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"No one likes an abortion provider until they need one": Examining Abortion Providers Perspectives on the Contextual Challenges and Opportunities Affecting their Recruitment and Retention to the Southern United States

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An abstract of
A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
Master of Public Health
in Global Health
2015

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By Pari Chowdhary

Following the landmark 1973 *Roe v. Wade* decision to legalize abortion in the United States, there has been significant movement to stem the accessibility and provision of abortion services in the southern United States. By adopting abortion-restrictive legislation, limiting abortion training, and forcing abortion provision into freestanding clinics, southern states and institutions have created and perpetuated abortion-hostile environments. Whereas the consequences of such abortion-restrictive environments on service provision is widely-recognized, the personal and professional implications of the southern United States' context on abortion providers is less known. State restrictions such as targeted regulation of abortion providers, certification requirements, facility standards, etc. affect providers' ability to practice and engage with their communities. As a means of informing strategies for provider recruitment and retention to combat the existing dearth of providers in the region, this study seeks to focus research attention on abortion providers working in the South.

To explore abortion providers' perspectives on their recruitment and retention to the southern United States, in-depth interviews were conducted with current providers and with medical students who have intentions of providing abortions in the future. Between February and April 2015, ten interviews with abortion providers and eight interviews with medical students were completed, with participants representing eight southern States (Alabama, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina and Texas). In-depth interviews were designed to understand the challenges that the abortion context of the South places on current and future abortion providers, and the potential for opportunities for improved provider recruitment, retention and support within this context.

Abortion providers in the South identified a multitude of personal and professional challenges that we grouped into four categories: legislation; organizational/structural barriers; personal life and safety; and professional practice and development. Underlying each of these were pervasive challenges of stigmatization and isolation. Given these challenges, possible recommendations include the development of networking and training opportunities for providers, and improved cooperation among and engagement in abortion advocacy by pro-choice organizations. Study findings could inform organizational strategies for provider recruitment and retention, and serve as the foundation for future exploratory research to address abortion providers' needs in the South.

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Chapter 1: Literature Review

History of Abortion in American Politics

On January 22, 1973, the Supreme Court of the United States announced two judicial decisions that re-defined abortion provision across the country. In its *Roe v. Wade* conclusion that a women's decision to choose whether or not to terminate a pregnancy was included in her constitutional right to privacy, and its *Doe v. Bolton* conclusion to eliminate restrictions on abortion access, the Supreme Court of the United States deemed abortion legal nationwide. The *Roe v. Wade* and *Doe v. Bolton* decisions rendered legislation restricting access to and/or provision of abortion unconstitutional and illegal [1,2]. The Supreme Court's landmark conclusions set a legal precedent on abortion access that have since been invoked for more than 30 ensuing cases related to abortion [3].

The *Roe v. Wade* and *Doe v. Bolton* decisions came at a time of changing attitudes about reproductive freedoms. In the 1960s, in an effort to overturn anti-abortion laws established in the mid-1800s, reproductive rights advocates had begun a strong lobbying movement. In the six years before the Supreme Court's Roe v. Wade decision, 13 states (including xx states in the South) had enacted reforms to their abortion laws and four had repealed them entirely [4]. Two Supreme Court cases of *Griswold v. Connecticut*, where the Court ruled that an anti-contraception law intruded on the right to privacy within a marriage, and *Eisenstadt v. Baird*, where the Court expanded that right to privacy to single people, helped set the stage for *Roe v. Wade* [4,5,6]. While a number of American states still had laws that outlawed abortion under most circumstances at the time of the *Roe v. Wade* decision, in the years leading up to *Roe*, the courts

of at least a dozen states were deciding lawsuits challenging the criminalization of abortion [4,7]. These were reflective of changes in the legislative landscape with respect to individual rights and liberties.

One of the challenges with the Supreme Court's *Roe v. Wade* decision was the recognition that although a woman's right to make her own pregnancy decision is worthy of designation as a constitutional protection, that right is not absolute [3,7]. Any individual state was deemed to have the jurisdiction to limit abortion in instances compelling state interests of safeguarding either maternal or fetal life except in situations that endangered the woman's health. To determine what constituted a compelling state interest, Supreme Court Justice Harry Blackmun devised a trimester-based tiered legal framework that lent states greater regulatory control of abortion as a pregnancy progressed [1]. Across each tier, the framework explicitly required abortions at all periods of a pregnancy in the circumstance of risks to the woman's health, and stated that state regulations that create procedural obstacles to a woman's abortion access are in violation of their constitutional rights [1]. Despite these conditions, this allowance of state-level regulation of abortion opened the doors to challenges to the *Roe* decision and set the stage for abortion-restrictive legislation in the Southern United States today.

In the decades following Roe v. Wade, the Supreme Court grappled with a number of cases dealing with the constitutionality of a women's right to privacy against proposed abortion statutes. Of these, the 1989 *Webster v. Reproductive Health Services* case was the first to legalize restrictions to women's abortion access when the Supreme Court ruled in favor of prohibiting the use of public facilities and workers for the provision of abortion [1,4]. This demonstrated a willingness by the Court majority to institutionalize state restrictions on abortion provision, and by 1992, during consideration of *Casey v. Planned Parenthood of Southeastern Pennsylvania*,

some of Roe's core holdings began to be debated. In its *Casey* decision, the Supreme Court reaffirmed the core principle of Roe that a women's right to decide to terminate her pregnancy is included within her constitutional right to privacy, but expanded permissions for state-level restrictions endorsing wait times and consent procedures [8,9]. Following this decision, a number of abortion-restrictive bills directed at reducing abortion care access were passed through many state legislatures across the United States. In 2007 in *Gonzales v. Carhart* and *Gonzales v. Planned Parenthood Federation of America*, the Supreme Court passed the first national legislation to criminalize abortion when it deemed it illegal to perform certain second-trimester abortion procedures even in situations of danger to a woman's health [10,11,9]. In doing so, the Supreme Court overturned one of the key principles of the *Roe v. Wade* decision that a woman's health must always be the paramount factor of consideration in abortion legislation [4,9]. The tiered legal framework originally developed by Justice Blackmun was altered to allow state interference in abortion regulation throughout the nine months of a pregnancy and to remove exceptions for a woman's health [1]. The Supreme Court decision to overturn Roe's provision for the health of a woman was a critical turning point for states with intentions to enforce restrictions on abortion.

Particularly in the South, lasting social conservative and anti-abortion sentiment caused the number of state-level abortion restrictions to surge following the 2007 ruling. Since then, many states, the majority of which are located in the South, have passed laws enforcing provider regulations, procedure wait times and consent processes including ultrasounds [4]. Within the Southern United States, Alabama, Florida, Louisiana, Mississippi, North Carolina, Texas have laws mandating ultrasounds and wait times, and almost all criminalize abortion past 20 weeks of gestational age [12,13]. Alabama, Georgia, Louisiana and North Carolina have outlawed abortion

at 20 weeks of gestational age or earlier based on the concept of fetal pain [14]. In addition to exercising restrictions on abortion services and access, every state legislature within the Southern United States has passed at least one bill legalizing the regulation of abortion providers and clinics, including facility requirements, transfer agreements with state hospitals, and admitting privileges for providers [14].

Situational Context of the American South

In the United States, disparate beliefs and cultural values have resulted in a political divide on certain social issues. Sociology academic, James Davidson Hunter, identifies that on "battleground issues" such as abortion, there exists a bipolar alignment within the United States population [15]. On one side of the debate are individuals who place importance on individual autonomy, and rely on facts and experience to inform their ethical and political stance on issues. On the other side are individuals who believe ethics to be absolute, defined by religious scripture and upheld by organized religion or particular civil authorities [66]. For the former group of individuals, considerations of morality are relative and subjective to context and place, whereas to the latter, morality is established and independent of any individual or circumstance [15]. The latter school of thought is commonly categorized as conservatism. While conservatism on one social issue does not necessitate it on all social, moral and political fronts, in the case of abortion, research shows a positive correlation between religiosity, social conservatism and anti-abortion attitudes.

Despite its constitutional focus on individual liberty, historic and current debates suggest that the United States is somewhat traditional on issues relating to sexuality and reproduction.

Relative to their neighboring developed nations in the Western Hemisphere, the United States populace is unique in its allowance of the consideration of religious beliefs in national and state-level politics, and the influence of religious institutions on political rhetoric [16]. A number of studies identified that in the United States, religious values are strongly associated with individuals' social perspectives and political leanings, and are particularly relevant to determining views on family values, sexuality and abortion [17]. This influence of religious affiliation on social beliefs is especially true within the Southern United States, where religious majorities often set the social agenda of a state. Although originally majority Anglican, by 1830, as a result of relocation by missionaries to the region in the 18th century, the religious make-up of the Southern United States was mostly evangelical [18]. At present, approximately half of the United States' Protestant population is located in the South and more megachurches are located in the Southern states than in the rest of the country [19]. Some researchers believe that this long standing religious homogeneity of Southerners has resulted in faith playing a larger role in cultural and social beliefs among them than any other regional populace in the country [20,21]. An analysis by researchers at Columbia University found that this regional difference in religion and social conservatism existed within particular racial groups prevalent across the United States [22]. Evidence strongly indicated that Caucasians and African Americans in the Southern United States were more religious and socially conservative than individuals from their respective racial groups elsewhere in the country [22,23]. Even within the Southern United States, researchers found regional differences with Caucasians and African Americans in Alabama, Georgia, Louisiana, Mississippi and South Carolina being more reactionary than their racial peers in Virginia, North Carolina, Florida, Arkansas, Tennessee and Texas [21,22,23].

While religion is undoubtedly a contextual factor of note in the Southern United States, its racial history is also a significant contributor to its current political state. As a consequence of being defeated over a cause that the regional majority felt strongly enough to enter into a war over, researchers believe the South's racial past to hold great importance to its cultural and social development [24]. The loss over the fight to maintain slavery, and by association, the distinctions between racial and economic groups, served to further embed ideological conservatism and has greatly influenced the South's political, economic, and social ideologies. Over time, feelings of animosity over the subsequent occupation of the South by Northern forces following the Civil War, translated into racial and social conservatism in politics [24,25]. The South has largely been dominated by a single-party government over the years and many researchers posit that the region's social and racial conservatism is more closely related to political party identification than in other regions of the United States [25]. Researchers at the University of Rochester were led to believe that in the South, racial prejudices and party identification are passed across familial generations after finding that households that owned higher percentages of slaves prior to the Civil War are currently "less likely to identify as Democrat, more likely to oppose affirmative action policies, and more likely to express racial resentment toward blacks." [23] These findings were reflected in that of other researchers regarding racial differences in conservatism. Caucasians currently living in the American South were found to be more ideologically conservative and racially antagonistic than individuals from all other racial groups in the region [21,23].

Within the social context of healthcare, the Southern United States too experiences differences in trends in marriage, fertility, pregnancy-related indicators and abortion relative to the rest of the country. Generally, states in the American South have high incidence of early

marriage and low cohabitation between partners [15]. Early fertility is common in the region as evidenced by high rates of teen pregnancy and high numbers of single mothers with grandparents as caretakers. While abortion rates across the South are low, the rates of unintended pregnancy are high [15]. With respect to demographics, a greater proportion of the resident population in the Southern states is comprised of African American and Hispanic individuals as compared to other parts of the country [15].

With its history of slavery and underpinnings of religiosity and conservatism, the South is likely best regarded as a politically and culturally unique region within the United States. No other region in the United States has been found to have as deep-rooted an influence of religiosity on politics or "as enduring a history of racializing differences" as the South [26]. Religion and race together have and continue to play a crucial role in informing the social and political views of the Southern populace. Questions of morality often interject regional politics as evidenced by the South's continued opposition to gay rights, immigrant rights, unionization, and expansion of national healthcare coverage [25,26]. This is especially true for issues of sexuality and abortion where historical hostility towards government involvement in social norms today translates into the Church and religion playing an influential role in state legislature.

Abortion Provision in the Southern United States

Owing to its history and religiosity, the South is a culturally, racially, and socially unique region of the United States. History plays a role for the South's stance on abortion as well. With both of the key Supreme Court cases of *Roe v. Wade* and *Doe v. Bolton* pertaining to laws in Southern states, abortion provision has long been an issue of contention in the South. Challenging a Texas

law that deemed it illegal for a woman to obtain an abortion outside of certain extenuating circumstances, *Roe v. Wade* was brought to the Supreme Court following a decision to maintain the law by a Texas District Court [1,2]. *Doe v. Bolton* addressed a Georgia law that permitted abortion only in certain situations and exacted multiple requirements of medical approval and limitations on the acceptable location of residence of women seeking abortions [1,2]. While each of these cases were crucial in affecting the state of abortion provision across the country, attitudes toward abortion in the South remained somewhat conservative and reflective of the original laws.

Since 2011 there have been drastic changes to abortion provision across the United States with the most significant and extreme of them taking place within the South. With abortion maintaining its legal status on a federal level, abortion opponents have worked to limit access to and delivery of abortion services through state-level legislation. By placing limitations on public funding for abortion, enforcing restrictions on women accessing abortion, and regulating abortion service providers, abortion opponents are placing a number of significant obstacles along a woman's path to obtaining an abortion [27]. In the South, every state had passed at least one abortion-restrictive provision by 2011 [28,29]. These provisions include mandatory pre-abortion counselling and ultrasound viewing, extended waiting periods and in-person requirements, bans on public funding of abortions, burdensome requirements of abortion facilities, and regulations on physicians providing abortions [14,28]. As illustrated in the following map, this multiplicity of abortion-restrictive actions has contributed to the creation of an abortion-hostile climate in every Southern state. In the below 2013 Guttmacher Institute map, a state is classified as hostile to abortion if it had at least four abortion restrictions in effect, middle

ground if it had two to three abortion restrictions in effect, and supportive if it had no or a single abortion restriction in place.

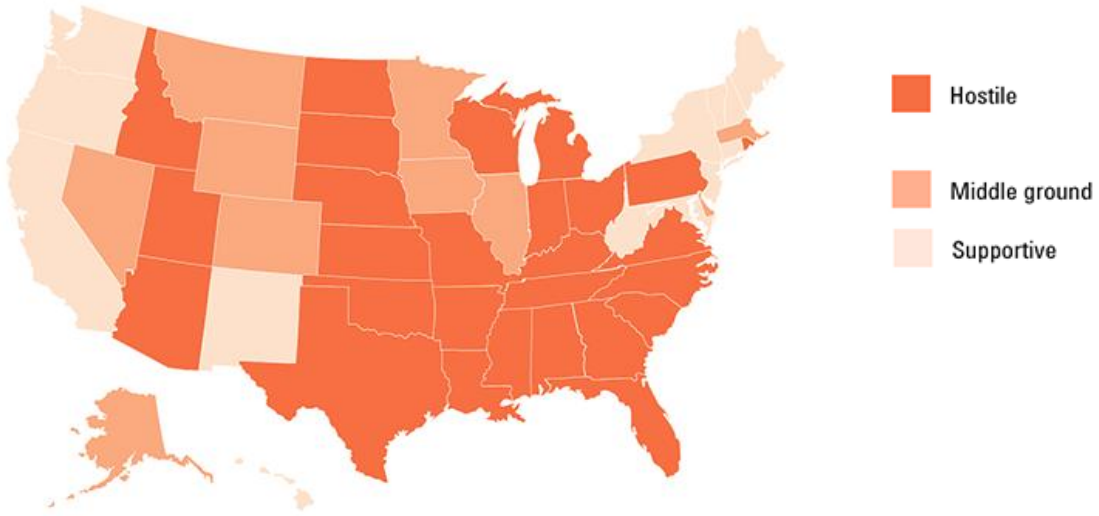


Figure 1: The level of abortion hostility of each American state in 2013, as adapted from the Guttmacher Institute [29]

Over the past five years, the following four types of abortion restrictions have dominated the legislature in the Southern United States – targeted regulation of abortion providers including facilities, limits on medication abortion provision, gestational age limits, and prohibited coverage of abortion under private insurance plans [27,30]. A state-specific listing of some of the enacted restrictions on abortion within the Southern United States is provided below:

STATE	REGULATIONS APPLY TO SITES WHERE:*			FACILITY REQUIREMENTS:					CLINICIAN REQUIREMENTS:		
	Surgical Abortion Is Provided		Medication Abortion Is Provided	Structural Standards Comparable to Those for Surgical Centers	Procedure Room Size Specified	Corridor Width Specified	Maximum Distance to Hospital Specified	Transfer Agreement with Hospital	Requires:		OB/GYN Certification or Eligibility
	Outpatient Clinics	Private Doctor Offices							Hospital Privileges	Hospital Privileges or Alternative Agreement	
Alabama	X	X	X	X		X			§	X	
Florida	X		X	X						X	
Louisiana	X	X		X	X		§		§	X	
Mississippi	X	X	X	X	X	X	30 minutes		§	X	X
North Carolina	X		X	X		X					
South Carolina	X	X	X	X		X				X	†
Tennessee	§	§		§			adjacent county		X		
Texas	§	§	§	§	§	§	§	§	§		
Virginia	X	X	X	X	X	X		X			

§ This law is temporarily enjoined pending a final decision in the courts.
† Only an obstetrician/gynecologist may provide abortions after 14 weeks of pregnancy.

Table 1: State-level enacted site, facility and clinician restrictions on abortion provision as of July 2015, as adapted from the Guttmacher Institute [29]

While limits on medication abortion provision, gestational age and insurance coverage of abortion greatly hamper abortion delivery through their impacts on the women trying to access care, legislation relating to the regulation of abortion providers seeks to shut down abortion service delivery at the source. The targeted regulation of abortion providers, known as TRAP laws, constitute a set of legislation that target abortion service delivery be enacting directives that either render the continued provision of abortion care financially or systematically impossible [30]. One of the more common TRAP laws in the Southern United States is the requirement that physicians providing abortions have admitting privileges at, or that clinics have transfer agreements in place with, local hospitals, effectively granting hospital institutions decision-making power over the continued existence of abortion facilities [28]. Another TRAP law is the requirement that abortion facilities comply with ambulatory surgical center standards including dimensions for examination rooms, entrances and parking lots [28]. The impacts of these restrictive and medically unnecessary laws are being seen across the South [31,32]. In 2013, North Carolina legislature passed a bill requiring abortion clinics to meet ambulatory surgical care center standards [33]. The costs of the facility renovations that would have been necessary to meet these standards were estimated to cost upwards of $1,000,000 per clinic [34]. As a result, since

then, four clinics in North Carolina and more than 12 abortion clinics in Texas have closed out of an inability to meet state-mandated TRAP provisions [31]. In Mississippi, currently only one abortion facility remains in the entire state.

In 2000, The United States Food and Drug Administration approved the use of mifepristone for medication abortion, and the World Health Organization and National Abortion Federation endorsed its provision by midlevel healthcare professionals [35]. Nevertheless, many states have placed restrictions that only allow the provision of medication abortion by qualified physicians and require in-person delivery of abortion-inducing drugs. At present, every Southern state mandates that individuals performing medication abortion be licensed physicians [35]. Alabama, Louisiana, Mississippi, North Carolina, Tennessee and Texas further prohibit the use of telemedicine for medication abortion requiring that providers be physically present with patients during the procedure [35].

Upon the passing the Affordable Care Act into law in 2010 at the federal level, states began to enact restrictions on abortion coverage and abortion insurance policies. Except in certain circumstances, abortions are banned from coverage under private insurance policies in the majority of Southern states. Abortion coverage is currently restricted under plans offered in the health insurance market exchanges in Alabama, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee and Virginia [36]. Abortion coverage is additionally restricted in insurance plans for public employees in Georgia, Mississippi, North Carolina, South Carolina and Virginia [36]. Other state-enacted restrictions on abortion provision include mandated fetal heartbeat and ultrasound viewing or provision. Alabama, Florida, Louisiana, Mississippi, North Carolina, and Texas require an ultrasound for each abortion and either mandate that providers display of the ultrasound image or offer the patient the option to view it

[12]. In Georgia and South Carolina, an ultrasound is not yet required but should an ultrasound be performed as part of the abortion procedure, providers are mandated to offer the patient the option to view the image [12]. A number of states have also instituted mandatory wait times in between an ultrasound and the abortion procedure. Louisiana, as an example, mandates a 24 hour waiting period between a woman's ultrasound and abortion, while Alabama mandates a 48 hour waiting period [13]. Others have in-person counseling requirements and wait times, or regulations mandating that the same physician complete the ultrasound, counseling and abortion procedure.

Each of these abortion restrictions adversely affects the women seeking abortion care and the health professionals working to provide it. According to the Guttmacher Institute, since none of these processes have been deemed medically necessary during first-trimester abortion, requirements for ultrasounds, wait times and mandatory counseling place an undue burden for both patients and providers [12,14]. The impacts of abortion-restrictive legislation and environments on providers are of crucial consideration to their recruitment and retention to the South.

Repercussions of Abortion-Restrictive Environments for Providers

Across the United States, hostility towards abortion and legal restrictions on provision have been found to have detrimental impacts on providers. In the past five years, the changing political and social landscape of abortion has contributed towards increased shortages of abortion providers, harassment and violence towards abortion professionals, and the stigmatization and isolation of abortion providers and of abortion as a profession.

Shortage of Abortion Providers

The single most significant impact of the targeted regulation of abortion providers at the state-level has been the closure of multiple medical and surgical abortion facilities across the Southern and greater United States. Despite the legal statutes for abortion provision outlined in *Roe*, since 1991, three quarters of the abortion facilities in the United States have closed due to restrictive legislation [37]. Between 2010 and 2013, 52 abortion clinics across 26 states have shut down [27]. In 2014 alone, 73 abortion facilities closed either for a period of time or permanently on account of a wave of stringent abortion facility and provider regulations [14]. At the end of 2014, there remained one abortion clinic in Mississippi, three in Alabama, twelve in Texas, and five in Louisiana. Four of those Texas clinics and three of the Louisiana clinics are expected to close by June 2015 as a result of an inability to comply with newly mandated facility and provider regulations [37]. The abortion clinic closures in those four Southern states since 2010 are depicted in this map:

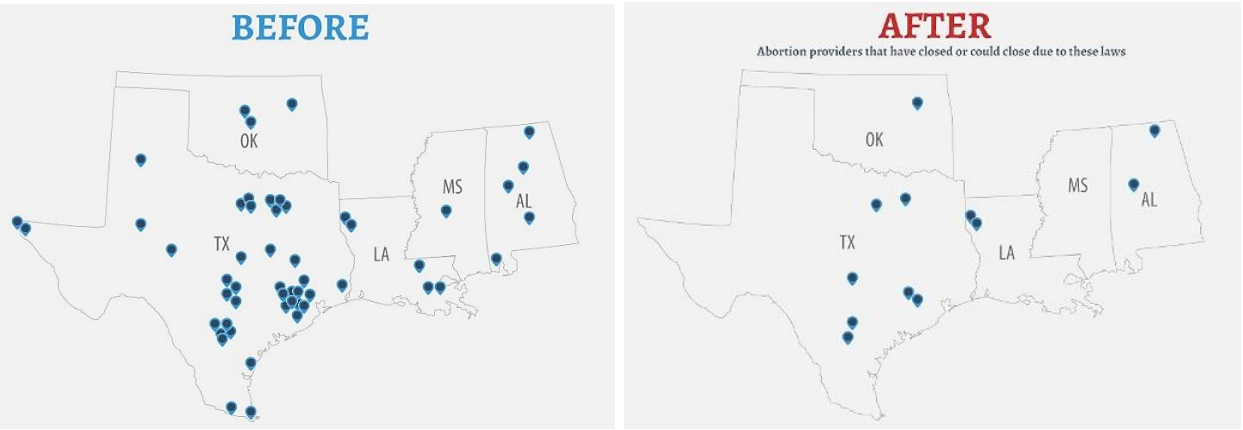


Figure 2: Abortion provider/facility closures in Texas, Oklahoma, Louisiana, Mississippi and Alabama before and after the enactment of State abortion restrictions starting in 2010 as of May 2014, as adapted from the Planned Parenthood Foundation [37]

Research suggests that the shortage of providers in the Southern United States is not a result of legislation alone but also a systematic lack of training opportunities for new providers. The American Congress of Obstetrics and Gynecologists reports that the current opportunities

available for the training of abortion providers is not adequate to meet the potential demands of the reproductive-aged population [38,39]. In a survey on abortion education, Espey et al. found that more than 25% of American medical institutions had no formal abortion training as part of their OB/GYN clerkship [40]. Fewer medical institutions located in abortion-hostile States are continuing to offer training in abortion techniques as part of their OB/GYN programs. At such institutions, willing future providers are often dissuaded from abortion practice as a result of being unable to obtain the necessary training [41]. A study with OB/GYN-practicing Medical Students for Choice alumni found that a lack of abortion training was the highest cited reason for not providing abortions even in instances where there was an initial interest in doing so [39]. At institutions with anti-abortion policies, many students complete their training without having experienced any mention of abortion procedures in the classroom [42,43]. Differential impacts of training on abortion providers are found even in scenarios where elective rather than opt-out or routine training is offered. A national survey of obstetricians and gynecologists found that individuals who attended medical institutions that had elective training in abortion were less practiced in first and second trimester abortion procedures that those who attended institutions with routine training [42]. Abortion training is extremely correlated to the future provider workforce [43]. Multiple studies have found an association between the availability of and exposure to abortion training during medical school and residency programs, and future provision of abortion services by physicians [41,44,45]. The dearth of training opportunities at medical institutions located in the Southern United States is therefore undoubtedly contributing to the regional shortage of providers.

At present, one-third of the reproductive-aged women in the United States live in a county without an abortion provider [32]. In Texas, 10 abortion facilities service a population of

5.4 million reproductive-aged women [37]. In Mississippi, one sole facility remains to service the reproductive health and abortion needs of a population of 603,000 reproductive-aged women [37]. The providers working in these Southern states experience significant workload burdens as a result of being one of few people qualified and able to perform the necessary work. Restrictive legislation and a lack of training opportunities impact abortion providers by resulting in and perpetuating a shortage of abortion physicians in areas of high service need.

Anti-abortion Violence

Since the legalization of abortion in 1973, the United States has seen an unfortunate campaign of violence towards abortion providers and vandalism of abortion facilities. As per NARAL Pro-Choice, between 1977 and 2015, there have been 6,800 acts of violence towards abortion providers and 188,000 acts of disruptions towards abortion facilities [46]. These acts include shootings, bombings and bomb threats, assaults, death threats, bioterrorism, arson, hate mail and phone calls [46,47]. Since 1991, there have been eight murders of abortion staff and seventeen attempted murders of abortion providers [48]. Most recently, in 2009, Dr. George Tiller, an abortion provider in Kansas was shot and killed upon leaving a Church service [46,49]. The clinic at which Dr. Tiller practiced, having previously experienced more than $70,000 worth in damages during two separate incidents of vandalism, was shut down following his murder and only re-opened in 2013 [48]. While his murder was condemned by many pro-life activist groups, the incident fueled anti-abortion sentiment among others. The founder of Operation Rescue, a Christian pro-life organization, referred to Dr. Tiller as a "mass murderer" who "reaped what he sowed", and a conservative political commentator described the murder as "terminating Tiller in the 203rd trimester" [50,51]. This framing of abortion providers as murderous, and violence towards

providers as deserved, continues to be a strategy adopted by pro-life groups and clinic protestors today.

Anti-abortion violence has severe consequences for providers, clinic staff and the pro-choice movement in general. Research has found that living within a climate of fear and/or experiences of violence and harassment can result in posttraumatic stress and anxiety disorder among providers [52]. Concerns for personal safety and the safety of partners and families were identified by providers as greatly impactful to their lives [53]. Fears of violence and harassment are aggravated in abortion-hostile environments, and have implications on the number of providers that are willing to practice in such areas [53]. The Guttmacher Institute has found that levels of harassment of abortion providers were especially high in the Southern United States with 75% of providers in the region having experienced at least one form of harassment [27]. An already existing shortage of abortion providers in conservative regions such as the Southern United States is exacerbated as a consequence of atmospheres of violence and intimidation. Although protective legislation has been enacted at the federal and state level to alleviate some of the potential for violence, harassment of providers and patients continues, and constitutes a serious threat to the personal safety and professional satisfaction of abortion providers.

Stigmatization of Abortion Providers

Each year, more than 1.5 million abortions are carried out in the United States [32]. Despite the commonality and legality of the procedure, abortion, the women who undergo one, and the physicians who provide it are stigmatized on multiple fronts. Abortion stigma has been found to permeate across various aspects of providers' lives with impacts extending beyond the

professional realm [54]. As per Kumar et al.'s framework, stigma occurs at the cultural, governmental, organizational, community and individual level [55].

Cultural perpetuation of stigma around abortion and abortion providers is linked to abortion attitudes in the United States. Since *Roe v. Wade*, the attitudes of the American populace towards abortion have remained somewhat stable with approximately 20% believing that abortion should be legal across all circumstances, 20% believing that it should be illegal regardless of circumstance, and the rest believing that abortion should be legal under certain circumstances [56,57]. Fluctuation in abortion attitudes among Americans since 1973 are depicted in the graph below.

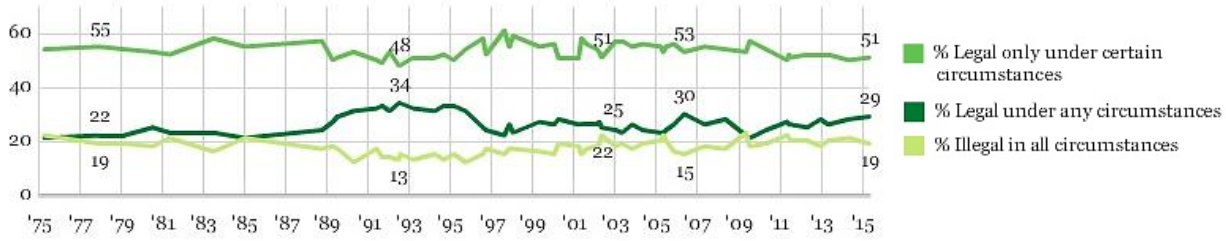


Figure 3: Abortion attitudes among Americans from 1975 to 2015, as adapted from Gallup [58]

As the majority of Americans are supportive of legal abortion only in circumstances of rape, incest, fetal impairment or danger to the life of the woman, and the majority of abortions occurring in the United States do not constitute these circumstances, this can have a polarizing effect on abortion providers [56]. Joffe and Weitz posit that performing work that is considered circumstantially unacceptable by the majority is stigmatizing and isolating for abortion providers [56]. Rather than creating supportive environments, societal beliefs of limited legality or acceptability of abortion serve to isolate the women seeking abortions and the physicians providing them for any reason other than those culturally deemed tolerable. There is also much evidence suggesting a negative relationship between abortion approval and religiosity, moral traditionalism and political conservatism [59,60]. In religious and socially conservative regions like

the South, this has translated into an abortion-hostile environment and culture. Where discourse on abortion is either limited or strongly polarized, abortion providers are stigmatized.

Governmental and structural barriers on abortion provision play a meaningful role in determining the stigma experienced by providers. Political assaults on abortion provision in the form of restrictive legislation greatly contribute to the stigmatization of abortion providers by distinguishing between their work and other medical practice, and likening abortion provision to criminal activity. Over the course of 2014, 335 different abortion-restrictive bills were introduced to State legislatures across the United States, which resulted in the enactment of 26 new abortion-restrictive provisions in 15 states [14]. With these, since 2010, the United States has seen the adoption of 231 abortion restrictions to state legislation [14]. As per benchmarks established by the Guttmacher Institute, the entire region of the Southern United States is hostile to abortion with the majority of states being categorized as extremely hostile [29]. Such an environment has drastic implications not only for abortion providers' ability to practice but also on their experiences of stigma and discrimination. Providers often discuss legislation instituted by state governments as a challenge that is immediate, ever-changing and difficult to combat [61]. Admitting privileges laws in particular were found to have stigmatizing effects on providers in that they discredited the legitimacy of providers' work and their capacity as qualified professionals [62]. Freedman found that providers often felt that the granting of admitting privileges was often entirely politically motivated rather than based on personal merit or hospital capacity, and yet their legitimacy as providers was contingent on their ability to obtain privileges [41]. This was evidenced by the case of an abortion provider at the last remaining clinic in Mississippi who has unsuccessfully applied for admitting privileges at 13 different hospitals in the state.

Abortion stigma is further perpetuated within the organizations and medical institutions where abortion providers work. Researchers have identified a few different mechanisms through which the stigmatization of abortion providers is contextualized within organizational and institutional settings. These include the isolation of abortion provision from mainstream healthcare, limited availability of training, differences in compensation of abortion and other healthcare providers, and anti-abortion attitudes of healthcare professionals [63]. Providers cited issues of stigmatization by other physicians and the medical profession in general, as well as by anti-abortion environments in organizations [63,64]. As legislation and abortion-restrictive institutional policies pushed the provision of abortion out of institutions and into freestanding clinics, thus encouraging the marginalization of abortion providers within medicine [64]. Joffe and Norris et al. found that for providers, this actual and perceived separation of abortion from the rest of sexual and reproductive health care is isolating and stigmatizing [54,65]. O'Donnell, Wear and Freedman found that this stigma extends beyond abortion providers to other abortion care staff as well [41,64,66]. A lack of training availability for new providers was also found to be an organizational issue that contributed to abortion stigma within institutions [61]. Limited abortion training options within an institution was found to be an indicator of an abortion-restrictive environment. Steinauer et al. determined that institutional anti-abortion attitudes can be additionally impactful even on providers that have undergone abortion training, with half of trained providers ultimately not providing abortions in their practice [43,61]. Differences in compensation and/or financial gains between abortion providers and other physicians is another organizational issue of concern to the inclusion and integration of abortion. Abortion provision has been found to be less profitable than other out-patient procedures due to insurance coverage restrictions, reimbursement challenges and services access issues [66]. This suggests a disparity in

financial capacity of abortion providers relative to other physicians with similar levels of medical training. In multiple studies, Harris et al. found that organizational and institutionally-perpetuated stigma cause providers to experience feelings of inadequacy and shame, and a loss of self-esteem [62,63]. Abortion providers discussed feelings of exclusion from medical networks citing incidents where colleagues maintained an environment of silence on abortion, thereby implying that abortion was outside of standard medicine.

Community and individual-level stigmatization of abortion most commonly manifests for providers as a struggle regarding disclosure of their profession. Joffe's research finds that providers practicing in conservative areas struggle with issues of how to identify within their community as a result of their profession [56]. Abortion providers often choose to hide their profession from community members out of concerns of denigration or social rejection [63,64]. Providers cited instances of interactions with family members, friends, and relationship partners where their disclosure of their occupation either caused a strain or ended the relationship [63]. Providers experience this phenomenon even within their workplaces with patients seeking abortion care expressing that they believed the work that the providers were doing was immoral or sinful [63,64]. The impacts of such community stigmatization are varied with providers experiencing a sense of isolation and disconnection from their peers, communities and/or families [63,64]. Both physicians that travel in to states to provide abortions and those that live in the states that they practice in, experience forms of isolation from their peers and community members [64]. On an individual level, this can also lead to providers experiencing difficulty reconciling their professional identity with that that they share with their communities. Norris et al. found that there are mental health consequences associated with the concealment of personal or professional identity due to fear of stigmatization [54]. Some researchers discuss the cyclical

nature of the detrimental impacts of providers' decision whether to disclose their profession [63]. In concealing their profession, providers recognize that they may be perpetuating ideas that abortion providers do not engage in legitimate work, and thus encouraging the very attitudes that are serving as cause for them to maintain occupational secrecy.

Abortion remains legal nationwide but the passing of restrictive legislation in multiple states creates an environment of legalized stigmatization of abortion seekers and providers. Because of their role as a key component in the abortion provision process, abortion providers experience stigmatization, discrimination, marginalization and isolation on cultural, governmental, organizational, community and individual levels.

Justification for this Research

While much evidence exists on the implications of political, social and culturally abortion-restrictive environments on women seeking care and the general patient population, the impacts on and perspectives of abortion providers are less documented. There is a need for an in-depth exploration of abortion providers' experiences and for greater recognition of this population in abortion research. This study seeks to extend research focus to the impacts of abortion access and provision barriers in abortion-restrictive environments on abortion providers. Most of the existing literature exploring provider perspectives is generalized to the entire United States and so this study is somewhat unique in its inclusion of only Southern abortion-restrictive states. Each of the states included in this study are classified by the Guttmacher Institute as either hostile or extremely hostile to abortion [29].

Importance of Abortion Provider Perspectives

Across the United States' abortion history, providers have played a critical role in the legalization, advocacy for and delivery of abortion services. The work of abortion providers also has widespread implications for patient safety by ensuring the availability of safe abortion, reducing maternal mortality from unsafe abortion practices, standardizing abortion care and service delivery, and insuring the full scope of reproductive healthcare for women. Despite the necessity and legality of their work, abortion providers are often shrouded in secrecy. It is difficult to identify another group of physicians whose work undergoes the same level of scrutiny, legal restrictions and social contention. The marginalization and stigmatization that abortion providers experience in their personal and professional lives, would not be tolerated of any other physician group, and highlights the need for recognition and exploration of provider perspectives on the impacts of their lived environments. In addition to the women seeking or accessing abortion care, providers are another population of individuals whose daily lives are impacted by the abortion context of their state. Being on the front lines of abortion provision, providers have an important story to tell of the personal and professional impacts of abortion-restrictive environments.

While political, social and cultural factors are of relevance, the availability of abortion care in the United States is ultimately entirely contingent on abortion providers' capacity and willingness to practice. Even in the most supportive of abortion environments, the provision of safe and legal abortion care would be impossible without an abortion workforce. In the Southern United States, where religiosity and social conservatism are prevalent, it is crucial to consider the needs and perspectives of abortion providers when working to ensure continued access to abortion. As evidenced by the research thus far discussed in this paper, providers are greatly and

uniquely affected by abortion-restrictive environments. This likely has significant implications for the recruitment of new providers and retention of existing ones. Obtaining the perspectives of abortion providers on their experiences living and working in the South will allow for a first-hand look and understanding of the challenges and potential opportunities affecting providers in the region. This is turn could help facilitate the development of strategies to better support providers and mitigate some of the challenges presented by the abortion-restrictive context of the South.

Research Objectives

The objective of this research study is to understand abortion providers' perspectives on the environmental context of the Southern United States, including social, legal, and political factors, as a means of determining ways to combat the declining number of abortion providers in the region. The specific aims of this study are to (1) describe current and future providers' perspectives on the adverse effects of the abortion context of the Southern United States on their personal and professional lives, to (2) document the challenges affecting the recruitment and retention of existing and new abortion providers to the Southern United States, and to (3) identify potential opportunities to mitigate these challenges and to better recruit, support and retain abortion providers to the Southern United States.

Chapter 2: Introduction

Of the many crises affecting abortion access in the Southern United States, a shortage of trained, qualified and willing abortion physicians is perhaps the most dire. Targeted regulation, intimidation and stigmatization of abortion providers in the South by politicians and abortion opponents has served to deter continued participation of existing providers and entry into the workforce by new providers. Studies commonly cite restrictive abortion policies, provider harassment and a lack of integration of abortion into obstetrics and gynecology when exploring the reasons why residents trained in family planning and intending to provide abortions do not eventually do so [61]. Each of these contextual issues impacts the motivation of abortion providers to practice in an abortion-restrictive region such as the American South. With the generation of physicians that joined the abortion workforce after having seen the consequences of illegal and unsafe abortions pre-*Roe* nearing retirement age, it is crucial to ensure a trained, qualified and willing replacement workforce. Given the many challenges that exist for abortion providers in the South today however, younger physicians, having not experienced a United States without legal abortion, are likely less motivated to enter the abortion workforce. Ultimately, a lack of abortion providers means a lack of access to safe abortion. In the Southern United States, abortion opponents have adopted this philosophy in their development and implementation of anti-abortion tactics directed at deterring abortion providers from practice. In order to ensure the continued access to safe and legal abortion for women in the Southern United States, we should consider the impacts of abortion-restrictive environments on abortion providers. In understanding the perspectives of abortion providers on their experiences working in the South,

it will be possible to develop strategies to mitigate their experienced challenges and combat the looming abortion provider shortage in the region.

Physicians have long been crucial protagonists in American abortion history. In 1973, the Supreme Court deemed abortion legal for all women in the United States in landmark decisions in the *Roe v. Wade* and *Doe v. Bolton* cases. The rulings lent decision-making autonomy around the circumstances necessitating an abortion to physicians rather than states [41]. At the time, due to social perceptions of the medical profession, physicians possessed what some experts refer to as medical, moral and cultural authority. They were not only abortion providers, but also abortion advocates and influencers of sociocultural norms. Unfortunately, the established legality of abortion was not accompanied by its integration into modern medicine or sexual and reproductive healthcare [52]. Despite their granted authority and declared legal nature of their work, physicians who had been providing abortions even pre-*Roe* were not absorbed into academic institutions or hospital facilities following the legislation [27]. In quite the opposite fashion, abortion and abortion-related medical services and care were excluded from many managed care institutions and mainstream medicine. Most major medical associations and regulatory bodies in the United States did not take an official stance on abortion or else were silent. In not fully embracing the integration of abortion into routine medicine, the medical profession effectively marked abortion as an isolated practice, and placed abortion providers on the periphery of standard medicine. Abortion provision was phased out of hospital institutions and the responsibility of meeting the increasing demand for abortion services was met by an, at the time, increasing number of freestanding abortion clinics [41].

The rise of a strong and violent anti-abortion movement during the Reagan and Bush years made evident the pernicious effects of resigning abortion provision to freestanding clinics.

On account of their visibility and isolation, clinics and their providers were made vulnerable and between 1977 and 2009, 175 arson crimes, 41 bombings and several hundred burglary and stalking incidents were reported by abortion clinics and providers [41]. The legislative environment was also changing during this time – Although the 1992 *Planned Parenthood v. Casey* ruling upheld the basic right to abortion, it removed physician autonomy and expanded individual states' ability to legislate access to abortion [27]. The ruling fueled anti-abortion extremism and between March 1993 and December 1994, five abortion providers were killed [52]. To date, eight abortion providers have been murdered in the United States as a result of their profession, and there have been countless other incidents of physical and verbal harassment and discrimination [46].

In the aftermath of the 1992 *Planned Parenthood v. Casey* decision, the majority of Southern American States have enacted restrictions on abortion access such as admitting privileges, facility standards, credentialing renewals, wait times, ultrasound requirements, etc [67]. All the Southern states discussed in this paper have banned the use of the state funds for abortion or abortion-related care [14]. While undoubtedly impactful on abortion service provision and access for women, these regulations also significantly impact abortion providers with respect to their professional development, career satisfaction, personal safety and other factors. Over the last 20 years, the number of abortion providers has declined by over 50% in Texas, Mississippi, Alabama and Georgia [37]. In the state of Mississippi, only 2 abortion providers currently remain for the approximately 603,000 women of reproductive age [37]. The shortage of providers in the Southern United States and issues of case volume are being further perpetuated by proposed legislation to restrict training of new providers. In April 2015, House Bill 465 proposed a ban on performing, supervising and teaching abortion procedures at medical schools in North Carolina.

If passed, the few remaining abortion providers in the state would either have to forego their practice or look elsewhere for work. Together, legislative barriers, marginalization of abortion, isolation from mainstream medicine, and potential for harassment create a potent combination to deter otherwise willing abortion providers from an already charged profession.

Existing literature on the impact of abortion-restrictive environments is focused largely on service provision and accessibility. The consequences of such environments on abortion providers is less documented and so this study serves to extend the research focus to the personal and professional impacts on abortion providers, specifically within the context of the Southern United States. The objective of this research is to understand current and future abortion providers' perspectives on the impact of the environmental context of the Southern United States, including social, legal, and political factors, on abortion providers, as a means of determining ways to combat the declining number of abortion providers in the region. The specific aims of this study are to (1) describe current and future providers' perspectives on the impact of the abortion context of the Southern United States on their personal and professional lives, to (2) document the challenges impacting the recruitment and retention of existing and new abortion providers to the Southern United States, and to (3) identify potential opportunities to mitigate these challenges and to better recruit, support and retain abortion providers to the Southern United States. A secondary purpose of this paper is to highlight the need for focused research and programmatic attention towards abortion providers and the abortion-related workforce as a means of ensuring continued access to abortion for women across the United States.

Workforce is an important and yet often overlooked aspect of access to health services. In the case of abortion in the United States, access is influenced by a multitude of factors including

a continually changing political landscape, cuts to service availability, limitations on public funding, and social issues. While providers play a crucial role in women's access to and utilization of abortion services, there has been little focus on ensuring their recruitment and retention to areas where abortion access is limited. This research is significant in that it addresses abortion access through the lens of service providers by identifying factors that could influence providers' motivations to work in abortion-restrictive environments. By exploring providers' perspectives on the personal and professional impacts of their work, and identifying potential opportunities to mitigate provider-experienced challenges, this study serves to address questions of abortion provider experiences in the Southern United States. The need for this research is especially apparent given the targeted regulation of abortion providers that is currently taking place in the South. With more legislation directed at placing restriction on abortion provider capacity and new provider recruitment, gaining the perspectives of abortion providers working in restrictive environments may help ensure their ability to continue to practice in the future. Ultimately, the findings of this study could inform the development of recruitment strategies for new providers and retention strategies for existing providers in the Southern United States. In highlighting the impact of abortion policy on providers, study results could also inform the development of a conceptual framework relating workforce and abortion access.

Chapter 3: Methodology

To determine providers' perspectives on the personal and professional impacts of living and practicing in the Southern United States, and the implications for provider recruitment and retention in the region, we conducted qualitative research with existing and future abortion providers.

Population & Sample

Given the study objectives, we identified two populations of interest for this research – abortion providers, and medical students with expressed intentions of providing abortions in the future.

Rationale for Population Selection: As this study aims to understand the perspectives of abortion providers on the challenges and opportunities that they experience when practicing in the Southern United States, we determined Southern-located abortion providers to be an appropriate study population. Another primary aim of the study is to document the implications that abortion-restrictive environments, such as in the Southern United States, can have on the recruitment and retention of abortion providers. To achieve this, we include the perspectives of incoming/future providers , specifically, medical students with expressed interest in providing abortions in the South in the future as an appropriate population for inclusion in the research.

Participant Recruitment: For the purposes of this study, the Southern United States was defined to include North Carolina, South Carolina, Georgia, Florida, Alabama, Mississippi, Louisiana and Texas. Participants were recruited to the study using purposeful sampling. Following the introduction of this study at two separate national meetings of abortion providers, we identified a group of Southern-based abortion providers with self-expressed interest in

research participation. As some Southern states have only a few abortion providers, we will keep confidential the names of the specific states from which providers were recruited to the study so as to protect participant privacy. Medical students were similarly self-selected into study participation following the inclusion of a description of the research study during an information session at a Medical Students for Choice conference. As a whole, study participants represented eight Southern American states, seven medical education institutions, and a variety of organizational settings for abortion provision.

Eligibility Criteria: Abortion providers were eligible for participation if, at the time of the study, they were (i) clinically qualified and (ii) were providing abortions in one or more Southern states in either a hospital or clinic setting. Medical students were eligible for participation if, at the time of the study, they (i) were in their third or fourth of medical school, (ii) had established interest in providing abortions in their future practice, and (iii) were currently or had previously lived in the Southern United States.

Ethical Considerations

Prior to data collection, all portions of the study were reviewed by Emory University's Institutional Review Board and determined to meet the criteria for exemption (IRB00079324).

Informed Consent: During participant recruitment, all potential participants received an email with an informed consent form specific to their participant group, with a request that they read the form in full before responding with confirmation of their interest in participating in the research. Before the start of each interview, we reviewed the informed consent form with the participant and proceeded with the interview only upon receipt of oral consent.

Study Procedures

Between February and May 2015, we completed ten in-depth interviews with abortion providers, and eight in-depth interviews with medical students.

Instruments: We developed and utilized two unique in-depth interview guides for interviews with each of the study populations, with the goal of identifying the challenges and opportunities related to new provider recruitment and current provider retention in the South. The in-depth interview guide for abortion providers was designed to bring about conversations on the career-related and personal challenges that providers experience while practicing in the South, as well as discussions of potential areas of opportunity and solutions to those challenges. The in-depth interviews with medical students were designed to explore factors such as compensation, training, mentorship, lifestyle etc. on their decision-making process when choosing where to practice, and on job characteristics that would incentivize practicing in the Southern United States. Interviews were structured in that each abortion provider and each medical student was asked the same set of questions as every other participant in their population group. In some cases, additional questions were used as prompts to gather more detail on or delve further into information shared by participants.

Settings: Interviews were an hour-long each and conducted either in-person or through a video conference via Skype depending on the participant's physical location. In-person interviews with participants took place at Emory University's Rollins School of Public Health. Each of the interviews was audio-recorded.

Data Management & Analysis

All study participants were assigned pseudonyms and audio recordings of the interviews were deleted as transcription was completed. Identifying data was removed from the interview transcripts and names of states were replaced with a numeric code. Following the completion of five abortion provider interviews and three medical student interviews, we began to develop a tentative conceptual framework based on the interviews and literature review. The framework was utilized to develop an early set of codes and identify potential themes of importance for each study population. Once all interviews were complete, the two codebooks were further developed and continued to be refined with inductive codes during data analysis. Using MAXQDA software, all transcripts were first memo-ed and then coded line-by-line. Certain ubiquitous codes such as "admitting privileges", "training opportunities", "safety measures" and "harassment" were analyzed across the two sets of transcripts. The parts of the abortion provider interview transcripts that discussed potential solutions or recommendations on their experienced challenges were analyzed slightly differently in that they were maintained as whole sections rather than isolated extracts to ensure that each proposed solution was accounted for in the transcript review. In addition to a code-based analysis of all transcripts, we indexed and charted transcripts per the thematic conceptual framework so as to identify and organize emerging themes across participants. Participant data for both providers and students were thematically analyzed and interpreted through an iterative process of exploring prevalent themes and mapping transcripts onto the conceptual framework.

Methodological Limitations

There are some limitations to the methods employed for this research. Although there are a small number of abortion providers in each Southern state, the small sample size and purposive

sampling provide a limitation generalization. Since our medical student sample pool did not include representation from every medical education institution in the Southern United States, limitations of sample size may be especially applicable to the results of the interviews with medical students. While our use of a convenience sample allowed us to effectively address the study aims, it constrains generalizability of the results even within the South. Moreover, the recommendations in this paper are specific to the Southern United States, and may not be relevant to other contextually-different abortion environments.

Chapter 4: Results

1.0 Motivations to Practice in the Southern United States

To effectively understand the factors impacting the recruitment and retention of abortion providers to the Southern United States, we first set out to explore current and future providers' motivations to practice in this region. We categorized our findings into three sub-sections: what current and future providers enjoy about the South; why current providers began and future providers want to begin practicing in the South; and what keeps current providers motivated to continue practicing in the South.

Across all abortion provider and medical student interviews, the high need for abortion service provision in the South was found to be a prevailing theme affecting individuals' motivations to practice in the region. Each provider expressed how access and income disparities within an already underserved population, and the dearth of abortion providers in the region, played a role in their decision to practice in the South. One provider reflected on her motivation to work in the South saying "knowing that there is such a need and that you're one of few qualified to address it, it'd almost be unethical not to." Many of the providers and medical students commented on how they believed abortion to be "just another part of women's health" and their intentions to practice in the South were motivated by a passion to actualize that belief for the women of the region. In addition to the need for services, all the abortion providers discussed a desire to engage and participate in work and bring about change for the state of reproductive health of women in the South. This concept of feeling that one's work makes a difference was the most prevalent theme across provider interviews when they discussed what

keeps them practicing here despite the restrictive environments of the South. One provider spoke to this when she said shared: “I make more of an impact here than I could anywhere”. Providers also expressed experiencing an immense sense of job satisfaction and appreciation from patients, and cited this as motivation to remain in the region. The chart below depicts fully the abortion providers and medical students’ perspectives on the factors that draw them to the South, make them want to practice here, and keep them practicing in the Southern United States.

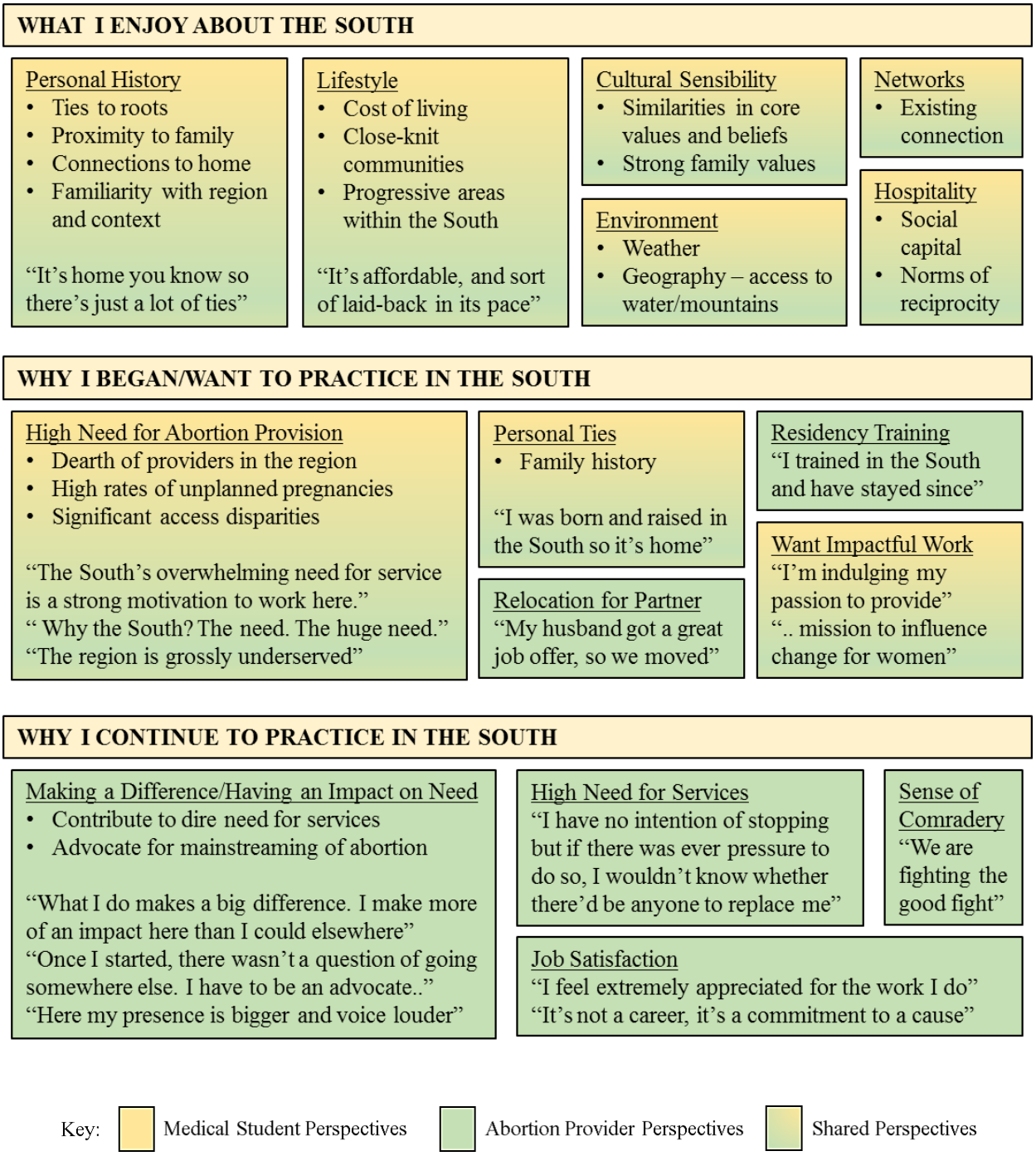


Figure 4: Summary of abortion providers' and medical students' perspectives on their deciding factors and motivations to practice in the Southern United States

2.0 Challenges Adversely Affecting Current and Future Providers in the Southern United States

In sharing their perspectives on the impacts of the reproductive health-related legal, social, and cultural context of the Southern United States on their lives, abortion providers and medical students reported experiencing a number of challenges. Those challenges with potential to affect recruitment and retention of new and current providers to the South were classified into four broad categories– Legislation, Organizational/Structural Issues, Personal Life and Safety, and Professional Practice and Development. While abortion providers and medical students occasionally experienced a unique set of challenges within these categories, issues of legislation, structure, safety and professional development together paint a picture of the effect of abortion-restrictive environments on, and barriers to recruitment and retention of, providers. Each of these four categories of challenges is described in detail below.

2.1 Legislation

Of the ten abortion providers interviewed, all cited abortion-related legislation to be extremely consequential to their daily professional lives. Providers shared that state-enacted and -enforced regulations on abortion facilities have severely restricted medication abortion and surgical abortion provision over the past decade, and have, in some states, led to the closure of abortion facilities. In discussing legislative barriers, abortion providers spoke most commonly of the targeted regulation of abortion providers, limits on medication abortion provision, and insurance coverage of abortion. Medical students discussed legislation affecting their ability to receive abortion training in the South, and enter into the abortion workforce.

Targeted Regulation of Abortion Providers

When considering the impact of legislation on their ability to practice, providers described laws relating to the targeted regulation of abortion providers (TRAP) as the most influential.

"*Being an abortion provider in [State] is difficult, but TRAP laws sometimes make it seem impossible."* – Abortion Provider

Even providers located in states with less restrictive abortion laws noted that their ability to practice would be greatly changed should their states adopt more targeted regulation of abortion provider laws. Providers described TRAP laws as regulations requiring abortion facilities to comply with functional standards equivalent of ambulatory surgical centers, abortion facilities to have transfer agreements with local hospitals, and clinicians to have admitting privileges at local hospitals. Of all the TRAP provisions discussed during the interviews, all ten providers identified the getting and maintaining of admitting privileges to be the most significant legislative concern to their ability to practice.

"*Figuring out how to work around TRAP laws is challenging. With admitting privileges in particular, I could have a great medical record and history with patients, and apply to every hospital in the area and still be rejected on no real grounds because hospitals do not want to engage in the politics of the issue."* – Abortion Provider

Providers also discussed how admitting privileges laws are designed to shut them down by requiring them to be board-certified and yet providing no other options or legal recourse if they are unable to obtain admitting privileges. In describing the impacts of admitting privileges laws on their desire to practice, providers shared that "it makes it so much harder" and places legislative limits on their motivations to provide abortions.

Medication Abortion

Limits on the provision of medication abortion was the second most commonly discussed legislative challenge by providers as impactful to their ability to practice. All the providers interviewed identified laws pertaining to ultrasound requirements, wait times, the physical presence of a physician, and the exclusion of other health professionals as problematic to their work. Restrictions on medication abortion service provision were found to burden providers by necessitating additional steps in the abortion provision process and mandating that physicians are the only healthcare professionals qualified to complete those steps. In states that require that the same physician complete a patient's ultrasound and the abortion procedure after the necessary waiting period, providers described occasionally experiencing difficulties managing their case volume and scheduling.

"*Sometimes I'll have patients all day and can't get to my paperwork until after my shift so I'll work in the evenings. There isn't another provider and the other staff can't do the counseling or procedures so I have to fit it all in to be able to see patients within the right gestational timeframe. It's exhausting*." – Abortion Provider

Some of the providers also expressed the sentiment that laws disallowing participation of physician assistants or advanced practice nurses from abortion care served to isolate abortion as a medical practice. A provider spoke to this point when he said that –

"Mandating that only doctors can do [abortion care] is ridiculous. It basically puts us in a vacuum. Is any other area of medicine is forced to operate in that kind of isolation?"

Two of the providers noted that nurses and assistants often receive extensive training in patient counseling and education, and that the forced exclusion of such midlevel healthcare

professionals from the medication abortion provision process was not reflective of the need for more access to primary care in the United States.

Insurance Coverage of Abortion

Many of the providers also identified legislative bans on the insurance coverage of abortion care to be significant to their ability to provide services. One provider stated that banning insurance coverage of abortion is a means of targeting facilities and providers at the "direct and literal expense" of women seeking care. Other than Texas, all of the states included in this study prohibit coverage of abortion in comprehensive plans in the health insurance exchanges. Providers expressed that this legislation is impactful to their work in that it places an additional financial burden on their patients, affects reimbursement procedures, and could potentially contribute to increases in unsafe abortions.

Consequences of Legislation for New Providers

Medical students' perspectives on abortion-related legislation differed from the providers in that they were less specific about the types of laws that they believed would have impact on their future work, and instead included consideration of the legislation as a whole. All the medical students interviewed identified legislation as a potential limiting factor to their future ability to practice, and as a resulting key component of their decision of which state in which to provide abortions once qualified.

"[Abortion legislation] *would likely be one of the biggest determinants of my work. I mean, I want to go where I am needed, but if I'm not allowed to provide there, then my intentions won't really matter"* – Female Medical Student

Medical students' discussions of legislation as a barrier to their intentions to provide abortions were not just limited to what they anticipated facing as providers, but also included their current experiences. In discussing the possible impact of legislation, each of the eight medical students noted that abortion-restrictive legislation has affected their medical education training in some way. At the time of this research, bill HB 465, which stipulates that abortion could no longer be supervised or performed at medical schools, was introduced to North Carolina legislature. A medical student studying at a North Carolina-based institution said of the bill –

"Before, laws targeted women getting abortions and the physicians trying to provide them. HB 465 adds a whole new target group of potential future providers. If passed, it could essentially ensure that there is never another new abortion provider in all of North Carolina."

Five of the eight medical students attended medical institutions that had restrictions on abortion-related training either as a result of state-specific laws, "religious affiliations" or a "conservative school administration".

As a whole, study participants identified legislation to be greatly impactful to their professional livelihoods and their current and future ability to live and practice in the Southern United States. Legislation had impact on providers' ability to practice by putting them in seemingly impossible circumstances of obtaining additional privileges, constraining their time to provide services, isolating them from other medical staff, and restricting them from insurance markets. All of this resulted in providers feeling overly regulated, marginalized relative to other physicians and limited in their practice.

2.2 Organizational/Structural Issues

Providers discussed a number of organizational and structural challenges that they believed to be a result of the socially conservative abortion context of the Southern United States. These included the separation of abortion from other medicine, a lack of support from organizational leadership, inadequate compensation models, and a shortage of training opportunities.

Separation of Abortion from Sexual and Reproductive Health

Of the identified structural challenges, the most commonly discussed issue was the separation of abortion from general sexual and reproductive health and family planning practice in the South.

"*Clinical sites often do not see providers as allies, and so even in environments that are supposed to be friendly,* we *feel like we're outsiders.*"- Abortion Provider

Providers discussed that this "organizationally and structurally-imposed" distinction between abortion and other medical care is sometimes indicative of a lack of support of abortion providers from other medical staff and organizational leadership. "How you are received within your organization can make a world of a difference to your professional life", said one provider. The impacts of the separation of abortion from other care was effectively described by a provider when she stated that –

"Being at a clinic or hospital where you have to tiptoe around the people working there is demoralizing and inefficient. It's difficult to deal with when you know and believe that you are providing a necessary medical service but are treated or viewed otherwise." – Abortion Provider

All the providers interviewed discussed a need for greater mainstreaming of abortion and abortion providers into sexual and reproductive health services by healthcare organizations and systems. When probed about why they believed this perceived separation of reproductive health services existed, providers identified three possible reasons – an undefined organizational stance

on abortion; "quiet" rather than outward support from organizational leadership; and a lack of abortion-protective policies at the institutional level. One provider told a story of how her hiring institution was aware of her abortion practice and although they did not have a publicly stated stance on abortion, she believed them to be supportive of her work. However, once she was "outed" in the community as an abortion provider, protestors began to picket outside her institution, prompting them to ask her to stop providing abortions in her other practice. When the provider refused to do so, the institution terminated her employment despite having originally offered her a contract with no restrictions on her outside practice. Across all the interviews, providers shared that in situations where they perceived a divided or restrictive work environment to exist, they often felt a lack of support for abortion from organizational leadership of the facilities and/or academic medical institutions. The importance of the need for supportive organizational leadership was elucidated by one provider when she spoke of how her –

"[Department Chair] *is openly supportive. He knows of my abortion practice, and has gone to bat for me a few times so I know I'm welcome here. There has never been a question of losing my appointment or having to choose, but I imagine things would be very different if he and* [Institution] *weren't that way.*" – Abortion Provider

The positive implications of receiving support from organizational leadership highlight the significance of such support to providers' ability to practice and professional lives.

<u>Inadequate Compensation Models</u>

Another finding that emerged from interview with abortion providers was the inadequacy of compensation models. Providers explained that compensation was often not equivalent to that of other types of physicians with equivalent number of years of training and practice, and was not

reflective of the amount of work required of an abortion provider. One provider reflected on this issue within the context of the Southern United States when she said –

"*It's not easy being a provider here... in the South, you have to deal with a unique set of problems and they're constant. If it were any other kind of job, there'd be a hardship salary or some other financial incentive, but not for abortion*." – Abortion Provider

Notably, of the six providers who shared that they found compensation models to be insufficient, five followed up that discussion by stating that money is often not an aspect of their job that serves as motivation for their work. As one provider put it –

"*No one becomes an abortion provider for the money or the lifestyle. At least in [State], this profession can't afford you those things. That's not the reason I do it. But the salary should at least allow us to live comfortably because we work hard for it.*" – Abortion Provider

When we asked medical students about the impact of compensation models on their interest in working as an abortion provider in the South, most shared the sentiment that they had "not thought much about the money since that's not really what I want to do it for." However, each of the eight interviewees stated that they do not believe that existing levels of compensation necessarily serve as incentive to work in this region, with one student stating that –

"*You're almost accepting that you'll make less than other physicians here if you become an abortion provider... especially if you aren't able do a full range of services*." – Medical Student

Both abortion providers and medical students identified that as a means of serving their interests, provider compensation models could be designed to include more non-traditional incentives such as loan repayment programs and professional development opportunities. This is described in greater detail in the Opportunities for Provider Recruitment, Retention and Support section of this paper.

Shortage of Training Opportunities and Partnerships

Training opportunities and partnerships was another important theme that emerged across all 18 participant interviews. Providers cited the training of new providers in the South to be important to them because of the long-term impacts of ensuring a continued abortion workforce in the region. One provider even suggested that training new providers is "our absolute responsibility because there won't be a future without them." Each of the ten abortion providers discussed that the training of new providers was crucial to alleviating some of the case volume challenges that they currently experience, and for improving the condition of abortion provision in the South in general.

"*The more providers you can bring in, the better because the more people you'll have working and advocating. So we have to get them to come here and an easy way to do that is by offering them training.*" – Abortion Provider

However, many of the providers noted that many reproductive care organizations do not prioritize new provider training and opportunities for training within the South are insufficient. One provider stated that "for the number [of providers] that we need, there is a scarcity of training availability in the South".

A lack of training partnerships between organizations and training programs or schools was also identified by providers as an existing challenge. Of the benefits to establishing training partnerships, one provider said –

"*I can appreciate that there are sometimes financial constraints to bringing in trainees or starting a new program, but partnering with groups like Medical Students for Choice or residency programs is a win-win... it's less costly and it works.*" – Abortion Provider

The impact of training partnerships on the recruitment of new providers was exemplified in medical students' discussions of the critical role that training initiatives and opportunities have played for them. Six of the eight students expressed a belief that had opportunities through Medical Students for Choice and Planned Parenthood not been available to them, they would not have received any formal abortion training at their institutions prior to entering residency. A student from Alabama described the unique necessity of training programs and partnerships in the South when she spoke of an instance when –

"*during my four years, abortion was spoken of only once when my instructor said "we're not going to get into the A-word", so yeah… training at my institution is out of the question.*" – Medical Student

Stigma surrounding abortion pervades educational institutions and likely contributes to the unwillingness of institutions to engage in abortion training for their students. This is demonstrative of the role that abortion stigma plays in limiting the availability of training for new providers, and the implications for new provider recruitment in abortion stigmatized environments such as in the South. Some of the abortion providers interviewed identified certain organizational and structural issues that have contributed to difficulties in and/or a lack of training of new providers, suggesting that improvements in "attitudes towards trainees" and "setting up systems that are more welcoming of trainee providers while also being empowering for current staff by allowing them time and space to do training" could address training-related challenges.

The need for greater availability of training opportunities was repeatedly highlighted in the interviews with medical students as well. One medical student expressed disappointment at the lack of training for new providers within her state –

"*Living in a conservative state going to a conservative school means you have to fight to find places that will train you and it shouldn't be this tough just to get started*." – Medical Student

Another student told a story of how he took an elective semester to fly to California and train at the University of California San Francisco because he "didn't really have any closer options". Medical students also reflected providers' thoughts in that they discussed the importance of training for the recruitment of new providers to the Southern United States. One student shared that although she felt strongly about wanting to work in the South,

"*Having to go elsewhere for training I think would make me less likely to return here because I'd have built up a network and familiarity and wouldn't want to lose that*." – Medical Student

When speaking to the role of training in new providers' decision-making processes, a Louisiana-based medical student shared that –

"*Availability or attitude towards training is something that I'd look for when thinking about where to practice. I want to go where I can get the skills that I need and if an organization is offering that, then it shows me that they are invested in my development as a provider*." – Medical Student

This serves as evidence of the potential implications that the provision of training opportunities could have on the recruitment of new providers to the South. For medical students, a lack in the availability of abortion training across the South means additional difficulties along their path to becoming qualified abortion providers. In situations where training was available, students often had to invest considerable time in setting up an opportunity or else fighting for it. In situations where travel to another place for training was deemed necessary, students were not able to leverage the networks that they had acquired during training for their future practice in the South.

Per the repeated mention of training availability, opportunity and partnerships across all the provider and medical student interviews, clinical training is clearly an area of significant interest and importance for the recruitment, support and retention of abortion providers to the Southern United States.

2.3 Personal Life and Safety

In exploring providers and medical students' perspectives on the contextual impacts of the abortion environments of the Southern United States on their lives, we identified a set of individual-level challenges that emerged as continuous themes throughout the interviews. These included safety concerns, identity as a provider, lifestyle choices, personal relationships and community belonging.

Safety Concerns

The most commonly addressed challenge was safety and concerns relating to safety of partners and families. While providers' experiences with safety concerns varied depending on the environments in which they worked and lived, all ten expressed having needed to consider either their safety or that of their families at some point during their career.

> "*It's like crossing a picket line every day. Even though it's not top of mind, you wonder whether something could happen*." – Abortion Provider

Providers' considerations of safety extended beyond traditional risks of personal/physical harm. Common themes across provider interviews during discussions of safety included concerns over personal and partner job security, privacy and future quality of life. One provider described

concerns over the possibility of her husband's "career and board membership being jeopardized" should his employer learn of her work.

For some providers, issues of safety meant having to deal with abortion protestors, and possible threats to their person as a result of being publicly known to provide abortions.

"*It's never comfortable with protestors at clinics. What made me really upset was when those protestors took my photos and posted my information publicly because now I can't ever truly know what to expect and or feel entirely sure about my safety.*" - Abortion Provider

This idea that protestors can have an extended negative impact beyond just their interactions with providers at abortion facilities was articulated by one provider when he shared that –

"*Protestors probably affect the patients more than me because I have developed a thick skin. But when anti's move beyond clinics and protest at other institutions that I am affiliated with, that has the potential to affect my appointments. When they go further and post my information online, that has potential to affect every aspect of my life*." – Abortion Provider

Providers located in rural areas, and in the states of Mississippi, Louisiana and Texas, reported a higher number and severity of safety-related incidents than those located elsewhere within the South. One provider told of an instance where "a protestor showed up at my kids' school one day" and explained that it made her feel especially unsafe because –

"*There's the glaringly obvious safety concerns associated with that and then there is this feeling of a complete loss of privacy. I don't just mean that they know who I am and where my kids go to school, but they forced me to have a conversation with my kids about what mommy does much earlier than I anticipated needing to do so. That – their ability to affect decisions that should have been mine to make – is just as scary*." – Abortion Provider

Another provider referred to the assaults on the safety and privacy of abortion providers in the South as "essentially terrorism". Many of the providers described having taken certain steps to ensure the protection of themselves and their families from the possibility of safety threats. These included the installation of home surveillance or alarm systems, listing property under names other than their own, leasing instead of buying vehicles, and establishing relationships with neighbors. Each of the ten providers described engaging in at least one protective behavior in daily life such as "entering the clinic through the back", "putting my doctors' coat in the trunk when leaving the car", "trying not to drive the same route each time", and "not engaging with hostile protestors".

Most medical students described anticipating safety concerns after they began providing but had not yet experienced any issues related to safety. A student in Alabama, however, shared that her interest in abortion work has resulted in unsolicited hostility from her colleagues. She spoke of an instance where after emailing the student body an advertisement for a Medical Students for Choice event, she received –

"*emails back from other students telling me that I was wrong and going against Christian values. Someone even wrote that they hoped that I would have to have an abortion someday so that I would know exactly what I was telling other women to do to themselves*." – Medical Student

When asked further about why the malicious nature of the emails made her feel unsafe, the student told of the personal impacts of an inhospitable environment of being a physician with future open intentions to provide abortions.

"*I definitely retreated initially but it's actually strengthened my resolve to do this work. The much bigger concern here is that those reactions came not from irrational people but from future physicians and my future colleagues… educated individuals*." – Medical Student

This concern over not being able to safely engage in dialogue with peers was shared by some of the other students interviewed. A student at a Louisiana medical institution talked about how –

"*There's a group of us that are pro-choice. We haven't had problems with people in our class that feel differently since we all mostly do our own thing. Really we should be talking about those differences and trying to address them but that's almost taboo here*" – Medical Student

The adverse consequences on the safety of abortion providers as the result of the strong division between pro-life and pro-choice thought in the South has potential to impact the recruitment of new providers to the region.

"*I want to go where I'm needed, but it'd be nice to also be wanted. If I always had to be worried about my safety, I probably wouldn't love working there*" – Medical Student

As demonstrated by the above quote, safety appears to be a significant factor of consideration for future providers when choosing where to practice.

Personal and Public Identity as an Abortion Provider

Issues of personal and professional identity emerged across all interviews with abortion providers. Challenges of identity were found to evolve through different phases depending on the length of time for which the provider had been practicing, the life stage of the provider, and the abortion environment within their state. Most providers described making a decision of whether to keep their choice of profession private outside of work when first entering practice. A provider explained this saying "if asked what I do, I just say I'm a gynecologist. It's not political". This decision was often informed by providers' individual concerns around safety and possible community backlash.

"*I'm in the closet about my work. I worry sometimes that I'll be found out, but dealing with that worry is still easier I think than being out here*." – Abortion Provider

Some providers discussed they felt that how feeling the need to stay out of the public eye was usually tied to family life and so diminished the older their kids became. Those who chose to keep their profession private described struggles associated with maintaining that confidentiality.

"*Being hidden isn't ideal – I want to be an advocate but I can't safely do that; I still feel like an outsider because my community doesn't know about my real work; I can't celebrate my work accomplishments, and I still live carefully*." – Abortion Provider

These personal consequences of not being able to be open about one's beliefs and interests were further elucidated by a provider when she said –

"*It frustrates me that I feel like I have to choose between being true to myself and to our cause, and ensuring the security of my family and lifestyle*." – Abortion Provider

For those providers who are open about their profession, either by choice or by consequence of their practice, struggles with identity within their communities and families were not as prevalent. All providers, regardless of disclosure of their profession, reflected that despite their belief in the necessity and legality of their work, they occasionally struggle with the discrepancy between the way they identify with their work and the way they are sometimes viewed in the restrictive environments in which they live and practice.

"*It can get draining to always have to have the energy to defend what I do. Just because I provide doesn't mean I'm never uncomfortable about it. There's more to me than just an abortion provider, but it's hard when that's all you're ever labeled as*." – Abortion Provider

Issues of disclosure of profession and identity as an abortion provider were found to affect multiple aspects of providers' personal and professional lives. Challenges of identity impact

providers' sense of belonging, as well as their relationships with partners, friends and family, and played a large role in their emotional satisfaction and personal well-being.

2.4 Professional Practice and Development

Abortion providers and medical students reflected on the Southern-specific contextual impacts pertaining to their professional practice and development. Issues of common interest amongst providers and medical students were scope of professional practice, the marginalization of abortion providers within medicine, competition between professional organizations, and limitations on financial gains.

Scope of Medical Practice

Many providers claimed that their involvement in abortion provision has negatively affected their opportunities to engage in full scale obstetrics and gynecological services or other medical practice. Commenting that they often were forced to choose between providing abortions and other medical services, the providers stated their scope of practice was limited in the South. They explained that often organizations, in the interest of not engaging in abortion politics, were not open to hiring abortion providers even if just for family care or gynecological services. One provider told a story of having been hired by an institution with –

"*..contract that said I could do whatever I wanted outside of my work hours. But when protestors made a public show of their views,* [hospital] *told me I needed to choose between my job and the abortions, and I was terminated the next day*." – Abortion Provider

Even the medical students expressed this concern with practicing in the South despite not yet having directly experienced it. Said a medical student from Tennessee –

"*Abortion is just one part of women's health and it is ridiculous that providers get pigeon-holed because institutions refuse to recognize that*." – Medical Student

All eight medical students also spoke to the disincentive that a limited scope of practice presents for individuals considering the South as a future place to work.

"*What's appealing about a place where you face constant pushback and also can't actually practice the way you want?*" posited one medical student.

Limitations to the scope of medical practice for abortion providers include not being able to engage in full scale obstetrics and gynecological services, or being forced to either only provide abortions or not provide abortions at all in their practice. These challenges negatively impact the professional development and satisfaction of providers, and as a result have implications for the recruitment and retention of providers to the South.

Marginalization of Abortion Providers within Medicine

All of the providers interviewed for this study shared the belief that abortion providers and abortion as a practice experience at least some level of marginalization within the medical community in the South. Providers commonly expressed the sentiment that other physicians and medical professionals were often discriminatory and non-supportive of their work. "I'm tired of being regarding as a lesser physician" said one provider about her experiences with colleagues. Another provider shared that although abortion work is legal, necessary and "arguably more challenging, I do not command the same respect or professionalism." One long-term serving provider remarked that he believed that this distinction between abortion and rest of the medicine was a consequence of how the medical profession "historically did a poor job of endorsing and integrating abortion" into standard medical care when abortion was first legalized. Some

providers expressed that this marginalization is made additionally challenging because they do not expect it from within their own profession.

"*The hardest thing is that these are supposed to be our people. They know about women's health. They know about the systemic issues that women face and the many circumstances that can exist around an abortion. They know better*." – Abortion Provider

One provider working within a hospital setting described instances of pushback from nursing and auxiliary staff on paperwork and scheduling matters. She described her colleagues as being acclimatized to "a culture of not talking about abortion, so my presence and work is uncomfortable." Some providers voiced concerns around the silence of other medical professionals in the abortion debate. A provider described her disappointment that –

"*We're under attack, there is mostly silence from our colleagues. Even when we're applying for privileges, physicians sitting on hospital boards aren't stepping up*." – Abortion Provider

These findings were also reflected in the medical student interviews. Although discussed within the context of safety, the stories shared by the medical students in Alabama and Louisiana of their concerns about their colleagues' views demonstrated that they too recognized differential attitudes of medical professionals towards abortion relative to other practice. Many of the providers also discussed how the marginalization of abortion and anti-abortion attitudes of medical staff also translated into challenges with finding willing support staff during abortion procedures.

<u>Competition between Professional Organizations</u>

Another commonly shared theme amongst abortion providers was the crucial importance of professional organizations to their ability to practice and professional development. Providers

repeatedly commented on the need for organizations such as Physicians for Reproductive Health, NARAL Pro-Choice, the National Abortion Federation, and Planned Parenthood as their advocates and sources of support. Providers described organization membership as "a source of support and an avenue to turn to when in need of help" and said that "it's nice to feel connected to other providers." While providers were in agreement about the benefits of organization membership, almost all of them commented on the cost-prohibitive nature. One provider analyzed the issue to say –

"*With the number of organizations, it's not realistic to join them all. Membership is costly and there isn't an exponential gain of joining all versus just one*." – Abortion Provider

This idea of the proliferation of professional organizations was mirrored across interviews with providers sharing that they felt that there was unnecessary competition between organizations. Providers described challenges with specific organizations with comments such as "Planned Parenthood needs to be less tribal and more open to sharing resources", "[National Abortion Federation] could be more cognizant of regionally-specific needs of providers", and "organizations with clinical sites need to be better about partnerships through referrals." In general, providers expressed that they often felt tensions and conflicts between professional organizations groups that could be working more collaboratively towards a common goal. The majority of providers also shared that they believed that room for partnerships between professional organizations existed and would have an immense positive impact on their personal lives as well as abortion provision in the Southern United States.

<u>Limitations on Financial Gains</u>

Often discussed in conjunction with the inadequacy of compensation models, providers also shared in their interviews that one of the issues related to their professional practice and development was the limitations in financial gain that they experience. While many providers noted that this was less impactful for them than other challenges relating to professional development, it was nonetheless a prevalent topic of discussion. Providers also voiced concerns over a loss of other professional development opportunities such as continued involvement in academic research. One provider effectively summarized the personal and professional impact of such loss of opportunity when she said –

"*If money is the only problem, then it's not a big deal but if I'm losing out on multiple things that are important to me, then maybe that's enough to make me re-consider*." – Abortion Provider

This also highlights the importance of the availability of other professional development opportunities to the retention of abortion providers to the South.

3.0 Overarching Implications on Personal and Professional Lives of Providers

As demonstrated thus far, challenges of legislation, organizational issues, personal life and safety, and professional practice and development each have particular personal and professional impacts on abortion providers. Legislative barriers impact current providers by undermining their ability to practice and their relationships with patients, which can affect providers' stress management and job satisfaction. Organizational and structural issues of the separation of abortion from reproductive health, lack of leadership support, and case volume place additional burdens on providers and result in discomfort in the workplace. Concerns of safety and personal identity have implications for the quality of life and mental health of providers. Limitations in

professional practice and development can contribute to feelings of lost opportunity and marginalization. Through these impacts, each of these challenges also has significant influence on the recruitment of new providers to the Southern United States. Alongside the challenge-specific consequences, there are overarching impacts of the abortion-restrictive context of the Southern United States on abortion providers that extend beyond any one particular issue. All of the challenges discussed by providers and medical students contribute to the stigmatization, and personal and professional isolation of abortion providers.

3.1 Stigma

In the Southern United States, abortion is a highly contentious and stigmatized area of medicine. By extension of their crucial role in abortion service and delivery, abortion providers are often highly stigmatized, not only within the general population but also within or by the medical community. This was strongly reflected in the findings of this study as well in each of the challenges that the current providers and the medical students shared. Abortion providers' experiences of being "in the closet" with their families and communities, and the subsequent consequences of their choice of or forced disclosure of their profession, was representative of the stigmas that exist toward abortion professionals in the South. A provider commented on this phenomenon, saying –

"*There's little space for me to publicly discuss without risk of violence or being ostracized. I have a mental screening process that I use before I tell anyone what I do*". – Abortion Provider

Another provider shared that she was asked to "go somewhere elsewhere once my Church found out", exemplifying the community-level stigma that is regarded to be prevalent in the South. Providers also struggled with whether choosing to maintain privacy around their profession

served to perpetuate their stigmatization by reinforcing community perceptions that abortion providers are "immoral" and "illegitimate." In choosing self-censorship to avoid stigma and harassment, providers claimed that they experienced adverse consequences to their mental and emotional health, such as stress and anxiety.

Abortion providers reported experiencing stigma and discrimination even within their workplaces and the medical profession in general. Many described instances of being "shut out from institutions" and facing "discrimination by credentialing committees". Challenges of organizational barriers and professional development, such as limited training opportunities, lack of support for abortion in institutional policies, non-protective hiring practices etc. are reflective of a general neglect of the professional needs of abortion providers. Some providers interviewed shared examples of interactions with other medical staff such as "other doctors don't want to share their waiting rooms" and "nurses just weren't willing to help with scheduling" that were indicative of the stigmatization of providers and abortion patients within institutions. Two of the providers interviewed discussed facing additional stigma from their medical colleagues as a result of traveling to multiple Southern states to provide abortion services. "You'd think there would be recognition of the effort required to be a traveling provider but they treat us like hacks", explained one of the providers. The phenomenon of being viewed as "lesser" by other physicians and institutions was common amongst providers and negatively impacted them as a significant source of frustration, anger and disappointment. One provider expressed that –

"*Being able to allow a woman the opportunity to make her own decision about her reproductive health is something I'm very proud of. It is important and difficult work but it is extremely upsetting that our profession doesn't feel the same way*." – Abortion Provider

The harmful experiences of stigma of anti-abortion sentiments in the Southern United states also manifest for providers in their interactions with protestors and experiences of harassment or violence. A provider aptly described the hostility that abortion providers face in some places when he said that –

"*The attacks on abortion and providers are a form of domestic terrorism. The horrible part is that even though we are the ones engaging in legal practice for the health of women, and the people terrorizing us are doing the opposite, we're still considered the bigger problem*". – Abortion Provider

Another provider reflected on the detrimental impact of living in an abortion-averse environment saying that –

"[when you're] *stigmatized by the law, stigmatized by your colleagues, stigmatized by protestors... I mean, that gets to you. It can affect even your day-to-day*". – Abortion Provider

Some providers shared that they felt as though this climate of fear was "practically endorsed by state governments" in their passing of restrictive legislation. "Passing so many bills on abortion basically shows an ideology that abortion is akin to criminal activity. It's the RE-criminalization of abortion", remarked one provider who continued on to explain that in such an environment, people who threaten the safety of abortion providers "don't face any consequences" thus perpetuating thought that it is acceptable to target and stigmatize providers.

3.2 Isolation

The challenges experienced by abortion providers often serve to isolate them in a variety of ways. Even aspects of their jobs that some may view as positive were described by providers as having adverse consequences of isolation. For example, providers spoke of often being regarded

as heroes, and that this valorization of their work is isolating rather than empowering. Providers shared that "all painting us as heroes does is make it out so that our work is somehow exceptional and that we are different than other doctors" and "[it] perpetuates misperceptions that abortion is somehow outside of standard medicine."

"*While it's nice that the difficulty of our jobs is recognized, it suggests that abortion providers are alone and doing impossible work… possibly disincentivizing others from doing it*."

Feelings of isolation among providers were found to extend beyond any single domain. Providers shared experiences of geographic, personal and professional isolation. Rurally located providers and those who were the sole providers for a large region reported experiencing physical isolation from other providers and the medical community as a result of their particular geography. A provider commented that "sometimes [the dearth of providers] is enough to make you feel like you're alone." Many providers cited feelings of personal isolation and loneliness as a result of challenges such as being unable to disclose their occupation and being ostracized from their communities.

"*It's lonely sometimes. People can't support you if they don't know what you do, but to protect yourself you can't tell them that so there's a disconnect*" – Abortion Provider

Reflecting on other aspects of personal isolation, one provider lamented not being able to celebrate professional successes with her social networks, commenting that "I recently became [position] at [organization] and I think that's a big deal but I can't share it."

Isolation within the workplace and medical profession was reported by every one of the providers that we spoke with. Many discussed that in forcing the provision of abortion into only free-standing clinics through restrictive legislation and anti-abortion institutional policies, states

have isolated abortion from standard medical practice and marginalized abortion providers as outsiders to institutionalized medicine.

"*Taking abortion out of institutions means taking us out of the network. We're now 'other'*." – Abortion Provider

Sentiments of professional isolation were also repeatedly expressed by providers in the form of concerns of not having enough providers available to "replace me if I ever needed to stop." In general, providers felt that their stigmatization and marginalization within medicine, and social and legally-imposed restrictions on abortion care resulted in a sense of professional isolation and seclusion.

4.0 Opportunities for Recruitment, Retention and Support of Providers in the South

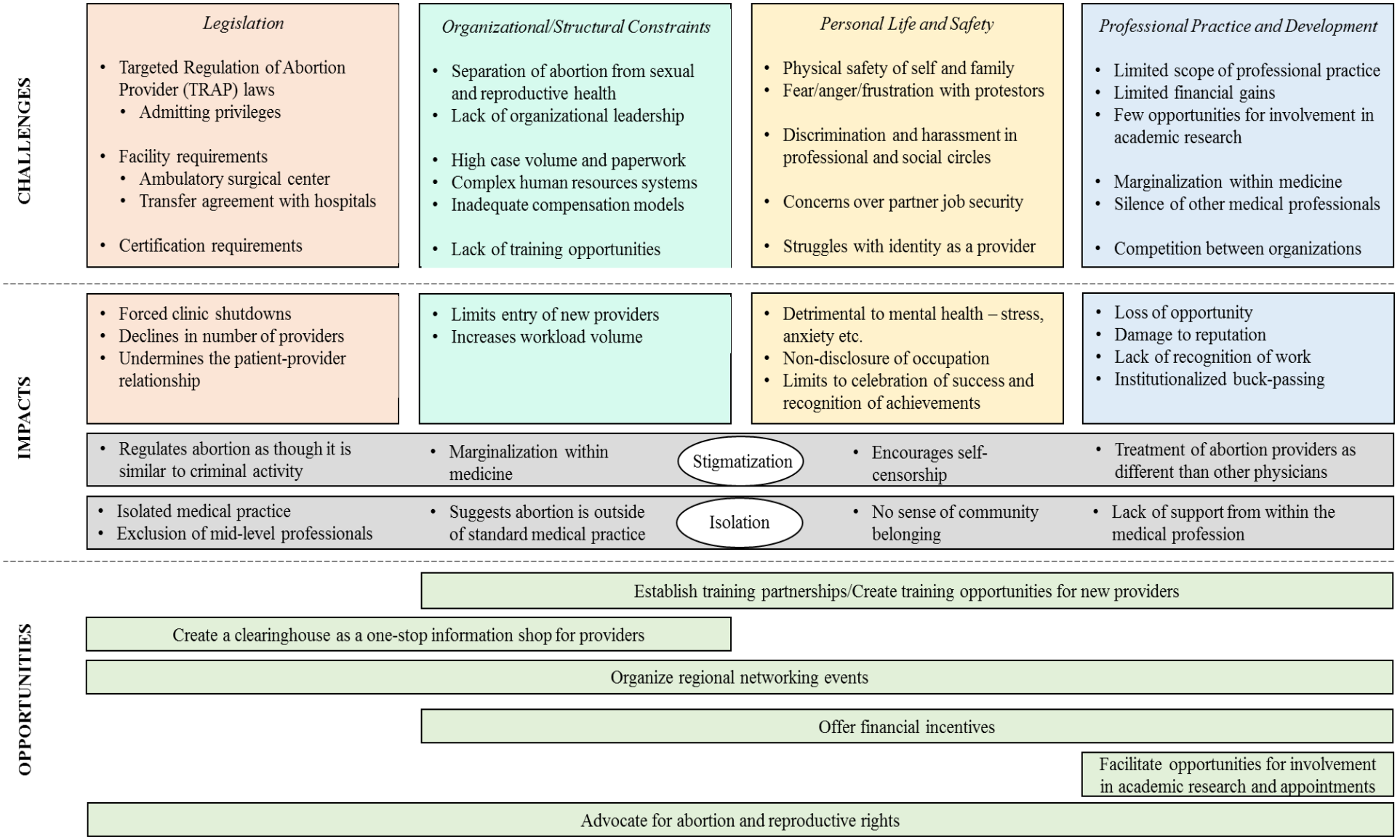
One of the objectives of this research was to identify potential opportunities for improved support, recruitment, and retention of providers to the Southern United States. Over the course of their interviews, medical students and abortion providers reflected on a number of differentially viable opportunities that they believed would alleviate some of their experienced challenges, and combat the issue of declining numbers of abortion providers in the region. These opportunities and their described benefits are identified in the table below.

DESCRIPTION OF OPPORTUNITY	PARTICIPANT-IDENTIFIED BENEFITS
Establish training partnerships or Create *more training opportunities for new providers*. This includes: • Relationships between OB/GYN departments and training programs • Fellowship and residency opportunities	• "Incentivize new providers to the South" • "Combat declining numbers of providers" • "Could improve standardization of care practices if everyone is getting same training" • " Resource sharing and greater investment in abortion provision"
Creation of a clearinghouse that could: • Facilitate/assist with licensing and credentialing application processes. • Maintain up-to-date information on a reserve pool of providers for times of scheduling conflicts. • Develop standardized compensation models for abortion providers	• Serve as a "regionally-specific concierge-type service" for providers • "Free us up from some of the paperwork for licensing" • "Connect us to be able to put out a call to other providers if we need a shift filled" • "Help make licensing and compensation and other things cost-neutral"
Regionally-specific provider networking events that could include: • Tri/biannual regional meetings held within the South • Psychosocial workshops	• "Just talking to other providers would be so helpful to refilling our proverbial canteens" • "Mentorship for newer or isolated providers" • "Meetings about the South in the South would help me feel more connected"
Financial incentives that could comprise: • Malpractice coverage and/or guarantee • Loan repayment for newer providers • Electronic privacy management services	• "Malpractice quotes are either astronomical or we're outright denied. We need coverage" • "Incentivize new providers to the South" • "Cover costs of internet sweeps for privacy and reputation protection"
Opportunities for provider participation or involvement in academic research post completion of residency training	• "I care about research and want opportunities to continue to carry out or engage in studies" • "Incentivize new providers to the South"
Abortion advocacy and deal-making by professional organizations to: • Engage pro-choice legislators • Inform public about provider challenges	• "Bring in people who can lend heavy weight to the fight for abortion rights" • "Approach the issue from all angles" • "[Hopefully] bring about legislative change"

5.0 Conceptual Framework: Challenges, Impacts and Opportunities

Since they are informed by the same environmental context, the challenges affecting current and future abortion providers in the South, although different from one another, are often interrelated. As a means of understanding the landscape of barriers to abortion provision the South and the implications of its abortion-restrictive environment on providers, we have mapped our study findings onto a conceptual framework. The conceptual framework describes the challenges experienced by current and future providers in the South, their perceived repercussions of those challenges for their personal and professional lives, and opportunities to mitigate some of these difficulties for providers. As illustrated in the framework below, providers experience adverse effects to their personal and professional lives as a result of the contextual challenges existing in the Southern United States. While some of these effects are limited to specific challenges, issues of stigma and isolation are more pervasive. Opportunities for improved recruitment, retention and support of abortion providers in the South, as identified by providers, are depicted in the framework is relation to the specific challenges that they have the potential to address.

Conceptual Framework



Chapter 5: Discussion

Given the current debate on abortion provision in the Southern United States, this study provides a timely focus on this region. Study findings provide a snapshot of the contextual factors surrounding the contentiousness of abortion, and paint a broad picture of the current state of abortion provision, with respect to the providing workforce, in the South. This study has facilitated the collection of powerful personal testimonies from members of the current and future abortion workforce of the South. Its findings are demonstrative of the courage and commitment that abortion providers bring to their work each day. Recognizing the challenges experienced by current and incoming abortion providers is an important step to better recruiting, retaining and supporting providers.

Study findings provide evidence of the challenges that the restrictive abortion context of the Southern United States places on abortion providers, and the subsequent impacts on provider recruitment and retention to the South. Challenges of legislation, organizational constraints, safety, and professional practice have profound effects on the personal and professional lives of abortion providers. With respect to legislation, the current onslaught of laws targeting existing and future abortion providers, as well as abortion service provision in the South, places significant burden on providers and is extremely detrimental to their ability to practice. By restricting their ability to provide and deeming aspects of abortion provision illegal, state legislation reduces the credibility of abortion providers, undermines their reproductive health expertise, and facilitates the stigmatization and harassment of providers. Organizational challenges have varying levels of influence on abortion providers' professional lives. Institutional and structural separation of abortion from other reproductive health care not only

isolates abortion providers but also encourages attitudes of marginalization of abortion among the medical profession. A systematic shortage of abortion training for new providers in the South is reflective of unsupportive organizational leadership and community attitudes. By deterring new providers from entry into the abortion workforce, the lack of training availability has implications for all abortion providers in the South by contributing to an already existing dearth of providers and increasing patient volume for those that continue to practice. Also impactful on abortion providers' professional lives are challenges related to practice and development. Limitations on their scope of medical practice and financial gains, marginalization of abortion within medicine, and competition between professional organizations all result in a loss of opportunity for providers, and perpetuate their stigmatization and experienced isolation. Providers often have to choose between their commitment to abortion care delivery and other areas of medical practice interest. Not being able to engage in full scale practice that they are trained for and interested in performing represents a loss of potential professional development for providers. Considering the personal impacts of the South's abortion context on providers' lives, concerns of safety and confidentiality of identity arose as issues of significance. Each of these challenges are decisive of providers' physical, emotional and mental well-being, and are impactful to their sense of community belonging and support.

Abortion providers in the South remain deeply committed to addressing the reproductive health needs of women in the region. In its identification of the existing challenges, their impacts and potential opportunities, this study is illustrative of the contextual environments within which abortion providers work in the Southern United States. While a multitude of challenges are present within this context, several programmatic and advocacy strategies can be implemented to mitigate them. Study findings highlight the importance of judicial decisions, organizational

and structural support, opportunities for professional development, and physical and mental safety to the personal and professional satisfaction of abortion providers. Current and future providers identified the creation of a clearinghouse, simpler means of networking, increased opportunities for training, financial incentives, professional development opportunities, and abortion advocacy by professional associations as potentially impactful to the mitigation of their experienced challenges.

While the results of this study augment and add to the existing body of literature on abortion provider perspectives and challenges, many of the thematic findings are consistent with those of past research. Abortion providers' and medical students' reports of the repercussions of restrictive legislation on their ability and desire to practice are reflective of the Guttmacher Institute's findings that abortion laws place undue burdens on providers [12,14]. The negative role that legislative regulation of abortion providers has on medical students' decision to practice in the South was mirrored in separate studies by the Georgia Maternal and Infant Health Research Group and Medical Students for Choice [39]. Within the organizational and structural barriers identified by abortion providers and medical students, findings on the separation of abortion from sexual and reproductive health, and on the lack of training availability are consistent with those of multiple other studies. Our study's findings of the impacts of the shortages of training opportunities on medical students' intentions to provide abortions in the future is consistent with Freedman's research on factors dissuading new providers from entry into the workforce [41]. National surveys by Jackson and Foster and Steinauer et al. reflected our findings that medical students at institutions with no or unsupportive abortion attitudes will often complete their obstetrics and gynecological training with no discussion of abortion [42,43]. Providers' and

medical students' experiences of hostility and harassment are in line with NARAL's findings on the incidence of violence and intimidation tactics assumed by abortion opponents [46,47].

The pervasiveness of stigma experienced by abortion providers and medical students in their personal and professional lives is indicative of Kumar et al.'s framework outlining the many levels at which stigma is perpetuated [55]. Study participants reported feeling stigmatized in the general reproductive health discourse, through state legislation, and within their professional communities and personal networks. The causes of feelings of stigmatization among providers were varied but included discussions of already existing hostile environments, limitations on the legality of their profession, marginalization of abortion within medicine, risks to safety, disclosure of profession and exclusion from other physician networks. These findings are all in line with Harris et al.'s work on stigma from the Providers Share workshop, O'Donnell et al.'s work on vulnerability to stigmatization in abortion work and Joffe and Weitz's research on abortion attitudes [56,63,64]. Closely related to the stigmatization of abortion providers, the personal and professional isolation experienced by providers in this research was also consistent with the findings of each of the above discussed studies.

Recommendations for Abortion Provider Recruitment and Retention

While the challenges that abortion providers in the South experience are significant, there is potential for positive change in a variety of areas in the short and long term. Based on our thematic analysis of provider challenges of legislation, organizational/structural barriers, personal life and safety, professional practice and development, and related opportunities, we

have identified a set of overarching recommendations for the support, recruitment and retention of abortion providers.

These include the development of networking opportunities for existing providers and training opportunities for new providers, cooperation between pro-choice organizations, and organizational engagement in abortion advocacy. While the development of networking and training opportunities could have more immediate effects in the short term, inter-organizational cooperation and advocacy work could affect long term change through potential impacts on a state's larger abortion context. Each of these proposed recommendations, described in further detail below, has implications for public health practice through its potential for impact on the abortion workforce.

Networking Opportunities: Interest in attending regionally-specific meetings for the purpose of networking and connecting with other providers was universal across study participants. Providers repeatedly identified networking as a means to mitigate some of their experienced challenges and spoke of the many perceived benefits of such opportunities. Establishing a calendar of regional meetings or a regional network of abortion providers for the purpose of conversation exchange and mentorship could contribute to reducing experiences of disconnect and isolation within the profession. Providers with more familiarity and comfort with the region could serve as mentors to newer providers and possibly assist with the development of personal strategies to cope with the associated challenges. Such a network could take the form of an email listserv, a regional meeting, or an electronic database.

Training Opportunities and Partnerships: Labelled as crucial to combating the shortage of abortion providers, the need for training opportunities for new providers was identified by study participants as a necessary recommendation for improving the recruitment of providers. Actively

working with medical education institutions, medical student groups and reproductive health organizations to develop and establish training opportunities and partnerships will have wide-reaching implications for abortion provision in the South. Existing literature has found that the geographic location of practice for providers is related to their geographic location of training. The provision of training opportunities at institutions within the South could incentivize providers just entering the workforce to consider the South as a future place of work. The provision of abortion training by an institution or organization can be considered to be reflective of its stance on abortion. Establishing more training opportunities and partnerships across the South could also bring about slow but positive change to the abortion environment of a state.

Cooperation between Organizations: While study participants noted the value and importance of pro-choice groups, professional associations and reproductive health providers to their work, many of their identified challenges and suggested solutions reflected a need for increased cooperation between these organizations. Collaboration between groups like the National Abortion Federation, NARAL Pro-Choice, Physicians for Reproductive Health, Planned Parenthood and state OB/GYN associations on issues affecting abortion providers is necessary to appropriately meet the needs of providers and affect positive change. Cooperation between these groups could facilitate resource-sharing for abortion service provision and advocacy work, and lend a united and powerful pro-choice voice to the abortion debate in the South.

Organizational Engagement in Abortion Advocacy: As a means of reducing the abortion hostility of the Southern states, a strategy with implications on provider recruitment and retention is the involvement of pro-choice groups, professional associations and reproductive health providers in abortion advocacy work. Based on our study findings, this could include legislative

advocacy to identify pro-choice legislators and work with them to encourage inclusion of pro-choice voices in the legislature. Abortion advocacy could also involve the development of partnerships by organizations with community groups and clergy to promote dialogue and facilitate discussion of reproductive rights. While organizations do currently engage in advocacy, this recommendation is intended to highlight the continued need for that work and encourage the development of regionally-specific strategies and partnerships. Organizational engagement in abortion advocacy could impact abortion providers by changing community abortion attitudes and contextual environments in the South.

In addition to the above discussed recommendations for abortion provider recruitment and retention in public health practice, the study findings also highlight the need for greater research attention on the abortion workforce. Focused research attention on the many barriers that new and existing providers undergo on account of being an abortion provider in the Southern United States could serve to reduce some of the stigma and isolation they experience. Publishing and sharing their stories with the general American public will bring to light and inform more people about the hidden consequences of the current war against abortion. This could also indirectly contribute to achieving the above programmatic recommendations as there is a possibility that increased publication of provider challenges could motivate the distribution of more funding towards abortion advocacy and provider training.

Implications of Research Findings

The findings of this study have significant implications for public health theory, research and practice. Our analysis and synthesis of participants' motivations to work in the South, challenges

associated with being an abortion provider in the South, and opportunities to improve provider recruitment and retention to the South can be used in a variety of ways. From a theoretical perspective, study findings are useful as they include a conceptual framework describing the unique impacts that the abortion-restrictive environments of the Southern United States can have on abortion providers. All of the findings are contextually informed and so include considerations of important environmental factors. Demonstrative of its implications for public health research, this study contributes to the existing body of literature on abortion provider challenges, and augments it by including perspectives of new providers and honing in on the South. Additionally, the findings of this study identify the causes for some of the personal and professional challenges experienced by providers, and could therefore contribute at least tentatively to an understanding of the causal pathways of provider stigmatization and isolation. The implications of study findings for public health practice are numerous. Reproductive health organizations can refer to the findings of this study to inform their strategies of abortion provider recruitment, retention and support within the Southern United States. Findings could also contribute to the development of programs targeting specific challenges experienced by providers. Each of the opportunities and recommendations presented in this study could potentially be instituted and put into practice with positive impacts on abortion providers. This study informs the improved recruitment and retention of abortion providers, and outlines strategies to ensuring an effective, supported and satisfied abortion workforce in the South. In highlighting the perspectives of abortion providers and focusing research attention on the needs of the abortion workforce, this study seeks to ultimately contribute to ensured access to abortion for all women in the Southern United States.

Strengths

A number of conditions lend strength to the results of this study. The use of qualitative interviews to explore and understand the perspectives of abortion providers allowed for the collection of rich and detailed testimonies that were embedded in state contexts. This facilitated an in-depth exploration of issues affecting providers and the identification of differential impacts of varying levels of abortion-restrictive environments on the personal and professional lives of abortion providers. Despite the inclusion of eight different Southern states each varying in its degree of abortion hostility, study findings were repeatedly consistent with providers and medical students reporting similar challenges and impacts. Providers and medical students in more abortion supportive states within the South corroborated the findings from other states by speaking to the importance of the need for supports that providers in more restrictive states were lacking. This is indicative of a need for regionally-specific strategies for provider support, recruitment and retention, and validates the study objectives.

By focusing on the Southern United States as the specific region of interest, this study generates context-specific findings that can be translated into actionable next steps for the region. All the findings of this study are deeply situated within state abortion contexts and were collected in response to local situations and settings. As a result, this study accounts at least in part for environmental, political, cultural, economic and social factors impacting abortion providers in the Southern United States.

The inclusion of current abortion providers and medical students with intentions to provide abortions in the future in our research population, allowed us to gather perspectives from providers at different stages of their careers. While medical students addressed the factors that

impact potential providers before they enter into the workforce, current abortion providers shared perspectives on those that are impactful upon entry into and once established in the workforce. Together, both groups paint an accurate picture of the challenges and opportunities affecting the recruitment of new providers and retention of existing providers to the Southern United States.

Through its objective of examining the impacts of abortion-restrictive contexts on abortion providers, this study highlights the need for increased research and programmatic attention to the abortion workforce as a means of securing abortion access in the South. This study fills in some existing gaps in the literature regarding the impacts of contextual factors on provider recruitment and retention in the South, and brings to focus a somewhat neglected research population.

Limitations

This research study has some limitations. A sample size of ten abortion providers and eight medical students can be considered a small population to appropriately reflect the abortion environments of eight southern states. While for some states, study participants included all of the current practicing abortion providers and/or representation from all of the medical education institutions, in states with multiple abortion providers and education institutions, the generalizability of the study findings may be reduced. As our sample size of medical students was small, the findings related to abortion education and teaching environments in the South were obtained from participant's experiences at particular institutions. It is therefore possible that those findings are not generalizable to every medical education institution in a given state or across the region.

Further contributing to a potential loss of generalizability of study results is the variation in state abortion contexts within the South. Given the experienced harassment by providers in some states, any presentation of state-specific findings in this paper was limited to the perspectives of medical students. To protect the confidentiality of the abortion providers, the analysis and presentation of their shared experiences was completed at a regional level. During data collection and analysis however, we found that there are regional variations in abortion attitudes and environments within the South. Relative to their neighboring states in the South for example, Georgia and Florida were found to be less restrictive of abortion provision. While this varied within individual states as well – findings from Florida's Panhandle region differed from the rest of the state; it is possible that the results of this study have less bearing on abortion providers in certain states within the South on account of being situation within supportive contextual environments.

Another potential limitation is the changing landscape of abortion service provision and training-related legislation in the United States, and the South in particular. As of July, 332 bills regulating abortion access and service provision were introduced to state legislative sessions in 2015. Of the eight Southern states included in this study, all had at least one abortion-restrictive bill introduced to their state legislatures, and five had more than three abortion-restrictive bills introduced thus far this year. Over the course of this study's data collection period, bills with potential impacts on abortion providers were being debated in Texas and North Carolina. One month after the completion of our data collection period, new legislation on consent requirements for abortion procedures for minors was instituted in Texas. While this may have impacts on current and future abortion providers in Texas, the timing of data collection and the passing of the legislation precluded it from inclusion as we did not yet know of the need to

address it during the in-depth interviews. Given that a portion of the study findings are reflective of current state legislation, a continually changing legislative landscape could have implications on their applicability. Had House Bill 33 passed in North Carolina, some of our findings would be outdated as it would mean that there were no more training opportunities for new providers in the whole state. As a consequence of this ongoing trend of increasing amounts of abortion-related legislation, the findings of this study may be limited in their relevance should the political landscape towards abortion change in any of the states included in this research.

Directions for Future Research

As demonstrated through the findings of this study, increased research attention on abortion providers is necessary to bring to light the challenges that they experience as a consequence of living and practicing in abortion-restrictive environments, as well as to develop potential solutions. Per the results and constraints of this study, there are a number of avenues and issues that can be explored in future research on this topic. To best develop strategies to combat the professional barriers and personal challenges experienced by providers in the Southern United States, a suitable next step is to conduct a situational analysis of the legal and sociocultural context of abortion in each Southern state. Doing so could facilitate an in-depth understanding of the state-specific context and the identification of potential pathways to affect change in the abortion environment. In addition to a state-specific analyses, follow-up research could seek to recruit current and future providers from within the same state so as to understand the state-specific constraints and opportunities for provider recruitment and retention. While this study

was able to achieve this to a certain degree, it would be helpful to have the perspectives of both abortion providers and medical students from each state.

Another avenue for potential future research would be a mixed methods study on the differences in abortion attitudes, training availability and institutional policies between public and private medical education institutions located in the Southern United States. During analysis, we found some trends of increased abortion support in private medical education institutions relative to public institutions within the same state. The causes for this could be multifold ranging from restrictions on use of public funds, donor relations, religious affiliations etc. Research could help identify whether there is a difference between private and public, and religious and non-denominational institutions in their willingness to train abortion providers. As training opportunities for new providers was found to be a theme of repeated occurrence and importance across provider and medical student interviews, it is an appropriate topic area for future research.

Each of the opportunities identified in this study was proposed by abortion providers and/or medical students as a means to mitigate some of their experienced challenges, and improve recruitment and retention efforts. Future research could seek to explore wider regional interest in each of these opportunities and examine the feasibility of implementation in different states. Other abortion providers and medical students in each state could be interviewed to understand their thoughts on the applicability and value of each of the proposed recommendations. A follow-up step could also be to identify who the players are in the implementation of each of the recommendations identified, and to communicate with them and the general pro-choice community, the need for additional work and collaboration in this area.

Future research could also hone in on specific topics that emerged in this study's findings. Issues of personal and professional identity, the pervasiveness of stigma, and marginalization of providers can each be further explored each independently or in relation to their impacts on provider shortages.

Chapter 6: Conclusion

In the decades since *Roe v. Wade*, the abortion provider landscape of the Southern United States has significantly deteriorated – the number of abortion providers has declined, abortion restrictive legislation has increased, training opportunities for new providers have become limited, and the challenges experienced by providers have multiplied. Today, providers in the South experience significant barriers to their professional and personal development and satisfaction. With more states and institutions adopting abortion hostile legislation, policies and attitudes, the future of abortion provision in the South hangs in the balance. The situation, however, is far from hopeless.

Despite the many constraints that the abortion-restrictive environments of the South place on providers, this study provides evidence that there is strong commitment from providers to practice in the region. By complementing providers' motivations to work in the region with supportive programming and legislative advocacy, pro-choice organizations can affect change to the abortion contexts of the South. Creating opportunities for provider engagement in training, networking, and professional development would demonstrate a commitment to the improved support, recruitment and retention of providers, and could greatly offset some of the negative consequences of practicing in the South. To effectively combat the issues that abortion providers experience within the conservative context of the Southern United States, there is also a dire need for concerted collaboration and cooperation between providers, pro-choice agencies, professional organizations and the medical profession. Only with the recognition and implementation of this will the state of abortion care and provision in the Southern United States be truly improved, for without abortion providers, there can be no safe abortions.

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