



→ ADVANCING NEW STANDARDS IN REPRODUCTIVE HEALTH

## Stigma Presents Barriers to Abortion Care

Asociación de  
Clínicas  
Acreditadas para  
la Interrupción  
del Embarazo en  
España

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# Overview

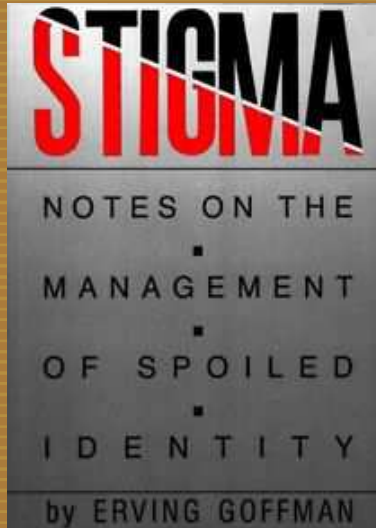
1. The sociological definition of stigma
2. What is abortion stigma?
3. How abortion stigma affects:
  - patients
  - providers
  - services
4. U.S. experiences with these problems



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# Sociological Definition:



- Classic book written in 1963 (Goffman)
  - “an attribute that is deeply discrediting”
  - person is “reduced in our minds from a whole and usual person to a tainted, discounted one”
- En sociología, estigma es una condición, atributo, rasgo o comportamiento que hace que su portador sea incluido en una categoría social hacia cuyos miembros se genera una respuesta negativa y se les ve como culturalmente inaceptables o inferiores.



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# What Becomes Stigmatized?

A thing?

A job?

***A person.***

How do people manage stigma?

- Hide it
- Divert attention from it
- Explain it
- **Redefine it: In-group pride**



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# What is Abortion Stigma?

“A negative attribute ascribed to women who seek to terminate a pregnancy that ‘marks’ them as inferior to ideals of womanhood.”

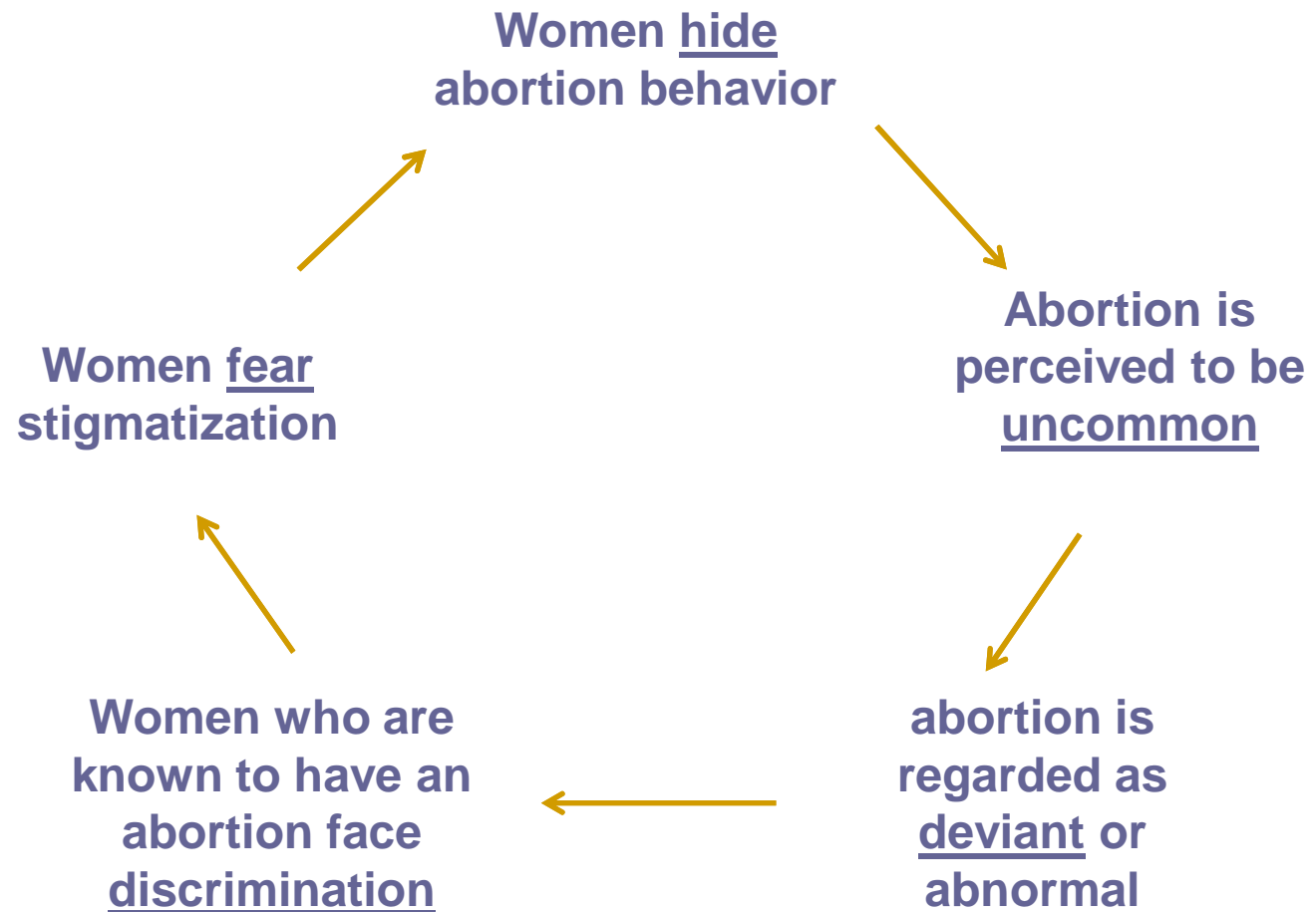
Kumar A, Hessini L, Mitchell EM. Conceptualising abortion stigma. *Cult Health Sex* 2009



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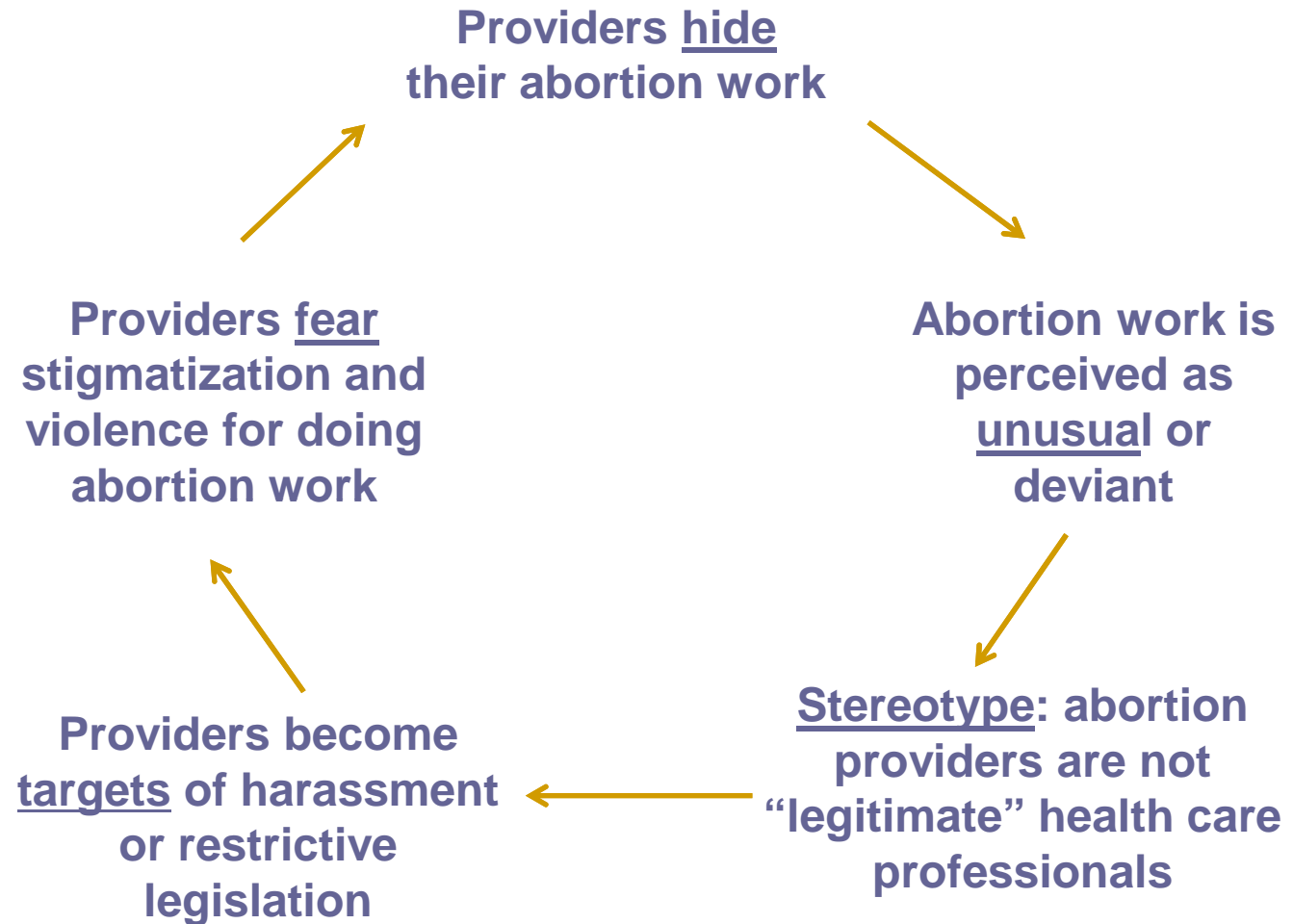
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# Prevalence Paradox----Women/Patients



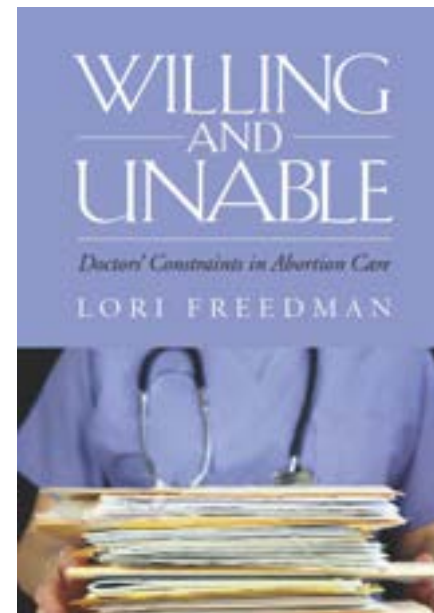
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# Legitimacy Paradox---Abortion Providers



# Institutional Stigma---Abortion Services

Stigma routinely and systematically shapes the way abortion care is delivered





# U.S. Background

- 1973 abortion legalized
- 1976 66% of abortions happened in abortion clinics
  - One-third of abortions occurred in hospitals & private medical offices –but this steadily decreased
- 2012 95% of abortions in abortion clinics
- 1990s Integration Movement
  - As a solution to problems of violence, harassment, stigma, lack of training, lack of access to abortion in rural areas



## Integrationist Dr. Jane Hodgeson

“The public should have been taught by medical leaders for the past 22 years that abortion is a necessary surgical service that should be available to whoever needs it. Abortion clinics should have been encouraged to occupy space in the large professional medical buildings, surrounded by other specialties, or, even better yet, to seek the protection of anonymity within hospital walls. Instead they have been forced into isolation as freestanding clinics. Removed from the mainstream of medical practice, they are more vulnerable to violence and harassment and less accessible to students and residents for the purposes of medical education.”

-British Medical Journal 1995



# Integration Successes within Medicine

- Medical Students for Choice = 10,000
- Accreditation Council of Graduate Medical Education (ACGME) mandated access to abortion training in 1995
- The Kenneth J. Ryan Residency Program
  - abortion training
- The Fellowship in Family Planning
  - post-residency specialization in complex contraception and abortion



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# Challenges to Integration

More abortion training  $\neq$  More abortion providers

- Only half of those who intended to provide abortions after residency did so
- Why?

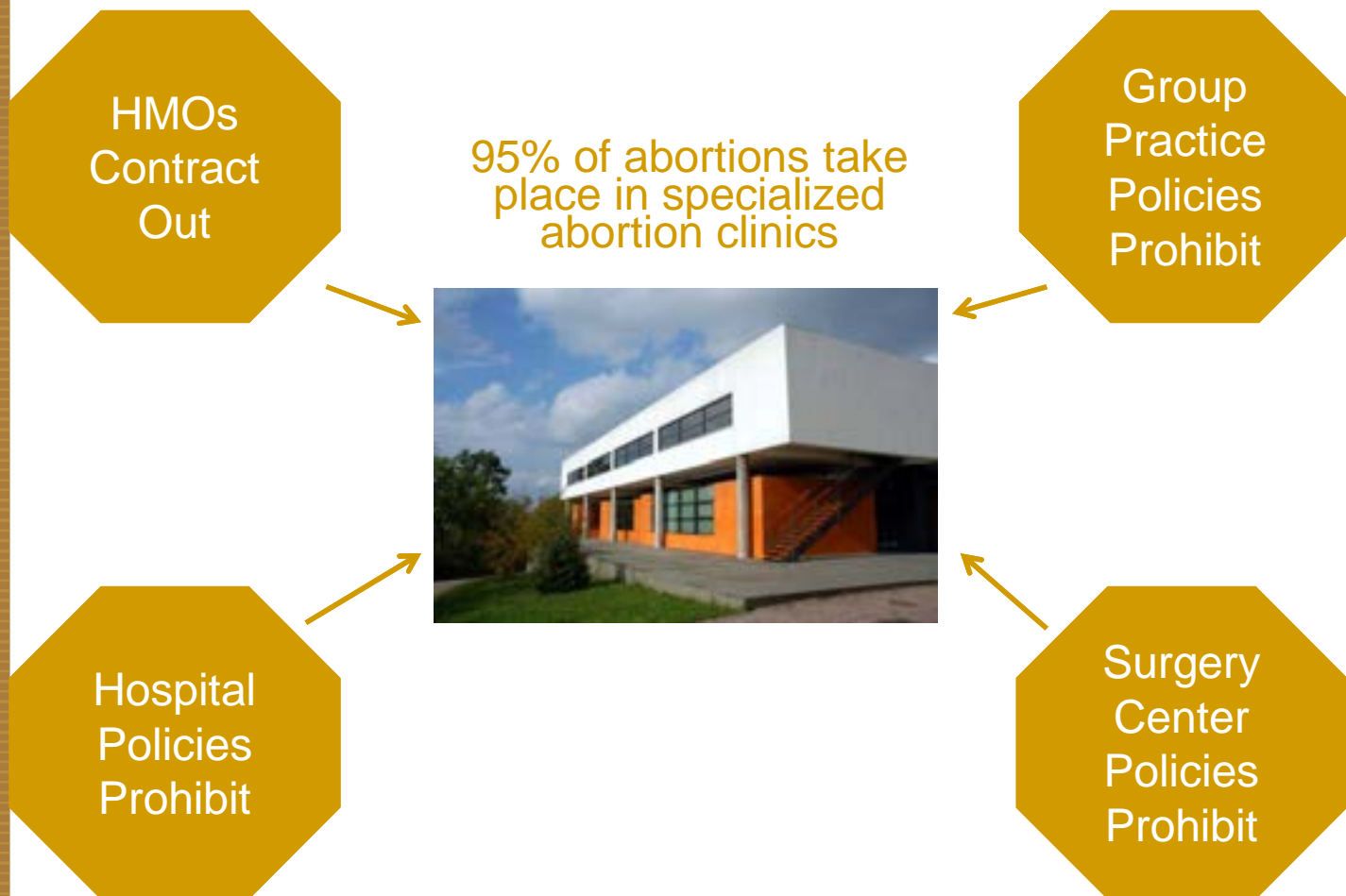


## Qualitative, In-Depth Interviews 2006

- Ob-Gyn graduates 1996-2001 (n=30):
  - 4 Residencies with routine abortion training
    - Western Residency (n=9)
    - Midwestern Residency (n=9)
    - Southern Residency (n=5)
    - Northeastern Residency (n=7)
- Supplementary interviews (n=10):  
Residency Directors, Fellows, Administrators



# Institutionalized Buck-Passing of Abortion Care in the United States



## Group Practice Policies

“My business climate right now is absolutely antagonistic toward even the idea of [abortion practice]. In private practice...if you get a sense that *that* is not going to go over well, you don't push *that*... it's not just your own practice that is in jeopardy, but your also putting your partners' practice in jeopardy by being associated with them.”



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8 de Noviembre| Slide 15

## Group Practice Policies

“There came an instant where somebody asked, when [medication abortion] first became available, if we were going to provide that in the clinic or if we would write prescriptions... And it just generated this unbelievable panic in the clinic. And people were very strongly, “No, we are not an abortion clinic. We don't do those kinds of services”... I was just an employee at the time... I just kept my mouth shut and didn't say anything.”



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## Hospital Policies

“Let’s say we have a sixteen-week [fetal] anomaly...we have to have a signature from the Chief of Staff, the Maternal Fetal Medicine doctor, the OB Chief-you have all these signatures that you have to get. And that actually made me realize [our hospital] doesn’t allow straightforward terminations.”

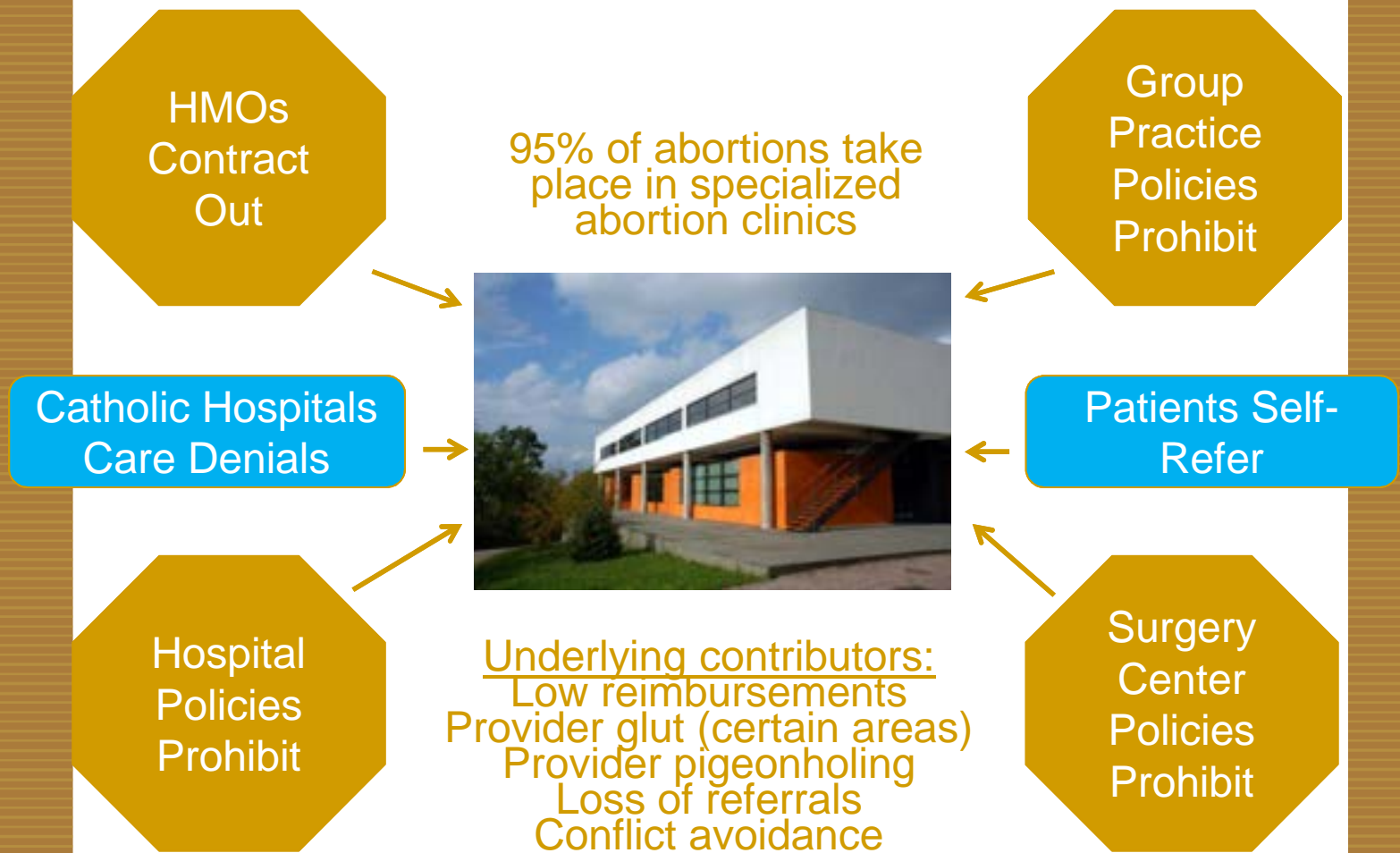


## HMO –Manage Care Organization Policies

“They’re sent out - for all [our patients]... the chief of my [obstetrics and gynecology] department told me that very early on...And she’s somebody who’s actually a supporter, but she was relieved as the chief not to have to deal with...who was going to do them, who wasn't going to do them, and whether the department had to be all in agreement about providing the service ...I don't know if they’re thinking that they don’t want to be a target that way or have people protesting ...It might just be a relief for them to just say we have these other [folks] do them and Planned Parenthood takes it all, *takes all the flack*.



# Institutionalized Buck-Passing of Abortion Care in the United States



## Who were the few who continued to provide abortion after training?

- Physicians who felt it was **VERY IMPORTANT** (worth the discomfort and risks to practice)
- Physicians who lived in liberal areas with liberal practice partners who are committed to abortion rights
- Physicians who became specialists in abortion and family planning



# Are there ways to reduce abortion stigma?

- Sharing abortion stories
- Compassionate care
- In-group collaboration, cooperation, and support



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Lori Freedman, PhD

# Thank you!



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