to the police 41 bombings and 175 arson incidents, plus hundreds of burglaries, stalkings, bomb threats and anthrax threats since 1977.

Since 1993, eight murders and 17 attempted murders of abortion clinic workers and physicians have occurred.

Sources: National Abortion Federation and Willing and Unable: Doctor’s Constraints in Abortion Care by Lori Freedman.