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# Structural stigmatisation of abortion in the health system: Perspectives of abortion care-seekers, providers, managers, and funders in England and Wales

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ABSTRACT

Abortion has been legally permitted in England and Wales for over fifty years, yet this health service continues to be stigmatised within the health system. Stigma is a dominant focus of abortion research, but a structural stigma framework is rarely used to understand how abortion stigma is produced at a macro-level. This study explored how structural abortion stigma is produced and experienced in the health systems of England and Wales, and its influence on person-centred care, including choice of abortion methods. Data from in-depth interviews with abortion care-seekers in 2022–23 and from key informant interviews with abortion care providers, managers, and commissioners in 2021 were analysed using reflexive thematic analysis. From the perspectives of key informants, structural abortion stigma is produced through the avoidance of abortion by decision-makers, the permitting of conscientious objection, and the exclusion of abortion from mainstream healthcare. These factors create health system pressures which increase abortion service fragility. The resulting vulnerability of abortion services reduces access to person-centred care, including abortion method choice, which can reinforce individual-level stigma. There are tensions between care-seekers' experiences of specialist abortion care as less stigmatising, while the 'abortion clinic' becomes a site of stigma due to its segregation from mainstream healthcare. This research contributes to a structural understanding of abortion stigma by identifying some of the mechanisms through which structural stigma is produced within health system institutions, and how these forms of institutional stigma might be resisted or dismantled. Power is essential to the (re)production of structural stigma within the health system, which can reinforce individual-level stigma for both care-seekers and providers. Restrictions on method choice and the increasing reliance on medication abortion can be a product of structural abortion stigma, and these limitations on method choice can also reproduce stigma at the individual level.

## 1. Introduction

Despite being a common reproductive experience, abortion is often highly stigmatised (Cockrill et al., 2013), and stigma has considerable influence over the environments in which abortion care is experienced (Sorhaindo and Lavelanet, 2022). Abortion stigma was first conceptualised by Kumar et al. as "a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood" (Kumar et al., 2009). This definition draws on Erving Goffman's theorisation of stigma as an 'attribute' held by individuals (Goffman, 1963), which has been criticised by scholars for ignoring the role of structure and power (Tyler, 2020; Link and Phelan, 2001; Millar, 2020). However Kumar et al. also employed work by Link and Phelan to illustrate how abortion stigma is produced (Kumar et al., 2009; Link and Phelan, 2001). By over-simplifying abortion and denying its frequency, 'women who abort' are labelled as 'different' from the norm, and this 'difference' is associated with negative attributes (e.g., being irresponsible, promiscuous, or selfish) (Kumar et al., 2009). This distinction between 'us' and 'them' results in status loss and discrimination for those associated with abortion (Kumar et al., 2009), including individuals having abortions, abortion providers and those who support people having abortions (Norris et al., 2011). Power is therefore essential to the social production of abortion stigma, as those who stigmatise have the power to define and label, to separate 'us' and 'them', and to control differential access to resources (Link and Phelan, 2001).

Structural stigma has been defined by Hatzenbuehler and Link as "societal-level conditions, cultural norms, and institutional policies that

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constrain the opportunities, resources, and wellbeing of the stigmatised" (Hatzenbuehler and Link, 2014). Increasingly, stigma researchers are focussing on the macro-level structures and forces that drive (re)production of stigmatising categories (Tyler and Slater, 2018) and abortion scholars have also emphasised the need to incorporate a structural understanding to work on abortion stigma (Millar, 2020; Strong et al., 2023). However, a structural stigma framework has been applied in very few abortion studies (Broussard, 2020; Makleff et al., 2023). A structural understanding of stigma aligns with a socio-ecological approach to theorising abortion stigma, recognising that stigma occurs at multiple levels: within communities, institutions, policies and laws, discourse and mass culture, as well as at the individual level (Kumar et al., 2009; Norris et al., 2011). Although research has examined the occurrence of stigma at many of these levels, each level is usually considered individually, without adequately understanding the ways in which different forms of stigma interrelate (Hatzenbuehler and Link, 2014).

England and Wales have legally permitted abortion on several grounds since 1967 and are among the minority of countries where abortion care is publicly funded globally (Footman et al., 2023). However, there is evidence of structural abortion stigma in this context. Legal scholars have argued that abortion is 'exceptionalised' within the United Kingdom's legal framework, with unique and excessive regulation limiting the way abortion care is provided and abortion continues to be criminalised outside of these regulations (Parsons and Romanis, 2021). The politicisation of abortion has delayed evidence-based updates to abortion policy (Jordan, 2020), national abortion guidelines were only recently published for the first time (Lord, 2017; NICE, 2019), abortion care remains almost the only acute health need not comprehensively provided for within the public sector National Health Service (NHS), (Pillai et al., 2015) and abortion was excluded from the 10 year Women's Health Strategy for England in 2022 (Department of Health and Social, 2022). These institutional conditions can constrain the opportunities, resources and wellbeing of the stigmatised: (Hatzenbuehler and Link, 2014) for example, delays in evidence-based updates to abortion policy have constrained access to quality care for people seeking abortion (Jordan, 2020) while the exclusion of abortion from the NHS has limited resources and support for those providing abortion (Footman, 2023b). However, the influence of structural abortion stigma through the policy and health system environment has not yet been empirically researched. This setting therefore provides an informative context to formally document and explore the mechanisms by which abortion may be stigmatised structurally in the health system, and the impacts of structural stigma on individual experiences of abortion care.

This paper also seeks to understand how structural stigma can influence choice of abortion methods (medication or procedural abortion), as evidence suggests that health system and legal constraints are limiting choice (Footman, 2023b), which may be products of structural abortion stigma. For a medication abortion (also known as medical abortion or abortion with pills), two medications (mifepristone and misoprostol) are taken which cause the pregnancy to pass vaginally, usually at home. A procedural abortion (also known as surgical abortion) involves a health provider conducting a gynaecological procedure to remove the pregnancy in a facility setting. Choice of abortion method is an important component of patient satisfaction and people place high value on this choice (Kapp and Lohr, 2020). In England and Wales, method choice is one of six quality standards for abortion care (NICE, 2021), but the growing dominance of medication abortion use in this setting has been linked to structural legal and health system constraints on procedural abortion, related to workforce, funding and infrastructure (Footman, 2023b). For example, the segregation of abortion from the rest of the public health system has created financial constraints on services that have reduced method choice (Footman, 2023b). International research suggests individual-level abortion stigma may influence method choice when stigma experienced by abortion providers limits the methods they are willing to offer (Harries et al., 2009; Glenton et al., 2017; Stifani et al., 2022), and that stigma can also impact care-seekers' preferences for their abortion method (Lie et al., 2008). An analysis of UK abortion provider survey data from 2021 found that provider stigma was not associated with their method preferences, but identified that over half were only providing medication abortion despite most preferring to offer both methods (Footman et al., 2024b). These findings suggest broader health system factors are influencing choice. However, little research has explored the connection between abortion stigma and abortion method choice (Sorhaindo and Lavelanet, 2022), particularly at a structural level. The relationship between health system factors that limit choice and structural abortion stigma have not yet been explored in this context or elsewhere.

In this paper, I apply a structural understanding of stigma to explore whether and how abortion stigma is produced at the policy and institutional levels of the health system, how the production of stigma within health system structures can interact with individual-level stigma, and the relationships between stigma and abortion method choice. From the perspectives of abortion care-seekers, providers, managers, and funders, this paper seeks to answer the research question: how is structural abortion stigma produced and experienced in the health systems of England and Wales, and how does structural stigma influence abortion method choice?

### 1.1. Context

Since the Abortion Act 1967, abortion has been legally permitted in England and Wales if two medical practitioners think it is justified under a set of grounds (including risk to physical or mental health) (UK Parliament, 1967). To be lawful, the abortion must be performed (or prescribed) by a doctor and occur in an approved place (UK Parliament, 1967). The Act also safeguarded the interests of health professionals by removing their duty to participate in treatment if they have a 'conscientious objection' (Sheldon and Wellings, 2020).

In 2018, the Act was amended to allow misoprostol to be administered at home, reducing the number of clinic visits required for medication abortion (Jordan, 2020). In 2020, home administration of mifepristone was also approved, which removed the legal requirement for any in-person appointments and enabled the introduction of telemedicine medication abortion (Lord, 2021).

The private non-profit sector has provided most abortion care since 1967 due to NHS gynaecologists' reluctance to provide abortion (Paintin 2015). Almost all (99%) abortions are NHS-funded but over three quarters are contracted out to three private non-profit providers that specialise in abortion care (Department of Health and Social Care, 2022).

Health policy in England has increasingly relied on marketisation of health care, with the Health and Social Care Act 2012 requiring commissioners to put most healthcare contracts out to competitive tender (Anderson et al., 2022). In Wales, local health boards are funded to deliver NHS care (Bevan et al., 2014) but abortion services are still commissioned from the private non-profit sector.

## 2. Methods

### 2.1. Data

I analysed data from interviews with key informants working in abortion care provision, management, and commissioning, and from in-depth interviews with recent abortion care-seekers. The data collection methods used for each set of interviews is described in detail elsewhere (Footman, 2023a; Footman, 2024a).

Key informants were eligible if they worked as a provider (any cadre) of abortion care, or in the management, organisation, or commissioning of abortion services in England or Wales in the past 5 years; were aged 18 or over; spoke English; and gave informed consent. I used multiple methods to recruit a purposive, convenience sample, including an email invitation to members of professional associations and campaign groups,

and personal emails to individuals identified through web searches and snowball sampling. I interviewed 27 key informants between August and November 2021 by phone or web calls, which lasted for 50–60 minutes. I started the interviews by asking the participant why they had been interested in participating in the study, and about their professional background. I then asked participants to discuss how abortion services had changed over the period that they had worked in abortion care, how much choice patients have within their service or area, and the factors influencing choice. As the interviews progressed, I included additional topics based on issues raised in previous interviews, such as the impact and role of the private non-profit sector and experiences of abortion training.

For in-depth interviews with care-seekers, I recruited participants from a private non-profit provider and from two NHS sites. I chose to interview people who have experienced more than one abortion to develop comparative insights and include a wider range of experiences. The other inclusion criteria were: had accessed an abortion one to four months before recruitment from a study site; consented to be re-contacted for research purposes or have their contact information shared for this study; aged 18 or over; spoke English; and gave informed consent. Recruitment procedures varied between the providers. I directly emailed or sent an SMS to the private non-profit providers' clients who had previously consented to be invited to participate in research. For NHS sites, patients were informed about the study at the point of service by a healthcare professional, either by email or verbally at the end of the patient's final consultation. Participants were offered £20 compensation. I conducted 32 phone or web call interviews between July 2022 and February 2023, and interviews lasted 30–70 minutes. I started interviews by asking participants why they had taken part in the study and asked them to tell me about themselves and their life. I then asked participants about their most recent abortion experience, their options for the care they received, how they wanted the abortion to take place, their experience of the treatment option, and how their most recent experience compared to previous abortions.

Both the key informant and in-depth interviews were semi-structured using a topic guide for each participant type (Footman, 2021; Footman, 2022). I audio-recorded the interviews and then immediately transcribed the recordings verbatim. Participant characteristics are described elsewhere (Footman, 2024a; Footman, 2023a).

### 2.2. Analysis

I used reflexive thematic analysis to analyse the data from a flexible perspective, informed by stigma theory while allowing for new inductively-developed themes (Braun and Clarke, 2021). I re-familiarised myself with the data by re-reading transcripts and then coded the full dataset in Dedoose (2022), tagging all segments of the text that had explicit or implicit meaning for my research question. I used an iterative process to develop initial themes by clustering codes with similar meanings and looking for patterns of shared meaning within the data. I then reviewed these themes against all tagged excerpts for the clustered codes and refined the definition and meaning of each theme.

### 2.3. Ethics

The London School of Economics and Political Science (LSE) Research Ethics Committee (REC) reviewed and approved the key informant interviews (ref: 23691, 7th June 2021). In-depth interviews received ethical approval from the British Pregnancy Advisory Services (BPAS) REC (ref: 2021/07/FOO, 21st October 2021) and NHS Health Research Authority (ref: 22/WA/0079, 31st March 2022) so were exempted from full review by the LSE REC (ref: 23692, 13th April 2021).

## 3. Results

I developed five over-arching themes from these data. These themes illustrate how structural abortion stigma is produced and how it manifests within the health system from the perspectives of abortion care providers, managers, and commissioners (key informants). The themes also portray how structural stigma influences choice, care experiences, and individual-level abortion stigma, from the perspectives of both care-seekers and key informants.

I found structural abortion stigma is produced through (1) the avoidance or de-prioritisation of abortion by decision-makers; and (2) the permitting of conscientious objection; which have enabled (3) the exclusion of abortion from mainstream healthcare. The resulting fragility of abortion services (4) reduces access to person-centred care, including method choice, which reinforces individual-level stigma; and (5) produces tensions between care-seekers' experiences of specialist abortion care as less stigmatising, yet the 'abortion clinic' becomes a site of stigma. Each theme is described in detail below.

### 3.1. Theme 1: Abortion care is avoided or de-prioritised by decision-makers

Key informants felt there is low willingness to be involved in or support abortion across a range of decision-making individuals and institutions, including providers, commissioners, politicians, policy makers, service managers, hospital and NHS trust leaders, medical schools, and postgraduate training bodies. Key informants perceived that this avoidance of abortion is a product of stigma at multiple levels due to decision-makers' individual discomfort with abortion or anti-abortion attitudes, the desire to avoid political controversy and negative media attention, or a lack of public pressure on decision-makers:

> *"At one brief moment abortion care appeared on our three-year plan because we had a* [clinical director] *who wasn't entrenchly against abortion care, um, which was a brief break in the clouds. And now we've got someone in who's entrenchly against abortion care, it's been removed from it."*
>
> (NHS doctor, Wales)

> *"Abortion commissioning, it's always been like trying to walk through treacle … I think it's really media friendly, isn't it? There is the political aspect to it. There's the anti-abortion lobbies. It's good to get, kind of, it's you know, a nice dirty story on the front of a tabloid newspaper."*
>
> (Commissioner, England)

> *"There isn't the outrage that there should be … if you had somebody who had cancer, and needed urgent cancer treatment within two weeks and the hospital was refusing to do it … People will kick up a fuss about that. People would be outraged. But with abortion, if you have somebody that needs an urgent surgical procedure before … they've gone over the limit, they're not going to kick up much of an outrage because, you know, abortion's quite stigmatised."*
>
> (Private non-profit sector nurse, England)

Decision-makers' avoidance of abortion has wide-ranging impacts due to their positions of relative power, and could produce structural stigma by facilitating its exclusion or avoidance within wider healthcare institutions:

> *"I think those* [negative] *views* [about abortion] *are perpetuated by the people who don't see abortion patients … Often these people are quite powerful and quite high up … and that trickles down to, to staff to take their lead from the person in charge."*
>
> (NHS and private non-profit doctor, England)

For example, key informants described abortion being excluded from NHS services, particularly at later gestations, and absent from medical training, due to anti-abortion sentiments or discomfort with abortion:

> *"The medical schools say, "Oh, we don't have enough curriculum time, we don't have trained people. And it's a sensitive issue, so we probably shouldn't be covering it" … there are lots of sensitive topics that we learn*

*about in medical school. We learn about euthanasia. We learn about palliative care. We learn about death … Why should abortion be any more sensitive than those and treated any differently?... It's definitely a combination of the lack of curriculum time because medical school curricula are jam-packed and apathy slash* [/] *active disdain for the topic of abortion"*.

(NHS doctor, England)

Key informants also described how the avoidance of abortion by government bodies and departments had produced abortion stigma through its exclusion from the broader national health care agenda and resulting lack of visibility:

*"Abortion care has not got a home in terms of NHS England, in terms of the Department of Health … it's just not on the health care agenda. We don't have a home and because we don't have a home, we don't have a voice …"*

(Private non-profit sector manager, England)

For example, key informants pointed to the lack of a national specification for abortion commissioning, the lack of a national strategy for abortion, and the exclusion of abortion from the government's sexual and reproductive health strategy.

Some key informants also portrayed a lack of ownership, knowledge, and interest in abortion within commissioning bodies. This was seen to relate to the relatively small size of abortion compared to the breadth of services that commissioners are responsible for, the fragmentation of abortion from commissioning of broader sexual and reproductive health (which is commissioned by local authorities), and in some cases, individual negative attitudes towards abortion and broader "women's health" issues. Some key informants connected this lack of ownership and knowledge among commissioners with harmful commissioning practices such as under-funding and unhealthy competition between providers, which have made abortion services vulnerable and limited their capacity to provide timely, person-centred care.

*"It's not funded properly. So there is a tariff for each procedure and the tariff for surgery is reasonably fair and accurate but it's just not paid at that … I think it's just abortion and it's simply because they've been able to get away with it … they all just think it's a bit yucky, and a bit 'women's problems' and it's all a bit something that one doesn't talk about in polite company."*

(NHS and private non-profit doctor, England)

### 3.2. Theme 2: Conscientious objection and reliance on dedicated individuals

From many key informants' perspectives, the legal protection of conscientious objection enables stigmatisation of abortion within the health system for both care-seekers and providers. Although conscientious objection was intended to protect the interests of individual health professionals, NHS providers described how in practice it limits entire services or hospitals from delivering abortion care, which delays or prevents people from accessing care or restricts choice of method:

*"We spent ages trying to work out what kind of contract … would allow us to take the abortion care within the NHS, repatriate it … And then the impetus for that collapsed as somebody left and the conscientious objection became very rigid again. … You point out that a person can have conscientious objection, a service cannot. But that's irrelevant …* [If] *the people who had the service have got every interest in excluding it, and are able to do so, then they will."*

(NHS doctor, Wales)

In some cases, conscientious objection was reported to be used beyond its legal scope. One care-seeker described her general practitioner (GP) not referring her directly to an abortion provider, while an NHS doctor shared how some consultants refuse to review medical information for abortion providers about individual patients. Conscientious objection is also employed selectively, with some hospitals or services refusing to provide abortion for *"social reasons"* as opposed to medical ones, or for certain foetal indications.

*"There certainly are some who actively will say, I do not do abortions for any reasons or I only do abortions for foetal abnormalities. And even people that say I will only do abortions for certain foetal abnormalities … or there are people that will say, well, I'll agree for an abortion up to a certain gestation, which is an arbitrary number of their choosing rather than what the law says."*

(NHS doctor, England)

NHS providers expressed feeling isolated professionally or being looked down on by other health professionals as *"morally bankrupt or unfeeling"* for providing abortion, due to the normalisation of conscientious objection. Some also felt a lack of support for their work:

*"It does feel like sometimes within our own care group there isn't much support for what we are doing. We're kind of like Nobby no-mates* [a slang expression for someone who lacks friends] *(laughs) …"*

(NHS nurse, England)

*"When I was a junior consultant first, I did feel it was quite an exposed sort of, you know, I got this sort of Cinderella feeling a little bit and I thought, 'God what am I doing here? Is anybody even interested for me to sort of move this on and get this right?'"* (NHS doctor, Wales)

However, many providers shared how abortion has become a lifelong vocation or career-defining issue for them and their colleagues, as abortion attracts individuals with a passion for the topic. The dedication of these individuals is relied on to keep abortion services running or expanding, despite barriers posed by the broader system. For example, the determination of individual NHS clinicians is often responsible for the existence of an abortion service or for their service offering a range of methods, later gestation abortions, care to people with complex health needs, or newer models of care such as telemedicine.

"[An NHS service] *did briefly* [have a telemedicine model] *… we're trying to reintroduce it at the moment. (laughs) … It was very much hinged on my presence and me jumping up and down and defending it"*. (NHS doctor, Wales)

"[An NHS hospital] *have amazing, very dedicated abortion consultants … They are so driven by offering choice and they have trained themselves and basically set up, the later term service, they basically just set it up themselves … taught themselves that technique that previously they hadn't known and then became fully competent at it … But, yeah it's not, there was definitely not a push from the hospital. It was definitely these individual consultants who, who pushed it through."*

(NHS doctor, England)

Others described their pursuit of abortion training being dependent on their own will and self-motivation, due to the exclusion of abortion in routine training.

However, this dependence on individual motivation creates vulnerabilities for abortion services, as retirement sometimes results in services closing or no longer being able to offer a choice.

*"Our previous consultant … he made it look so seamless because he had his foot in all camps. And it wasn't until he left that we realised … And then the obstetricians were like 'no no no, we don't wanna', and the gynaecologists were like 'no no no no, you get on and you sort it out'. But [another new consultant] is building bridges … it's happening in a roundabout way, not a formal way, but a roundabout way (laughs). But it would be nice if we had some sort of formal planning."* (NHS nurse, England)

### 3.3. Theme 3: Abortion is excluded from mainstream health care

Key informants described how abortion has been excluded from the mainstream public health system due to NHS providers' reluctance to be involved in abortion, which produces abortion stigma. These participants explained how the resulting reliance on the private non-profit sector has been exacerbated in England by competitive commissioning policies that incentivise commissioners to contract out abortion, and enable sub-tariff reimbursement of private non-profit providers (Footman, 2023b) which is not allowed for NHS provider reimbursement. This under-funding of abortion care in the private non-profit sector means NHS hospitals are unlikely to bid for financially unviable abortion contracts, further deepening the reliance on the private sector.

Several key informants argued that the segregation of abortion from the public health system and from broader sexual and reproductive health care has made abortion services fragile. In addition to the negative impacts of competitive commissioning, private non-profit sector providers do not get the same financial support or system improvement initiatives as NHS providers:

> *"We're not seen on the same level and foot-holding as an NHS provider. So COVID, for example, you know, the NHS hospitals were chucked a load of cash to help them support the service during COVID-delivery. The independent sector, we had absolutely nothing in terms of additional financial support. Um, and that was really challenging … we spent nearly a quarter of a million pounds on PPE* [personal protective equipment] *… The discrepancies in the way in which we're viewed, I think is a real negative."*
>
> (Private non-profit sector manager, England)

Providers and service managers felt that these vulnerabilities in the private non-profit sector limit the capacity of the system to deliver required volumes of timely care, reduce choice of method as medication abortion is cheaper to provide, and make providers less collaborative as they compete for funding.

Reliance on private non-profit providers and the separation of abortion from broader sexual and reproductive health care also reduces health workers' exposure to abortion in the NHS, which allows NHS health professionals and managers to continue avoiding its provision:

> *"I guess in a bit of kind of chicken and egg scenario, a lot of the reason why abortion services in the NHS has been neglected is because the independent sector does so much of it and does so much of it very well. And so, so much of it is contracted out … basically relieving the NHS of its obligation to provide an in-house abortion service means that the entire subject is neglected and just not dealt with … I think that because it's not visible within* [the NHS's] *services, then the problem is ignored."*
>
> (Private non-profit sector nurse, England)

By reducing training opportunities, this lack of exposure was also seen to result in workforce shortages and low understanding of abortion among NHS health professionals, including obstetrics and gynaecology trainees and GPs, which could reinforce individual-level abortion stigma among providers.

> *"I think as well when moving the service from NHS provision to independent sector, what we've got now is a hugely de-skilled NHS service in terms of surgeons able to provide surgical abortions, but also nurse and midwives, you know, some of which have never been exposed to abortion care. And I think that um, that develops a real, perverse perception of what our service is and what we're about … We really struggle sending clients to the NHS because there's a reluctance to accept them … I think it's around fear, because of the lack of understanding and lack of competency and skills within the NHS to deliver abortion care."*
>
> (Private non-profit manager, England)

Some providers described this causing distrust of the private non-profit sector among NHS providers, who only see complicated referrals and are not aware of the volume of uncomplicated abortion care provided by private non-profit providers. Others described the private non-profit sector being considered as "*not properly professional*" or being "*dismissed in terms of our knowledge and understanding because we are private providers, we're not part of the NHS*". This distrust was also demonstrated by some commissioners and NHS providers who described private non-profit providers as "*businesses*" and expressed concerns about the quality of care they provide.

### 3.4. Theme 4: Reduced access to person-centred care reinforces individual-level stigma

In interviews with both key informants and care-seekers, there was evidence that the health system pressures produced by structural abortion stigma can reduce access to person-centred care, and in turn reinforce individual-level abortion stigma.

One way in which health system pressures impact person-centred care is through constraints on choice of abortion methods. Key informants explained how under-funding of abortion and competitive commissioning cause private non-profit providers to limit timely, local access to procedural abortion due to its higher costs, workforce, and infrastructure requirements, and to offer medication abortion as a "*default*" (Footman, 2023b). Negative impacts of competitive commissioning on provider collaboration also limit choice. For example, one NHS doctor explained how the region's sole private non-profit provider only offers medication abortion locally. People who want procedural abortions could be referred to the doctor's NHS service which offers this service locally. However, instead, the private non-profit provider only offers the option to travel to one of their own clinics in a city 90 miles away, to avoid losing funding from commissioners. Key informants also felt that the lack of training and exposure to abortion in the NHS restricts choice by limiting procedural abortion skills and by reducing exposure to newer modes of delivering care. For example, an NHS nurse explained why a consultant in her service doesn't offer procedural abortion under local anaesthesia:

> *"I don't think she feels comfortable with somebody awake when she's trying to do something … And she hasn't had training in that area. Whereas one of the new consultants, [name], um, I think she's had experience because she also works in the private sector … she would offer it to a lady if that's what the lady wants."*
>
> (NHS nurse, England)

Another NHS doctor said that progress towards offering telemedicine medication abortion had been slow in the NHS because many hospital gynaecologists have a skewed perception of its safety, as they are mostly exposed to the small proportion of care-seekers who require treatment for complications. Key informants and one care-seeker also described some NHS services still requiring patients to return to the hospital to administer misoprostol, despite this unnecessary legal requirement being removed in 2018 (Jordan, 2020).

Among care-seekers, the lack of choice over abortion methods could reinforce individual-level abortion stigma due to discomfort with the method that they had to use or due to increased feelings of stress from having to use a method that didn't suit their needs. For example, one care-seeker who was not able to have her preferred method (procedural abortion) because of the travel requirements explained:

> *"I wouldn't have had to physically go through it [if I had surgical], if that makes sense. Like taking, like before taking tablets when you have like a little bit of a moment and you feel a bit bad … I wouldn't have to do it through the whole process. And I'm not sure, but like I've got to take a pregnancy test in a couple of days to make sure everything's gone. I'm not sure if I'd still have to do all that* [if I'd had a surgical]. *Like, still be thinking about it three weeks later."*
>
> (Care-seeker, 20–24, Wales)

Others described differences in how emotionally difficult they found their abortion, based on the method they used and whether they had felt it suited them, or felt concern for other care-seekers who might find one method more difficult than another. This was also recognised by some providers, who highlighted that:

> *"Lots of people find abortion quite an emotional time. And I think we try and minimise that stigma when they're talking to us, but you can't get rid of it. So actually, enabling people to access the care that they want … kind of allows them to process it and move forwards a little bit."*
>
> (NHS doctor, England)

Choice is also limited in some cases by delays accessing care, causing some care-seekers to have a procedural abortion despite this not being their preferred abortion method, which could reinforce feelings of stigma for those who were uncomfortable with the method:

> *"I think it's the nature of the procedure … it just looks like they're putting a straw into your like privates and sucking out. And I just imagine it's just crushing up what's in there … I know what I'm doing is bad [laughs]. I just, that really, like, made me feel quite sad … Even thinking about it now, I just feel a bit sad about it … At least when I did the pill, I just felt like oh … like … uhm … [it was] just leaving it alone, just letting it come out by itself."*
>
> (Care-seeker, 25–29, England)

Key informants explained that waiting times and delays in accessing care are linked to the health system pressures described above, including a lack of capacity in the system due to under-funding in the private, non-profit sector and unavailability of services in the NHS. Key informants and care-seekers also described how care is delayed in some cases due to the fragmentation of abortion from mainstream health care, which creates communication gaps between providers. As well as causing some to have non-preferred procedural abortions, for some care-seekers these delays result in forced disclosure of abortion to family or friends if they had to have clinic-based care or general anaesthesia. Long waiting times to access procedural abortions for those who preferred or required this option could also be a source of individual-level stigma. Some care-seekers described growing feelings of guilt during long waiting times because of increasingly bonding with the pregnancy, having too much time to think, feeling uncomfortable with having an abortion when the pregnancy was more developed, or having certain pregnancy symptoms (e.g., leaking colostrum) that "*messed up my head*". Some care-seekers also felt they had to isolate themselves from friends and family to keep the pregnancy a secret due to long delays.

> *"The fact that I had to wait for quite a long time, it was, everything was going in my mind, then I couldn't think straight. And then I was thinking am I doing the right thing, am I not doing the right thing? I think if I was able to go straight there, straight to it and everything else, then I think I would have felt a bit better in a way. I wouldn't have keep changing my mind and keep feeling as if I'm the bad person and feeling awful about myself … you have to sit there and wait for what, a couple of weeks, you know, but what goes through your mind in a couple of weeks? And then you see people out with their babies and you're like oh but that could be me and-. But then it makes you feel guilty, cos you know that it's not the right thing right now."*
>
> (Care-seeker, 20–24, England)

Separation of abortion care from the mainstream public health system can also result in fragmented experiences of care. Key informants explained that non-profit providers do not have the facilities to provide comprehensive care for people with complications or with complex health needs and are often not commissioned to provide related services, such as contraception. Some care-seekers described a lack of access to follow up support when experiencing problems with post-abortion contraception, or delays in accessing abortion care because their case was too complicated for the private non-profit sector to treat. This fragmentation of care also influenced feelings of stigma among some care-seekers, from having to re-explain their abortion to providers who might not be supportive:

> *"When I did call the after line and they just kept saying, look, you need to go to A&E, I feel like I would have wanted to maybe see them* [the private non-profit provider] *first … Just because waiting in A&E when, it's, when you're bleeding really heavy and you're not feeling great. And obviously the wait times in A&E, it's, it's not nice … And then obviously* [the private non-profit provider] *know why I'm going through what I'm going through, so I wouldn't have to explain. Um. So I feel like the process would have just been a lot more comfortable for me."*
>
> (Care-seeker, 20–24, Wales)

### 3.5. Theme 5: Tensions in care-seekers' experiences of specialist versus mainstream abortion care

Care-seekers' accounts suggested that the separation of abortion from mainstream healthcare can enable more positive patient experience, but this separation could also be a source of abortion stigma. Although prior experiences of other private non-profit providers were not uniformly positive, most care-seekers described very positive care experiences during their most recent abortion in the private non-profit sector, with friendly and non-judgemental staff.

> *"I just remember after the first time, I was really, like, happy. Um, I think because with anything like abortion, I think there is sometimes stigma with it, isn't there? And I think because I didn't feel like I was stigmatised in any way, you know, I, I was just really happy with what had happened and how it had happened."*
>
> (Care-seeker, 35–39, England)

Several participants referenced feeling like they were not a number in the system, that their care was personalised, and that they were listened to as an individual. Some care-seekers connected these positive experiences to their perception that providers working in specialist abortion environments are unlikely to have negative views about abortion.

> *"It was all just kind of easy … obviously people working there are in that profession because they're, they're fine with abortion. I don't think they'd hire someone who's anti-abortion to go to it. But you do feel no judgement whatsoever."*
>
> (Care-seeker, 20–24, England)

Similarly, some care-seekers explained that they would prefer not to go to their usual source of care or to a more mainstream health service for abortion. Their reasons included concerns about the speed of getting a GP appointment and about receiving less safe or effective care, fear of judgment or of not feeling as supported, desire for anonymity, and to avoid being around people who might be seeking care for a wanted pregnancy.

> *"I find comfort in speaking to someone who can sympathise with you in the situation, whereas I know if I called my GP … she would kind of be like 'ok yep alright, when can you come in?' - very quick … you feel like you're just a number she's gotta get through, whereas with* [the private non-profit provider] *I felt like they were listening, the lady was listening to me …"*
>
> (Care-seeker, 30–34, England)

However, the separation of abortion from mainstream health care could also produce the 'abortion clinic' as a site of stigma. This stigmatised perception or experience of abortion clinics among some care-seekers was related to the presence of protestors outside, the sense of abortion clinics being a "*sad*" or "*morbid*" place, the feeling of everyone knowing why you are entering the building, and the knowledge that everyone inside is there for an abortion. Waiting room experiences were

discussed by many of the care-seekers, who described feeling guilt, embarrassment, or awkwardness from being in a space where everyone is having an abortion.

> *"Sitting in that waiting room with a lot of other girls, um, initially I felt embarrassed that I'm here. You know that, I felt like, you know, just sick, almost like."*
>
> (Care-seeker, 40–44, England)

> *"I think you're all just sat there in the waiting room and nobody really looks at anyone because I think we've all sort of, we're all probably feeling a little bit of guilt."*
>
> (Care-seeker, 30–34, England)

The absence of abortion in the public mainstream health system could also produce more stigmatising experiences for those who must seek related care in the NHS. Although almost all care-seekers had received their most recent abortions in the private non-profit sector, some had previously accessed care in an NHS hospital or had been referred to other NHS providers for certain aspects of their care. Having ultrasound scans in the NHS was a particular source of stigma for some care-seekers, who described providers showing them the image, unmuting the heartbeat, describing the level of development of the foetus or embryo, or assuming that the care-seeker would be pleased about the pregnancy. In some cases, the provider had not checked the care-seekers' pregnancy intentions, but in other cases, care-seekers reported the provider was aware they were planning to have an abortion.

> *"The woman said to me there, "oh, I can see little one's heartbeat, I'll show you". And she's turning the screen round at me - to me … And even after, and I'd not even said anything, they were trying to push a scan over to me and say, you know, here, she said, do you want the photo and she's put the photo in front of me. And I'm saying, no I've already put down, it should be on my notes that I'm not planning on going ahead with this … So I found that really awful as well … Because I just think the hospital aren't to know but if I was going to* [the private non-profit provider], *I could've just made my life so much easier because those guys would know why I'm there."*
>
> (Care-seeker, 35–39, England)

Some care-seekers who had sought abortion care or abortion-related support through mainstream NHS services (including GPs, accident and emergency, the non-emergency helpline 111, or gynaecology departments) described positive experiences. However, one care-seeker faced a delay due to their GP being unwilling to refer them (despite a GP referral not being necessary). Another described being unable to access mental health support after their abortion because:

> *"The person that I ended up speaking to basically said you can't talk to me about any of that* [i.e. her abortion] *because they're not trained in it … They did say they'd try and find me something else but they said there wasn't any, anything in the area for me to talk to"*
>
> (Care-seeker, 20–24, Wales)

Key informants were also aware of people sometimes being mistreated in NHS settings due to the reliance on the private, non-profit sector and fragmentation of care:

> *"I have heard of cases, directly of cases, where that person is not really, that woman has not really received great treatment because they've come in after an abortion. So, you know, we're not going to see them, or we'll send them home and then they can go to BPAS on Monday. Whereas if it was somebody who had come in after a miscarriage treatment that they'd provided from their own EPU* [early pregnancy unit] *they'd have a very different take on it … Rather than - here's a woman who needs help, you're on call, you help her. That's, I thought that was the deal, if you're a doctor. But it's not. It really isn't."*
>
> (NHS and private, non-profit doctor, England)

Finally, as one key informant highlighted, the desire to be treated in a specialist abortion setting was partly produced by abortion stigma, which might be reinforced by the continued separation of abortion from mainstream healthcare:

> *"It's often argued that it's really important to have choice of provider to the patient because … you know, somebody not wanting to have in their hospital record that they've had an abortion … sometimes women just want to go somewhere where they don't go for anything else … but the political part of me says that the only way around changing is just to make abortion, you know, abortion is normal health care. And … you shouldn't have shame around it and stigma."*
>
> (NHS doctor, England)

## 4. Discussion

To understand, prevent and resist abortion stigma, more explorations of its structural manifestations are needed (Millar, 2020; Strong et al., 2023). This paper contributes to an understanding of structural abortion stigma by identifying mechanisms through which structural stigma is produced and how it manifests within the institutions of the health system: avoidance by decision-makers, permitting of conscientious objection, and exclusion from mainstream healthcare. Some of these mechanisms are also reflected in studies from the United States of America and Australia, which have similarly identified how abortion is exceptionalised through its exclusion from health worker training and medical curricula, its location outside of professional specialties, the existence of a conscience clause, and its marginalisation in standalone abortion clinics (Joffe and Weitz, 2003; Ripper, 2001; Millar, 2023; Augustine and Piazza, 2021). Efforts to reject or resist abortion stigma require a greater focus on dismantling structural stigma (Strong et al., 2023). Recent progress in reforming the UK abortion law has demonstrated the power of collaboration between health system stakeholders (Lord and Regan, 2024). This paper suggests additional strategies for dismantling structural stigma could include integrating abortion with mainstream health care, addressing stigmatising views and behaviours among decision-making individuals and institutions, and re-examining the protection of conscientious objection.

This research furthers our understanding of structural abortion stigma by demonstrating how different layers of stigma interact. For example, institutional stigma can (re)produce individual-level abortion stigma (for care-seekers and providers) through negative care experiences or professional isolation. Individual-level stigma can also reinforce institutional stigma, as there is lower public pressure to improve services when stigma prevents people from speaking out if they lack access. Institutional stigma can also interact with stigma in the media (Purcell, 2015) as concern about tabloid controversy can limit decision-makers' engagement with abortion. These findings also contribute to existing work by highlighting the circular reproduction of structural stigma. For example, this study found that the fragmentation of abortion from mainstream health care and from sexual and reproductive health commissioning can produce stigma. However, these divisions are also products of stigma: abortion was initially provided by the private non-profit sector due to NHS providers' unwillingness to offer abortion (Paintin 2015), while abortion commissioning was fragmented due to concerns about abortion being politicised if handed to local government (Lowbury, 2019). The findings also support existing work by further illustrating how power is essential to the reproduction of structural stigma (Link and Phelan, 2001). Avoidance by decision-makers had wide-ranging impacts due to their positions of power. The effects of conscientious objection were also furthered by power hierarchies, as objection among clinical leaders reduces training opportunities and can result in institutional objection across entire services or hospitals (Merner et al., 2023). As a result, NHS providers are not exposed to the service in practice or training, which reproduces stigma through inaccurate perceptions of abortion safety and distrust of private non-profit providers.

This study demonstrates how restrictions on method choice and increasing reliance on medication abortion in England and Wales (Footman, 2023b) are influenced by the structural stigmatisation of abortion. Choice is limited by the exclusion of abortion from mainstream health care as private non-profit providers are more vulnerable to the harmful effects of competitive commissioning practices. Conscientious objection restricts choice due to limitations on training opportunities and exposure to abortion in the NHS. The lack of leadership and attention among decision-makers has also influenced choice, for example due to exclusion of abortion from medical curricula and a lack of standards for abortion commissioning. The resulting constraints on method choice can reproduce individual-level stigma by increasing discomfort, stress or emotional challenges experienced in the process of seeking an abortion. These findings indicate the need for more nuanced discussion and research about the trend towards increasing medication abortion use. Although this shift in abortion methods is often understood as a form of empowerment for people seeking abortion care (Footman, 2023a), the growth in medication abortion use can also be a product of constraints on method choice due to structural stigma, highlighting the need to acknowledge complexity when navigating discussions about self-care (Christofield et al., 2021). As constraints on abortion method choice are experienced inequitably (Footman, 2024a), this analysis additionally illustrates the need for further research on the structural factors that shape individual-level stigma, to tackle inequities in abortion care (Strong et al., 2023).

Finally, this research highlights the tensions between person-centredness in abortion care and the role of mainstream versus specialist provision. This study suggests that separation of abortion into specialist services might result in more positive experiences of care. However this separation can also reproduce stigma by reinforcing the concept that abortion is different and shameful (Cockrill, 2014) and can increase the fragility of abortion services (Augustine and Piazza, 2021) which impacts person-centred care. Yet it is difficult to advocate for abortion care to be integrated into mainstream health services if this will create a more stigmatising environment for care-seekers (Astbury-Ward, 2015). These findings suggest the need for greater public sector involvement in abortion care in order to destigmatise abortion. First, change will be required to expand NHS exposure and capacity whilst increasing collaboration with private non-profit providers to enable training opportunities, referrals, and trust. Another effect of segregating abortion from mainstream health care is the production of the abortion clinic as a site of stigma. Although research in South Africa has found abortion waiting rooms to be a place where stigma is resisted (Mavuso and Macleod, 2019), in this research and another UK study, stigma was reproduced in waiting rooms (Hoggart and Newton, 2015). The aversion to being around others having abortions might relate to 'othering' being a means by which stigma can be perpetuated, as people sometimes characterise their own abortions as exceptional to reject the identity of 'a woman who's had an abortion' (Purcell, 2015). Abortion clinics were also characterised by some participants in this research as 'sad' or 'morbid' places and a source of enacted stigma due to the presence of protestors. This reveals how the separation of abortion into specialist clinics produces stigma (Norris et al., 2011), as the construction of abortion clinics as scary or depressing places is realised by anti-abortion hostilities and the measures that clinics have to take to manage these hostilities (Kimport et al., 2012). More work is needed to understand how abortion clinics can instead be a source of comfort and normalisation through their physical spaces and waiting room experiences (Broussard, 2020) but efforts to improve abortion clinic experiences must also consider the structural mechanisms by which these clinics have been produced as sites of stigma.

### *4.1. Limitations*

Although this study draws on interviews with a diverse range of stakeholders, the purposive sampling methods used have limitations. Due to challenges with NHS recruitment, most (n = 31) care-seekers were recruited from the private non-profit provider. Care-seekers were selected who had multiple abortions, who may not be representative of the national population of abortion care-seekers (Footman, 2024a). For example, an analysis of survey data from Great Britain in 2011 found that people with a previous abortion experience were more likely (than those who have had one abortion) to have increased age and parity, to be Black, to have left school at an earlier age and to live in rented accommodation (Stone and Ingham, 2011). These individuals have a valuable comparative perspective as they may have experienced more than one method or service type, more than one provider, and they may have made treatment decisions informed by previous lived experience. Although several recruitment methods were used for key informants, these participants also do not represent the full range of views that might be held by those working in abortion provision and commissioning. Key informants were reassured they would be anonymised but concerns about how the research would be written up or about how their organisations would be represented might have influenced their accounts.

## 5. Conclusion

Understanding structural manifestations of abortion stigma is essential to dismantle stigma operating at the macro-level and to ensure access to person-centred care. Using a structural stigma framework, this paper identifies some of the mechanisms through which abortion stigma is produced within the institutions of the health system, highlighting how institutional stigma interacts with stigma at different levels and how power is essential to the re-production of structural stigma. This research also suggests that restrictions on method choice and the increasing reliance on medication abortion can be a product of structural abortion stigma, indicating the need for greater acknowledgment of complexity in discussions surrounding trends in medication abortion use.

## Ethics

The London School of Economics and Political Science (LSE) Research Ethics Committee (REC) reviewed and approved the key informant interviews (ref: 23691, 7th June 2021). In-depth interviews received ethical approval from the British Pregnancy Advisory Service REC (ref: 2021/07/FOO, 21st October 2021) and NHS Health Research Authority (ref: 22/WA/0079, 31st March 2022) so were exempted from full review by LSE (ref: 23692, 13th April 2021).

## Declaration of competing interest

The author declares no competing interests.

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## Data availability

Data will be made available on request.

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