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Examining Independent Abortion Providers' Perceptions and Needs for Social Support: A Qualitative Social Ecological Study in the Southern and Midwestern US

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2019

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Abstract

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Abortion stigma is highly common and experienced by individuals seeking, receiving, or providing abortion services. To combat this stigma, individuals have relied on their social support networks of families, friends, and communities. Social support has proven to mitigate stigma yet a limited number of studies have examined social support for abortion personnel, and studies that explore stigma or support focus solely on physicians who perform abortions. The objective of this study was to examine social support perceptions and needs among abortion providers of all levels working in independent clinics. This study was a retrospective cross-sectional qualitative semi-structured interview format. Information was collected through in-depth interviews with abortion providers (N=15) across the Midwestern and Southern United States. This analysis adapted the Social Ecological Model to the context of abortion providers working in independent clinics, evaluating their perceptions of social support at interpersonal, organizational, community, and public policy networks. Participants received high social support from their organizational, or clinic, networks and that varied support came from their interpersonal networks of family and friends. However, lack of support largely came from communities and public policy networks of vendors and anti-abortion legislation, respectively. Results demonstrate the importance of understanding social support experiences of abortion providers of all levels and that these experiences may be different than providers working in similar healthcare settings. These findings also indicate the power of independent clinic culture in providing respectful care to patients and how this culture can combat abortion stigma.

Keywords: social support, abortion providers, abortion stigma, disclosure

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Literature Review

Abortion Trends in the United States

Abortion and abortion work has long been highly stigmatized in the United States (U.S.). Since the legalization of abortion with *Roe v. Wade*, abortion has become a point of contention and division. While independent and private clinics are experiencing less physical violence than what was common in the 1990s, anti-abortion opinions have shifted into policies targeting abortion clinics, providers, and individuals seeking abortions. Between 2014 and 2017, the number of state restrictions to operating independent clinics increased in the Midwest and South due to the fact that independent abortion clinics provide the majority of abortions [95%] compared to hospitals and private clinics [5%] (Jones et al., 2019).

In the U.S., around one-fourth of women receive an abortion in their lifetime (Jones et al., 2017). The procedure is highly common, especially among non-white women [61%] and those who fall within a lower socioeconomic bracket [75%]. Additionally, 59% of women seeking abortions already have children (Jerman et al., 2016). Overall, abortion services help those with limited resources who often have families or children to care for. These statistics contradict the narrative that individuals seeking abortions do so as a form of birth control, are irresponsible, or are simply not good people.

To understand where individuals are getting abortions, it is important to recognize the impact of independent clinics. Independent abortion clinics are defined as clinics not affiliated with hospital or healthcare networks whose services are more than 50% related to abortion. In 2017, there were 808 clinics across the U.S., a 2% increase from 2014. However, this increase only affected certain parts of the country; clinics increased in the Northeast [16%] but West [4%] and decreased in the Midwest [6%] and South [9%] (Jones et al., 2019). In states where abortion

provision is highly restrictive, independent clinics have greatly decreased and are struggling to stay open. As of 2020, Mississippi, Missouri, North Dakota, South Dakota, and West Virginia each had only one abortion clinic remaining with independent providers operating three [60%] of those clinics. Additionally, Louisiana and Wyoming relied solely on independent clinics, with three and two clinics remaining, respectively. (Abortion Care Network, 2020).

The number of providers who work in abortion care has also decreased over the past few decades due to the high emotional labor of this work and abortion services as an opt-out training in over half of obstetrics/gynecology and family medicine residency programs in the U.S. Summit et al. (2021) interviewed 28 family physicians in the U.S. who received abortion training during residency to understand barriers to and enablers for abortion provision. They found that only a minority of the physicians practiced abortion care because of the various barriers they encountered. Barriers included individual clinic and hospital policies, societal stigma, state-specific laws, and colleagues' lack of support, which all contribute to this provider shortage.

Barriers to Abortion Provision: Violence and Legislation

Violence

Historically, stigma towards abortion clinics manifested as violent, targeted attacks on clinics, but also towards abortion providers themselves. Through changes in legislation, certain forms of protection have led to slightly safer environments. Most notably, the federal government passed the Freedom of Access to Clinic Entrances (FACE) Act in 1994, prohibiting intentional property damage or threats to injure or intimidate anyone entering a health care facility. Currently, fourteen states have enacted laws prohibiting "certain specified actions aimed at abortion providers," including the creation of buffer and bubble zones that limit anti-abortion protestors to specific distances away from clinic entrances as well as prohibiting intimidation and

harassment of clinic staff (“Protecting Access,” 2022). However, violence continues partially as a consequence of these protections going unenforced. Though these protections are meant to decrease assaults towards clinics, patients, and providers, they have not proven to be effective.

As recently as December 2021, a Planned Parenthood clinic in Knoxville, Tennessee burned down in an act determined to be arson. It was the second time this clinic was under attack; in January 2021, someone fired a gun through the entrance doors. Similar incidents have occurred in the past including a handful of physician murders and bomb threats to clinics (“Protecting Access,” 2022). Physical violence and verbal harassment towards providers, patients, and advocates continues to persist as well as potential harm towards clinics. When clinics are damaged, they close for repairs, creating barriers for patients to seek time-sensitive services and for providers to care for their patients.

Along with violence, providers cite professional barriers that prohibit them from pursuing abortion as part of their training. Freedman et al. (2010) interviewed 30 obstetrics and gynecology residents to explore barriers in providing abortion services. Barriers included private practice prohibitions, strained relationships with peers, and institutional restrictions. Most physicians explained the pro-life nature of their peers or religious hospital systems as a barrier to abortion provision in private clinics. Due to this, it is clear why providers in independent clinics perform the majority of abortion services across the U.S. Yet there are several legislative barriers prohibiting independent clinics from providing care.

Legislation

Since Roe, abortion has been under duress. Politicians and anti-choice organizations have lobbied for and passed targeted restrictions on abortion providers, colloquially referred to as TRAP laws. TRAP laws are structural barriers affecting abortion providers and consequently,

individuals seeking abortions. These laws differ by state. As of January 1, 2022, 18 states mandate counseling services before an individual can get an abortion, 25 states require a waiting period between making an appointment and receiving an abortion, 36 states require abortions to be performed by a licensed physician – 19 of those states require an abortion to be performed in a hospital after a specific point in the pregnancy and 17 of those states require the involvement of a second physician after a certain point. Overall, TRAP laws have increased patient costs, created delays in accessing care, and increased abortion providers' workload and burden (Mercier et al., 2015; Austin & Harper, 2019). Furthermore, legislation also impacts clinics' abilities to stay open; a total of 96 independent abortion clinics across the country closed between 2015-2020 (Madsen et al., 2017; Abortion Care Network, 2020).

Mercier et al. (2015) explored the Woman's Right to Know (WRTK) Act passed in 2011 by interviewing 31 providers of different levels at eight freestanding abortion clinics in North Carolina. Lawmakers passed this bill "to ensure that women seeking an abortion are notified, before giving informed consent to receive an abortion, of the medical risks associated with the abortion procedure and the major developmental characteristics of the unborn child." It requires a counseling session with a licensed professional, abortion providers to share the gestational age of the fetus, any medical risks associated with abortion as well as any developmental characteristics of the fetus such as the heartbeat, organ development, facial features, etc. All providers in their sample had negative views towards WRTK because it increased institutional burdens and did not provide patients any additional benefit to knowledge or safety. They also noted that TRAP laws affected hospital and clinics differently; clinic hours were extended, and counseling took place outside of regular clinic hours (Mercier et al., 2015).

Using the same dataset and performing a secondary analysis, Britton et al. (2016) sought to understand how WRTK impacted abortion providers' professional identities. This study focused on licensed medical professionals of physicians, nurses, and physician assistants who were the only providers allowed to conduct counseling under WRTK. The authors found that providers continued this work because of their belief in its importance and their shared values of providing non-judgmental care.

Though these reflect abortion providers' attitudes and experiences who work in North Carolina, they can extend to states with similar TRAP laws. However, further research needs to occur in hostile states to understand the full impact of these laws across the U.S. as well as include all backgrounds and levels of abortion providers.

Abortion Stigma

Abortion literature primarily focuses on individuals who have sought and/or received abortions as well as the stigma they face as a result of their decision. Coined by Kumar et al. (2009), abortion stigma is defined as "a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood." Kumar et al. (2009) argues that abortion stigma stems from patriarchy because [cisgender] women are viewed as caretakers and future mothers. By rejecting the idea of motherhood in that moment, individuals who have sought or received abortions are making a decision that is the opposite of what society expects. The result of this decision can lead to ostracization, judgement, and anger towards women who have received abortions. Additionally, they pose that abortion stigma is socially constructed because of the various ways it affects women in each country, which have their own laws regarding abortion.

Abortion stigma has been studied extensively among individuals who have received abortions. Most are qualitative or mixed-methods studies seeking to understand experiences of these individuals. Women considering or seeking abortions were looked down upon by people close to them and their communities, and reported that their partners, friends, and family held anti-abortion attitudes (Gelman et al., 2017; Foster et al., 2018; Biggs et al., 2020). Family and the larger community are not the only groups who perpetuate abortion stigma – the medical community holds these beliefs as well. The Turnaway Study conducted at the University of San Francisco found that women experience economic hardship and insecurity and serious health impacts if denied a wanted abortion compared to those who received abortions (Foster et al., 2018; Gerdts et al., 2015). Various studies have identified how and where abortion stigma stems from and have sought to understand how this stigma manifests along with its impact in different countries.

Building from literature and study methods examining stigma experiences among women who have sought or received abortions, research has expanded to include abortion personnel's experiences and perspectives on providing this form of care. Stigma towards abortion providers manifests as "marginalization from healthcare" and "increases their vulnerability to violence and impacts their general wellbeing" (Kumar et al., 2009). These studies have primarily focused on physicians as the sole abortion provider. Harris et al. (2013) describes a "legitimacy paradox" abortion physicians experience; although physicians who provide abortions hold similar educational and residency experiences as physicians in other fields, they are seen as different and "less than" physicians not in the abortion field. Physicians providing abortion services are ostracized from the medical community and often bear the brunt of responsibility if

complications during procedures occur. Additionally, they are compelled to justify their careers and the abortion movement, something that is not asked of physicians in other fields.

Stigma experienced by abortion providers has been measured through surveys, interviews, and workshops. Harris et al. (2011) piloted a workshop for abortion personnel titled "Providers Share." The workshop was held over three months at an abortion clinic in the United States in 2007 with doctors, nurses, managers, and surgical assistants. In the six sessions, 17 providers discussed what abortion work means to them, memorable stories from their careers, abortion and identity, abortion politics, and future directions for self-care. Providers experienced stigma in different spaces inside and outside the clinic, when making new friendships and maintaining old ones, in their local communities and institutions, with family, and through legislation. In response to this stigma, providers regulated their responses and actions; some providers chose not to engage, or to stay silent, while others would not disclose their job position in certain contexts and situations. Despite providers facing various forms of stigma, they were still were proud of their positions and felt that they were making positive contributions to society. The Providers Share workshop demonstrates the importance of a space where abortion providers can discuss their experiences and build a community. However, while these workshops provided safe spaces for providers to share and discuss their experiences, they did not address larger, systemic issues that continue to perpetuate anti-abortion rhetoric and stigma. Workshops also place the responsibility of addressing and solving this stigma on abortion providers rather than holding systems and institutions accountable.

Extending from Harris et al., Martin et al. (2014) sought to understand how abortion providers' experienced stigma affects their professional work. They conducted the Providers Share Workshop at seven sites (at private and nonprofit clinics, public and private hospitals, and

states with and without Medicaid abortion funding) across the U.S. from 2010-2012 and distributed the Professional Quality of Life (ProQOL) survey to 79 abortion providers to measure compassion satisfaction, burnout, and compassion fatigue, and aimed to understand whether there was a relationship between the Abortion Provider Stigma Scale (APSS) and ProQOL. Out of the 59 providers who completed the initial survey, researchers found that there was lower experienced stigma among providers working in hospitals compared to providers in independent clinics, that abortion stigma decreased over time, and that abortion stigma relates to lower compassion satisfaction, higher burnout, and higher compassion fatigue. This study demonstrates the difference in experienced stigma based on facility type and recognizes that abortion providers have established various forms of coping with the high stress of their work.

Similarly, Janiak et al. (2018) were interested in how clinic type and job role influenced stigma and occupational stress. Through a cross-sectional study from 2014-2015, they collected surveys from 136 nurses, medical assistants, and counselors from four freestanding abortion clinics and five hospitals in Massachusetts, U.S. They found that hospital-based abortion providers were at a lower risk for experiencing burnout compared to abortion providers at freestanding clinics, while accounting for abortion stigma and job characteristics. Though there were no differences in stigma experienced on clinic type, counselors had lower stigma and burnout scores but higher levels of depersonalization scores, indicating that job role influences how providers internalize and cope with their work. Due to the cross-sectional nature of this study, there is a chance that participants' recall bias led to results which contradict Martin et al.'s (2014) findings. Despite the differences in their findings, these results demonstrate the importance of creating ways for abortion providers to gain support in order to decrease levels of burnout and turnover rates within this field.

Chowdhury et al. (2022) explored abortion providers' experiences working in the Southern U.S. Through interviews with 12 abortion providers defined as those who were credentialed and working in a hospital or clinic setting, the authors identified legislation, clinic and hospital structures, and alienation of abortion physicians from the medical community as results of stigma layered with working in the South. Additional research should aim to identify providers of all levels to understand their experiences of abortion care in the South.

Social Support

Within public health, social support is measured through social integration or perceived support available or received, and social support is often categorized as emotional or instrumental (Reblin & Uchino, 2009). Social support networks include the people individuals are close to and feel comfortable and safe with. It has been documented to increase mental health outcomes, physical health, and longevity. Additionally, community-level contexts are important in establishing social support networks. These include educational, workplace, and healthcare settings where people develop relationships and have social interactions. These spaces strongly influence attitudes, behavior, and social experiences (Holt-Lunstad, 2018).

Within healthcare, social support networks can serve as outlets for medical professionals working in stressful settings and studies are linked to the positive impact of social support on occupational burnout. Boland et al. (2020) employed a cross-sectional survey to understand prevalence of burnout and the association between burnout and social connectedness within the workplace. They focused on 167 emergency medical service (EMS) providers working in a single agency in Minnesota. Their results demonstrate that social isolation outside the workplace is associated with burnout regardless of age, gender, and years working in the EMS profession. They also found that social support mediates occupational burnout among healthcare workers

and higher levels of perceived organizational support lead to lower rates of burnout. Social support is important both inside and outside the workspace, especially for healthcare providers working in stressful environments.

Yet social support has not been studied among abortion providers but has focused on individuals who have received abortions, often in relation to stigma and disclosure. In a systematic review of 79 articles from 33 countries, Rossier et al. (2021) found that women who sought abortions in low and middle income countries (LMICs) carefully chose who to disclose to within their social networks for two reasons: the availability of anonymous access to abortion information and resources and level of stigma. Disclosure patterns differ depending on context and who participants are disclosing to or seeking information from. By extension, this can be applied to understand how an abortion provider's context influences their disclosure patterns to their social networks, as well as how they perceive social support from these networks.

Studies have also found the benefits of social support from individuals' healthcare social environments. Grieb et al. (2018) explored the impact of the clinic environment among people living with HIV (PLWH). PLWH perceived support through connections with their healthcare teams and through clinical activities. Though not all support was welcomed, they recognized meaningful supportive relationships within the walls of their clinic. Similar to HIV-focused clinics, the space within and around abortion clinics is highly stigmatizing. However, abortion spaces are politized and seen as "abnormal" spaces in healthcare (Arey, 2021). This politicization leads those within the abortion clinic space to create temporary relationships and rely on each other during the process. This was seen for patients as they bonded over their shared experience of getting abortions but relationships between clinic staff and patients were also important; providers supported patients through abortions and post-abortion care. The clinic

itself serves as a supportive atmosphere for individuals who are ostracized by their communities and by society.

Community support is an extension of social support. In public health, community mobilization efforts include models and programming specific to increasing positive health behaviors and outcomes. One such effort is the implementation of mobile helplines for women seeking abortions while living in restrictive settings. Baum et al. (2020) interviewed 30 women living in Brazil, Nigeria, and Poland who had medication abortions and received support and education from counselors. Helplines and counselors were based in each country and were run by non-profit or local organizations. Women calling into the hotlines felt the counselors they spoke to were well-informed about the medication abortion process and relayed information in a timely and nonjudgmental manner; this was in contrast to conversations they had with providers in formal healthcare systems in their respective countries. Though this is one recent effort that relies on telecommunication methods that may not be universally available or relevant to individuals in abusive homes, it provides insight to community-based interventions to address issues surrounding abortion in restrictive areas. Applying community-based models to educate individuals and provide them support they do not receive elsewhere is necessary. If similar models are incorporated within independent abortion clinics, the clinic space would be one where patients and providers can exist without threats of harm or harassment.

While these studies explain provider-patient and some provider-provider relationships, there are limited studies examining provider-community perceptions and relationships.

Social Capital

The theory of social capital recognizes the impact of community networks into individual well-being. Social capital refers to “features of social organization such as networks, norms, and

social trust that facilitate coordination and cooperation for mutual benefit." In relation to healthcare, social capital is associated with "a variety of important indicators of community health including better child welfare and school performance, decreased crime and aggressiveness, better health status (Putnam, 1995).

Among healthcare providers, social capital is linked to job satisfaction, burnout, and work engagement. Studies in Sweden have found relationships between high social capital and less burnout as well as higher job satisfaction and work engagement over time (Stromgren et al., 2016; Jutengren et al., 2020). These studies explored how healthcare providers in hospital and clinic settings perceive social capital in their workspaces. Stromgren et al. (2016) examined social capital in five hospitals through a prospective cohort design. Participants (physicians, registered nurses, and nursing assistants) answered a questionnaire on social capital for job satisfaction, work engagement, and engagement in clinical improvements at two timepoints with 1,602 participants at baseline and 1,548 at one-year follow-up. Analyses were based on 477 respondents answering at baseline and follow-up, to the conclusion that increased social capital predicted higher general work engagement and job satisfaction. Jutengren et al. (2020) found similar results among 250 healthcare workers of all levels in dental clinics and hospital settings. They found a positive predictive effect of social capital on both work engagement and job satisfaction; they believe both can improve interpersonal trust and acceptance among work group members. Though these studies were conducted outside of the U.S., they illustrate important associations of how social capital influences individuals in various healthcare settings of hospitals and clinics.

Another form of social capital includes reproductive social capital. This was defined by Jones et al. (2013) as, "features of social organizations, such as norms, and social trust that

facilitate reproductive health within a community." They explored what African American women sought from those close to them and from strangers to make their pregnancy experiences better through a community-based participatory action project. Through focus group discussions with 55 pregnant and postpartum African American women in Los Angeles, researchers found that the most common request from these women was emotional support from people close to them including their partner, family, and friends. From strangers, participants requested common acts of kindness that were less personal which included giving up a seat for them in public, holding the door open for them, smiling, etc. The researchers conclude by hypothesizing that social connectedness to communities can establish new social norms in how pregnant women should be treated.

By extension, community social connectedness can be applied to abortion providers: How does the local community treat someone who is an abortion provider? Does the community provide safeguards or protections for abortion providers? What forms of community support do abortion providers want and receive? This thesis seeks to answer these questions, focusing on what abortion providers perceive of and seek from their communities, however they choose to define them.

Conclusion

The importance of social and community support networks in any field has shown to be beneficial in addressing individual well-being and relationships within and outside work environments for providers. Yet the existing evidence demonstrates a lesser understanding of how abortion providers, specifically, experience and perceive social and community support. This is important to understand due to high levels of provider burnout, narrowing number of physicians, and increasing state-level restrictions targeting abortion provision, which are unique

challenges that come with working in abortion care. Social support from close networks can mediate these issues and social connectedness with communities can assist in establishing safeguards and social norms that support abortion providers and independent clinics.

Purpose Statement: This thesis will examine social and community support perceptions and needs amongst abortion providers working in independent clinics in the Midwestern and Southern U.S.

Framework for Analysis

The framework for this thesis draws on the Social Ecological Model (SEM) and posits that the networks of support for independent abortion providers extend beyond the individual to macrosystems. Theorized in the 1980s, the SEM explains relationships between an individual and their surroundings and can be contextualized to understand specific issues at different levels including individual, interpersonal, organizational, community, and public policy (McLeroy et al., 1988). Within public health, the SEM focuses on specific health issues or behaviors and social and environmental factors that directly impact that health issue/behavior.

The SEM has been adapted for different fields in public health research such as reproductive health, HIV, health promotion, etc. in various settings. In a study exploring adolescent contraceptive use in Southeast Nigeria, Ezenwaka et al. (2020) explained barriers through the five levels of the SEM. This included lack of individual knowledge or poor awareness of contraception, poor parental communication of sexual and reproductive health matters with adolescents, cultural, religious, and social norms, health system barriers to access and use of contraception, incomprehensive sexual health education in schools, and lack of social networks and community support. To understand HIV stigma and fear of contracting HIV among pregnant women in South India, Placek et al. (2019) organized their results by following the SEM. They focused on three levels of the model: individual, interpersonal, and institutional/community. The individual level included each woman's HIV knowledge, the interpersonal level included HIV-positive disclosure to family and friends and perceived reactions to HIV-positive status, and the institutional/community level included perceived reactions to HIV-positive status from religious and community leaders, healthcare providers,

community organizations, and employers. These demonstrate the adaptability of the SEM to different concentrations within public health.

This study draws on the SEM because abortion providers experience different forms of social support at each level of the model. In addition, these forms of support at multiple levels may interact with one another to form the full experience of support for a provider. In Figure 1, located below, the individual level has been excluded because this study aims to understand the complex relationships between abortion providers and their external support networks. The SEM has been applied to explain the importance of social support for abortion providers working in independent clinics through interpersonal, organizational, community, and policy levels. Interpersonal circles consist of family and friends, organizational levels of clinics and funds, community levels of local vendors and the larger abortion community and lastly, state levels of policies towards abortion.

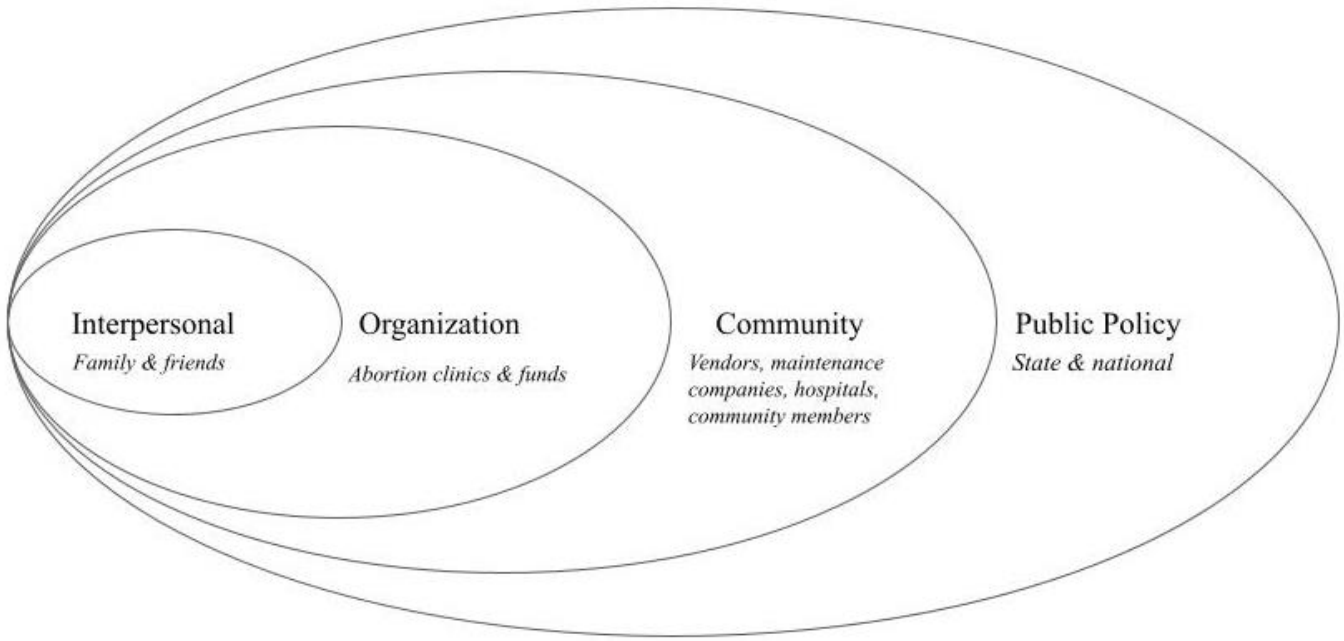

Figure 1. Adapted Social Ecological Model Explaining Levels of Social Support for Abortion Providers

Methods

The purpose of this study is to understand abortion providers' perceptions of and needs for social and community support. Data for this thesis was drawn from the dissertation of Amy E. Alterman, a PhD candidate at the University of California, Los Angeles. Alterman's larger study explored the efficacy of comedy and performance for relaying information about local health clinics and the role comedy shows could play in mobilizing support networks for abortion providers. In her dissertation, Alterman conducted 98 in-depth interviews from May to November 2019 at 19 freestanding abortion clinics across the U.S. Eighty-five interviews were conducted with abortion providers, 5 with researchers who study abortion, 4 with stand-up comedians, 3 with non-profit abortion movement professionals, and one with an abortion activist. Participants were selected by the clinic director or recruited upon arrival to the clinic. Interviews ranged from 20 to 120 minutes and touched on a range of issues including challenges providers face in their work, what keeps them in their work, barriers patients face in accessing abortion care, what providers desire from their communities, and how they are treated once people find out they are abortion providers. Alterman conducted in-person interviews with participants and stayed in touch with clinics. At the time of data collection, no funding was available to monetarily compensate but Alterman provided other forms of support to those she interviewed in the form of catered meals and volunteer work for the clinics. Interviews were recorded and transcribed verbatim using GoTranscript transcription services. These transcripts were utilized in their original form for the secondary analysis of the study sample.

Population and Study Sample

The study population included only abortion providers defined as personnel working at all levels of the abortion care experience, from administrators to clinic personnel. The rationale

for the broad definition of abortion providers was purposeful in order to represent a wide range of experiences across the abortion care spectrum and probe differences that might exist between personnel roles. Further, we hoped to understand the varied preferences and perceptions of community support relative to abortion personnel roles. The study sample was limited to 15 abortion providers working in independent clinics in 9 states: Alabama, Louisiana, Minnesota, Mississippi, Nebraska, New Mexico, North Dakota, Tennessee, and Texas. Clinics were chosen as part of Alterman's activist work, clinic availability, and legislative landscape. The states chosen were usually classified as "hostile" or "very hostile" to abortion rights and limited abortion access (Nash & Guttmacher, 2019). Only providers with at least five years of work experience in independent abortion care at the time of the study were included in the sample because they had richer understanding of the context of the abortion clinic and community. Therefore, they were able to provide deeper understandings of the complexity of abortion care in relation to their communities and social support networks. Additionally, 40 participants met this criteria at the outset of the original study design, however saturation was reached on the research question with 15 interviews.

Study Design

This study was a retrospective cross-sectional qualitative semi-structured interview format. Information was collected through in-depth interviews with abortion providers. The interview guide was developed by Alterman and included questions about the participant's role, challenges faced in their work, how they desire support from their communities, personal experiences of stigma, job disclosure, and the potential benefit of creating a position specific to community outreach. These questions stem from prominent themes in abortion literature of stigma, disclosure, and challenges unique to abortion care.

Data Analysis

Analysis for this study occurred from July – October 2022 using MAXQDA 2020 (VERBI Software, 2021). To develop the initial codebook a random selection of six interviews from the subset of 15 were read and a set of codes were created to address the research question. Deductive codes were identified from literature searches on abortion stigma and social support experiences for abortion providers. After reading and memo-ing six transcripts and identifying common themes, a final codebook was developed summarizing common themes and ideas from each interview, along with definitions and examples (Appendix A). Codes were applied using a constant comparison method. Themes emerged and were captured through discussion with the team.

Ethical Considerations

This study was deemed exempt from Institutional Review Board (IRB) by Emory University because of the secondary nature of analysis and de-identification of data prior to its disclosure. Alterman, owner of data, received confirmation from UCLA's IRB that this project did not require additional IRB approval beyond the initial study agreement.

Limitations

This study must be approached in light of certain limitations. First, the data for this work was obtained from a secondary source. Therefore, not all information in the transcripts was pertinent to the research question but provide context to participants' thoughts and experiences. Second, we are leaving out providers with less than five years of work experience leading to missing differences in social support for those who are starting their careers compared to those who have been in this field for longer and consequently, have more established networks.

Results

Fifteen total abortion providers from states across the Southern and Midwestern U.S. were included in this analysis. Providers' occupations are described in Table 1. Twelve participants identified as female [80%], two as male [13.3%], one as nonbinary [6.7%], and providers' tenure in abortion care ranged from 6-39 years (Appendix B). Independent abortion clinic providers face high levels of stress due to the nature of their work, which counteracts different levels of stigma daily and often continually. We found that to combat unique stressors, abortion care personnel draw on unique forms of social support to continue their work.

Table 1. Study Participant Job Titles (N=15)

Position	Number of providers
Administrator	4 (26.7%)
Clinic Director	4 (26.7%)
Counselor	2 (13.3%)
Director of External Affairs	1 (6.7%)
Director of Patient Advocacy	1 (6.7%)
Floor Supervisor	1 (6.7%)
*Owner	3 (20%)
Physician	2 (13.3%)

*Percentages do not equal 100% because all owners held dual positions

Individual and Interpersonal Networks: Family and Friends

When asked about support, most providers described relationships with their immediate family, close kin, and friends. Participants highlighted their spouses or partners, parents, and siblings. Central to these relationships was disclosure. Globally and locally, disclosure has widely been studied but has focused on individuals who sought or received abortions. For

abortion providers, disclosure refers to sharing details about their job and specifically in relation to abortion with family, friends, or others they know. Depending on who participants disclosed their occupations to, responses differed and depended on the other party's views towards abortion. For some providers, they highlighted when relationships with family members were supportive and when that support was provided to continue their work in abortion-related careers.

> *"…my family is totally supportive of what I-what I do and helped me actually…I wouldn't be here right now if it wasn't for my-my parents…no bank would finance me and I was trying to come up with the money to buy the building from, uh, from [previous owner]. You know my parents are the ones, my dad gave me, uh, gave me a large amount of money. And then my sister went into her retirement and pulled out…to help me…"* – Abortion Provider, Alabama.

Some were more open to sharing their occupations than others. One provider explained,

> "*I'm open with everybody. My grandmother knows where I work...my-my mom's friends, my parents' friends. Sometimes they're like, 'Oh she works in a clinic.' And I'll leave it at that, but if they ask me straight up, I'll tell them*" – Abortion Provider, Texas.

In contrast, some providers did not explicitly disclose their careers to their family members because they feared negative reactions. They explained that they did not want to cause any unrest or division within those relationships and aimed to avoid the potential backlash that often comes with this type of disclosure. One participant described her relationship with her extended family,

> *"And there's some family members that still don't know the job that I do and I've been here for eight years. Just because I don't wanna fight. I fight every day when I come to*

> *work here. Whether it's coming in the door and listening to those fucking people or on the phones…I-I'm always fighting. So at home, it's kind of like, I don't want to fight anymore"* – Abortion Provider, Nebraska.

Providers acknowledged that disclosure of their work in abortion care changed and sometimes had a negative impact on some relationships. After providers disclosed their job positions to family members or friends, some relationships continued, others ended, and some required understanding from both sides to continue. One participant explained that her parents were aware of her working within the abortion field but did not know her specific job position. She felt that she was hiding a part of her identity by not sharing that aspect of her life with her parents. She stated,

> "*...abortion is 95% of my life...it's my identity...I think it's unfortunate that they are not, sort of, privy to that, that they don't get to see part of it*" – Abortion Provider, North Dakota.

Despite not having her parents' support, this participant relied on her sisters and spouse. In describing conversations with her sisters and spouse, this participant discussed the complexity of her family dynamics and how much her parents should know about her career,

> *"You know, my sisters and I talked about it and we said my parents don't need to know. My husband disagrees. He thinks I should tell my parents. He thinks my dad would be proud. He thinks my dad would be proud that I own a building. That I bought a, um, a business."* – Abortion Provider, North Dakota.

Similarly, other providers described ending or being cut off from long-standing relationships with people in their interpersonal network but to offset those losses, gained support from others.

It seems that despite losing some relationships, providers relied on others within their circles. One participant described this experience,

> *"Uh, my biggest concern was reaction from family…And those that mattered to me actually ended up being very supportive. My mom in particular. I would have never thought that woman – that she was pro-choice but lo and behold, she became my biggest fan. So, that was a lovely thing…The person I considered my best friend in the world, we haven't spoken since I came to work here"* – Abortion Provider, Louisiana.

Some providers were more permissive towards having friends who were not supportive of their jobs but respected the fact that they were working in abortion clinics. For instance, one provider explained that her friends did not believe in abortion but,

> "*They've never judged me that I know of…I'm fine with someone who doesn't-doesn't believe in abortion...it's when you try to force your choice on somebody else is where-where the problem always comes*" – Abortion Provider, Mississippi.

Three main themes arose from this network: (1) the individuals in interpersonal support groups were mainly family and friends, (2) disclosure led to a range of reactions from support networks and (3) despite losing some relationships, participants still felt supported by other relationships. There seemed to be a balance of losing and gaining or maintaining relationships within this network.

Organizational and Community Networks: Where Clinic Space and Public Space Converge

Independent abortion clinics exist between public and private spaces. They are visible to the public and consequently, have become spaces for discourse and protests. Participants explained a range of support networks in describing their personal and clinic-related professional relationships with their communities beginning within their clinic and extending outwards.

Within each workspace, providers relied on each other for support. Their shared experiences working in abortion clinics led to trustworthy and dependable connections. These relationships created positive work environments which participants expressed through humor and outside of work, by taking part in collective activities. One provider explained that her clinic staff,

> "*…will go to karaoke, and just bond and, you know, decompress*" – Abortion Provider, Texas.

Along with team activities, most participants noted the importance of using humor within the clinic. Though humor may seem mundane, it served as a necessary tool for abortion providers to manage the emotional nature of abortion care. Similar to other work environments, providers developed a language incorporating humor only they could understand and use,

> *"…we all have a-a weird sense of humor [laughs]… part of dealing with that is just like, you know, there are only jokes that I can—there are- there are only ways that I can talk about things with people here. And outside of that, no one would get it…"* – Abortion Provider, Louisiana.

Providers also utilized humor with certain patients.

> *"This is- this is how we cope. It's about smiling and laughing in here, even- even with the patients and staff. You know, we-we crack jokes with the patients, they laugh. This is how you make it through the day. I mean, it's—the patients [are] coming through that war zone out there. You want them to feel comfortable here and you-you know, you don't want them to feel like everybody's uptight and everybody's mad and serious…you know"* – Abortion Provider, Mississippi.

The unique relationships that are formed as a result of working in abortion care creates a special form of communication that only the people who experience it can understand. Participants used humor as coping and distraction mechanisms amongst themselves and with their patients. This allows relationships they establish inside clinic walls to become cordial and comfortable. In this manner, abortion providers create supportive and reliable relationships with each other and with their patients.

Yet the environment outside the clinic directly opposes the one inside. Outside, providers encounter protestors who badger and harass them daily. As providers leave the walls of their clinics, the space becomes more dangerous and less supportive. These public displays signal the community's lack of support for their local independent clinic, regardless of how many people are protesting. It is important to note that these protests are not novel. The history of anti-abortion demonstrations, violence, and aggression targeting clinics and providers is extensive. One provider explained the impact of potential violence on the clinic's ability to run as a business,

> *"We've had a couple of bomb threats, but it's been years since we've had a bomb threat and we've never had one in this building. When we were, um, in our first building because we've had to move three times, then we [had] a bomb threat, the first one…and I mean, it was just a threat, um, but still, you know, you think about it"* – Abortion Provider, Minnesota.

On the same note, another participant expressed how the constant presence of protestors has affected her daily routine both physically and mentally,

> *"I mean, I'm vigilant at all times cause I'm just, I've been doing this so long. I watch every little thing that I can even like leaving work, coming to work, when I come outside*

> *at home, you know, it's just like- it's like- it's become a natural reflex to do that…wow, this has actually become normal to me because I've been doing it so long and-and you know, and like…I mean, that's kinda s-scary, you know, but I didn't realize it. It is kind of scary. It's just so normalized now-in my brain to where it is-it's not a scary situation. It's more of a, just pay attention to your surrounding situation and I do that literally everywhere I go, not just here…it's just an automatic thing now"* – Abortion Provider, Mississippi.

The continuous protests and harassment abortion providers face are internalized and force them to take precautionary measures either consciously or subconsciously. Their sense of safety is affected and decreases as they go to and from work.

At clinics, all providers wanted protestors to disappear but had different ways of reacting to them. Some described frustration seeing and hearing protestors' aggressiveness on a daily basis and not being able to respond,

> "*…and it was hard for me after especially having worked here and knowing what people actually like go through to have someone yell at you like that. You really – I mean, it is—I mean it's-it's, uh reminds me of like when I see images of what people went through during like the-the civil rights era…and someone's like, you know, threatening you. How do you respond to that-in a way that doesn't put the clinic in a compromised position? You know, like it's really tough."* – Abortion Provider, Louisiana.

Not only do providers struggle with how to internally process this harassment, they also recognize that they represent their clinic. Others echoed this sentiment but one described her thoughts in responding to protestors,

> "*And, you know, it's just you wanna say something, but it does absolutely no good to say anything."* – Abortion Provider, Louisiana.

Providers' perceptions of safety vastly differed because they recognize protestors' power and how it would reflect upon their clinic and the abortion community at large.

However, clinics are not the only location demonstrators make themselves visible and heard. Some make the effort to protest at providers' homes. One participant recounted a time when protestors disturbed not only him but also his neighbors and children,

> *"…they definitely have been more personal, you know, where they used to picket my house and even now they'll come by and put something in neighbors' mailbox[es] that says, 'Pray for [participant's name], he's-he's doing abortions…well, part of it is-is we always look if these people are being, you know, stupid and nuts. So even when, you know, they were, um, picketing outside the house, the kids didn't get scared"* – Abortion Provider, Texas.

When protestors appear at providers' homes, providers' families are exposed to this harassment. Depending on how the provider reacts and how much their family knows about their occupation, their families can be deeply impacted by the proximity of these protests.

Broadly, abortion providers described two forms of clinic-related support they received from their communities: public and private. Most participants discussed support they received as private, through donations. Participants expressed that while private support was helpful, they wished for vocal, or public, support from their communities and states. One participant explained,

> *"…I don't think we have enough support. We have a lot of support privately. We don't have enough public support…private donations, thank you cards…and, you know they—*

> *people tell you all the time how they support you and believe in what you're doing, but a lot of these are the same type of people who wouldn't dare say it in certain environments."* – Abortion Provider, Mississippi.

Another provider described what public support at clinics can look like,

> *"…I think it would be great to have a lot more people involved in the sense of counter-protesting, being out there to help escort patients…um, but being just, uh, more involved in I think that would- that would really help boost something there…"* – Abortion Provider, Nebraska.

Depending on where providers were located, individuals in their communities were not comfortable expressing their support for their local clinics but did so by privately donating to them. If these individuals demonstrated public support for clinics, it might contribute to reducing stigma and improve perceptions of abortion clinics in those communities.

To understand community-wide support for abortion clinics, participants explained relationships and experiences with maintenance companies, law enforcement, vendors, university groups, hospitals, and other physicians. Because all clinics in this study were located in hostile states, most participants described an overall lack of community support from these groups. Providers reached out to maintenance companies, vendors, and hospital systems from a business standpoint yet received little to no reciprocation.

Providers faced trouble in keeping their clinics up to date and physical spaces current because they could not find maintenance companies to work in their clinics. One participant explained that her clinic had to wait,

> "*...18 months just to get somebody to finally do stairs for us because we used to have wooden stairs that were literally falling apart…we get people to come in, they give us*

> *quotes. They're like ridiculous quotes that nobody would ever pay…because they just don't want to do it and they don't want to say it but a lot of people just turn us down outright to do any work with us, so" –* Abortion Provider, Nebraska.

Some contractors were more comfortable increasing costs for clinics rather than telling providers why they did not want to work for them, despite both parties knowing why. In some cases, participants often had to disclose to vendors the nature of their work in order for vendors to decide if they wanted to conduct business with the clinic. One provider described her experience with multiple vendors,

> "*I-I mean, it sometimes, it's, um, when—If we have to get a new vendor, I may tell him, you know, upfront before they even come in, 'You know, we are an abortion facility, do you have a problem dealing with that?' That-that's ridiculous to have to say that…" –* Abortion Provider, Louisiana.

This participant expressed frustration at the necessary disclosure of her clinic's business. She went on to describe her struggle in finding an air conditioning company because the company that worked with the clinic suddenly stopped their collaboration,

> *"…so I said, 'Let me call, [friend's name], you know my good friend…They have a huge plumbing contract company here and they see everything. So, I called [friend's name],*
>
> *I said, '[friend's name], we're kind of in dire straits, I really need some help. Um, I need a contractor to come look, I think we need to have some work done for our unit to work properly.*
>
> *And, um, 'But [participant's name], I don't know even where you work?'*
>
> *And I said, 'I work at [clinic's name]…it's an abortion clinic.'*

'Oh gross. That's what you do?'

And I went, Wait a minute, I grew up with this girl. She was my roommate at college…

And, um, she called back and she said, 'They don't want to deal with you.'

Okay, I mean, that blew my mind" – Abortion Provider, Louisiana.

In these instances, providers had to leverage their personal relationships to keep their businesses running. However, they still experienced stigma and received limited support for business activities such as building repairments, affecting clinic upkeep and their ability to serve patients.

Providers' relationships with law enforcement varied. The majority of providers across all states did not feel supported by law enforcement when they called for support or de-escalation. They explained that law enforcement officers were often judgmental when responding to calls at clinics, influencing their response time and treatment of clinic staff and patients. One participant explained her interactions with police officers and emergency medical services (EMS),

"*...I feel a little anger towards them. Um, if we call for a support, whether that's transporting a patient, or, you know, support from police, I want them to come and give me unbiased support...I don't wanna see...judgement on [their] face*" – Abortion Provider, Texas.

Another provider described the relationship between her clinic, protestors, and the police,

"*The police aren't allowed...to pick a side...I don't have an issue with that. I have an issue when we have city ordinances that are-aren't being followed and-and the police aren't doing anything about it*" – Abortion Provider, Mississippi.

In this instance, protestors were breaking city rules but the police were not stopping them; clearly protecting abortion providers and patients is not their priority.

Some providers mentioned other vendors such as local restaurants, churches, and university groups who supported them. These forms of support strengthened the relationship between the clinic and their local community. One provider described her clinic's relationship with a restaurant owner,

> "*He's been just a really strong supporter...he'll donate, you know, food to us, um, and also just, you know, make donations and, you know, help us try to think of fundraising. And he's not afraid to, um, come out and, you know, support us...he sells our t-shirts in his [restaurant]*" – Abortion Provider, Minnesota.

Additionally, some providers felt supported by local churches,

> *"I mean, I feel like we get a lot of s- we get a lot of support from [the] Unitarian Church. We have now, um, right now a chapter meets here, oftentimes, and there's a lot of advocacy. Even if people aren't able to physically show up, like I feel safe in my community."* – Abortion Provider, Louisiana.

However, this was not common; rarely did clinics have strong relationships with community groups.

Local hospitals were another source of sparse support for providers. Some participants explained that they had business relationships with local hospitals which comprised of referrals. However, many providers – especially physicians – felt disconnected from hospitalists and physicians outside of the abortion field. Both physicians in this study discussed feeling judged by other physicians for providing abortion services. Though they referred to specific physician

communities, these providers practice in different states and have a 30 year age gap – clearly these issues cross state lines and are intergenerational. One physician elaborated,

> "*Um, and then because of the-the stigma around abortion, sometimes even other healthcare providers, sometimes even other pro-choice healthcare providers, uh, will judge us differently when we have a negative outcome, as opposed to when someone in a different field has that outcome."* – Abortion Provider, New Mexico.

Another participant expressed mistrust in hospital systems for this reason. She stated,

> *"…I have a fear of the kind of OB/GYN establishment. They're very threatened by the midwifery model and by what we're doing, some of the older folks and the more traditional folks, and they would like to see this fail. And so sometimes…if a mom comes in and like has to transfer [to] a hospital, you know, people will try to make it out to be something that, you know. So we just have to be super careful about document[ing] everything in the chart, you know, just to cover our asses major, major, major"* – Abortion Provider, Tennessee.

The presence of providers with conservative or traditional views can influence clinics and hospital boards to accept or reject certain types of care. In the example above, the participant mentions the midwifery model of care which is patient-centered and takes a human rights approach to pregnancy, birth, and postpartum care, leading to safer births and lower obstetric-related morbidity and mortality (Alonso, 2020). There are many similarities between this model and independent abortion care, which some see as different or opposing to hospital-based care and culture, creating tension between the two communities.

Another challenge when collaborating with hospital systems was getting resident physicians to perform abortions at independent clinics. Hospital systems, mainly ones that have

religious affiliations, prohibit physicians from providing abortion services after completing residency. One participant explained,

> "*But, um, you know even with some of our top docs, we use residence. Um, and a lot of the residents say they wanna do abortions. But then, um, once- once they finish their residency program and they get their- their job, you know, they don't look into the hospital system that's employing them to find out if they can even do abortions because there's a lot of hospital systems where you couldn't do abortions…"* – Abortion Provider, Minnesota.

Finding physicians to commit to working for independent clinics full-time is another struggle abortion providers face, especially when the closest hospital systems establish rules against putting in additional time with clinics. Overall, participants described a culture of judgment among physicians outside of abortion, private clinics, and hospital systems towards the abortion field.

Organizational and community networks were opposing sources of support for abortion providers. For most providers, support diminished as they left their clinics' walls. Community-wide support for abortion providers and local clinics was layered, complex, and irregular; often, support depended on individual groups' personal beliefs towards abortion.

Abortion Community Network of National Funds and Clinics

The larger abortion community network consists of funds and clinics that are independent or private. The majority of providers discussed the difference in attention and financial support given to non-independent clinics. One provider explained the high buying power larger clinics have compared to independent clinics, which drastically changes the cost each entity pays for

resources. She explained this in the context of buying intrauterine devices (IUDs) using some example numbers for compensation,

> "*For example, you know, this great new generic Mirena that they were researching forever and they were promising like, 'Don't worry, we're done, you're going to be able to get it for 50 bucks.' Bullshit. [national organization] gets it for 50 bucks. The FQHC's* [federally qualified health centers] *get it for 75...but independent-independent abortion providers, we don't get that $75 IUD. Which means that our patients don't get IUDs...Because if it was $75, do you know how many free IUDs we would be giving out here? But it's $800. We cannot afford to pay for our patients to have $800 IUDs" –* Abortion Provider, New Mexico.

Differences within the abortion community extended beyond finances. Independent clinics provide a different type of care compared to private clinics and funds, affecting their business hours. One participant expressed frustration at this distinction,

> "*...a fund might get to take three weeks off around Christmas and New Year's. Clinics, don't get to take that time off. Patients still need us. And so there's a tension there like, 'Oh, you get to take time off, you get to close your doors and turn off the phone and not do anything for three weeks. What a luxury? We don't get to do that. Patients still need us. We're bending over backwards. We're still providing the service. You're going to take a sabbatical for six months because the work gets hard. Hmm. Who's going to take care of business when you're gone."* – Abortion Provider, North Dakota.

Independent clinics constantly face threats to staying open and providing care, along with the added challenge of finding money for resources that benefit their patients. Despite these

struggles, providers described the importance of independent clinics in their local communities. One participant explained the connection independent clinics have compared to larger ones,

> *"...it's like, you know, Walmart versus, like your neighborhood grocery where you know everyone and we know what vegetables and fruits you-[you] like...it's a weird metaphor but, like -you know, like, 'We're here to serve the community. [national organization] is there to, like, provide a service."* – Abortion Provider, Louisiana.

It is important to note that there are forces beyond independent clinics that influence how their businesses are conducted. Their ability to stay open and provide care is largely affected by their local community's attitudes and their state's policies towards abortion.

State Networks: Public Policy and Attitudes

States' abortion policies impacted providers in various ways. Participants described the majority of challenges and frustrations in providing abortion care came from state policies restricting abortion provision. Most notably, TRAP laws place restrictions on physicians while other forms of abortion regulation restrict who can perform ultrasound services, counsel patients, and when individuals can receive abortion. Participants expressed anger and frustration towards TRAP laws and described how these regulations increased their workload and consequently, their stress and overall well-being. TRAP laws oppose the culture of support, trust, and respect that abortion providers create and maintain in their clinics because policy changes impact how abortion services are implemented in clinics and how patients respond to these changes.

One participant described the 24-hour waiting law that was implemented in her state, which requires individuals to receive abortion counseling at least 24 hours before receiving an abortion (Guttmacher, 2021). She explained the impact of the law on both patients and providers,

> *Participant: "Um, I would say the biggest barrier that we have is our 24-hour waiting law here. Just for the sense that most patients don't understand what that means. And that can be frustrating for them because they think that, "Well, if I'm calling today, then I can get in tomorrow." Well, it depends on timeframes and, you know…they have a hard time understanding. And that really frustrates me cause, you know [chuckles]."*
>
> *Interviewer: "Do they blame you?"*
>
> *Participant: "They do. They-they-they essentially, just 'cause they don't understand. And I understand that frustration on-on that. And because, you know, they're just seeing this and not seeing the bigger picture of everything, so"* – Abortion Provider, Nebraska.

Additionally, state policies can influence community attitudes and reactions towards abortion, mainly in how protestors react to policies being discussed in the legislature or ones that have recently passed. One participant described what happened when an abortion-related law was up for debate in her local government,

> *"There was a time, uh, several years ago in which there was a 20-week ban that they were working on here in the city. And I'm pretty sure it was around that time that they were—started like protesting outside my house"* – Abortion Provider, New Mexico.

In some states, information on abortion facilities is public record. This gives anyone the ability to find information about abortion clinics and providers who work there. One provider explained how this law affects his clinic and staff's safety,

> *"…you're always thinking about the safety and well, they can get the- the layout of your clinic and all that…Hell, they already got the layout because the plans are public record…they already know what type of fire alarm system we have in here, and security*

> *system and everything else, cause everything is- it was public record, um, down in, um, Montgomery. They know what days we work because we have to submit our schedules to the State of Alabama…so the protestors already have all these…"* – Abortion Provider, Alabama.

National attitudes and policies can also influence how individuals view abortion in each state. A participant described this relationship,

> "*And I think [protestors] have some kind of innate need for [protesting] and they love it as much as I love coming in here, you know. So, um, attention or whatever their thing is, they get plenty of, you know, by implementing their plan. So, uh, I-I know that the atmosphere in the country is different now and I'm sure they draw from that as well. You know, that's, uh, um, it has be—it has become, uh, uh, brought to the forefront, you know, through the laws and through Congress and-and those kinds of things. So it's- it's kind of out there."* – Abortion Provider, Mississippi.

Overall, participants did not feel supported by state networks due to the policies their state legislatures passed which increased barriers to abortion provision, influenced negative attitudes towards abortion providers and individuals seeking abortions, and decreased feelings of providers' safety.

Discussion

Analysis of abortion providers' perceptions and experiences of social support demonstrate three main themes: 1) the way abortion providers discuss and feel social support may be different than others who provide care to people who can become pregnant and that social support affects providers' interpersonal networks, 2) abortion providers do not always have a choice in disclosing their occupations to others, and 3) independent abortion clinic culture can be a protective factor to combatting abortion stigma.

Social support for providers varies by and within networks

Social support is based on participants' identity as abortion providers and influence both their personal and work lives, which is unique compared to other medical providers and individuals who have received abortions. However, similar to prior abortion research, we found that stigma is a main factor that drives social support (Shellenberg et al., 2011).

Providers indicated that the majority of their support is from interpersonal and organizational networks and that lack of support largely comes from community and public policy networks. Participants who had high social support from their interpersonal networks received it mainly from family members or friends. Participants described social support in interpersonal networks as falling on a spectrum. This differed for organizational networks, where support was usually binary; participants described high social support because of their shared experiences as abortion providers.

A few participants could identify at least one community organization that supported their local independent clinic but many could not point to even one. This can be due to the fact that participants lived in states defined as hostile towards abortion as well as the impact of abortion stigma that is public and prominent in these areas. Many participants were denied

services, struggled in establishing their clinic, and faced harassment from protestors daily. It is rare to see healthcare professionals being denied services or being disrespected because of their profession. If anything, they are celebrated. Yet abortion personnel do not receive the same prestige or recognition and are targeted and treated differently once they disclose their work (Dunne, 2019).

Community and public policy networks work together to perpetuate this stigma. This is reflected through TRAP and TRAP-related laws that display abortion exceptionalism. Abortion exceptionalism is the idea that abortion services are treated differently than other forms of healthcare. It is what courts use to pass and uphold laws restricting abortion access and provision (Vandewalker, 2012). These restrictions place burdens on individuals seeking or considering abortion but also burden abortion personnel to accommodate laws into their clinic's daily activities. Literature on regulation demonstrates that TRAP laws restrict who gets to provide specific services and how these regulations impact clinic activities. Mercier et al. (2016) found that mandatory counseling regulations forced clinics to hire more nurses, change schedules and tasks, and extend work tasks since only clinical practitioners could provide counseling services. Additionally, those working in independent abortion clinics experience high burnout and fatigue compared to those in hospitals (Martin et al., 2014). Within abortion clinics, there is large overlap in job responsibilities because clinics are often understaffed. This is essential for understanding the impact independent clinics have on their communities compared to larger clinic and hospital systems. Ultimately, communities need to recognize the importance of their local facilities in order to support them.

Due to the limited number of abortion clinics in the United States, there are fewer providers working in independent clinics. The future of abortion care is becoming less clear and

more centralized as states continue to pass restrictive abortion-related laws, causing clinics to close. 56 independent abortion clinics closed between 2015-2017 and 41 closed between 2018-2020 (Madsen et al., 2017; Abortion Care Network, 2020). As clinics continue to close due to financial pressures and anti-abortion legislation, abortion care will fall on certain clinics and their providers will be overworked and face high risks of burnout. This is already seen in certain states such as Texas, where abortion is becoming more restrictive leading to patient numbers decreasing at independent clinics and providers reducing the level of care they can give patients in need (Harper, 2021). Because the national abortion community is getting smaller due to state restrictions that target abortion provision and services, it is necessary to explore the ways independent clinics – and providers working in those clinics – are impacted because their presence directly relates to how their communities are being served.

Providers are not the only ones affected by abortion stigma

Some providers recalled having protestors outside their homes along with outside of their clinics. However, they are not the only ones affected– their families experience this stigma as well. Children grow up seeing and hearing protestors outside of their parents' workplaces and their homes, and are treated differently in certain social situations. Individuals in providers' interpersonal networks can experience abortion stigma as a consequence of their association with abortion providers. This association can leave lasting impacts on those in providers' interpersonal networks but has not been studied within the scope of abortion research.

Disclosure is not always a choice

Similar to individuals who have sought or received abortions, disclosure was central to providers' relationships with their support networks. Literature explains the depth of abortion stigma and its impact on providers, concluding that providers across the country have similar

stigmatizing experiences and that one conflict providers face is deciding who and which contexts to disclose their occupations to (Harris et al., 2011). Disclosure is also sometimes a challenge for individuals who have received abortions, who often disclose because they are seeking resources to find abortions (Rossier et al., 2021). Additionally, disclosure is linked to perceived abortion stigma or stigma consequence, which can extend to how abortion providers choose to disclose (Shellenberg et al., 2011).

The providers in this study echoed these struggles, yet demonstrate a nuance of disclosure: disclosure often was not a choice. Within their interpersonal networks of family and friends, providers chose who to disclose to. However, within community networks of vendors and maintenance companies, providers often had no choice but to disclose that they worked in an abortion clinic. Ideally, companies and vendors should provide services regardless of who their customers are but as seen in this sample, they treat abortion clinic personnel differently. This contrast is only seen among abortion providers, not other healthcare professionals or individuals who have received abortions.

Clinic culture

Abortion providers felt most supported within the walls of their clinics. Positive clinic culture and work environment were constant across all participants. Their shared experiences working in a field that is attacked, harassed, and constantly changing brings about a safe space and a sense of understanding between those involved. Abortion clinics face high external pressure yet provide nonjudgmental, quality patient-centered care (Madsen et al., 2017). There is something to be said about the tenacity and willpower of abortion providers who continue to fight and work despite the various challenges they face. This might have to do with their experience in this field and the type of care they provide their patients. The way providers treat

their patients is a reflection of how they treat each other, and vice versa. All providers spoke on the importance of not judging their patients for their decisions and ensuring that patients were given the support they needed during this time. The fact that they continue to work despite this pressure and stigma proves that they are resilient but also shows that they need more support from all networks, especially the ones that impose and enforce these regulations.

Participants took pride in the fact that they treated each patient with compassion, empathy, respect, and felt their occupations were meaningful and necessary. This is consistent with how abortion care is perceived by individuals in the field, as it is associated with provision of compassionate, supportive, and nonjudgmental care (Gould et al., 2012). This form of care is not seen among traditional medical practices – many individuals feel judged by their primary care practitioners because of their weight or health concerns they bring to the clinic – especially if they are people of color or lower-income individuals, which influences patients' trust in their providers and perpetuates health disparities (Chapman et al., 2013).

Participants also recognized that working in the abortion field is not a "normal job" compared to other healthcare professions. They stay in this field because they believe their work is their calling and consider it rewarding and fulfilling, despite the way abortion and abortion providers are portrayed and treated in the U.S. Negative public perceptions and propaganda of abortion, abortion providers, and individuals seeking abortions as "wrong" or "evil" have permeated public rhetoric for far too long (Kumar et al., 2009). However spaces within abortion clinics are the opposite of what anti-choice activists and supporters have made them out to be. The public's disapproval of abortion has not invaded the clinic space but lingers directly outside in the form of protestors. This can be another reason why abortion clinic personnel are able to

continue their work; they recognize that they are collectively working to dismantle public perceptions towards abortion and provide quality care to their patients in a hostile atmosphere.

Strengths and Limitations

This study has several strengths. First, it explores the experiences of different levels of abortion providers instead of focusing solely on physicians, who are often the source of abortion provider research. In addition, the focus on independent clinics rather than providers working in hospitals, physician offices, and larger hospital networks is important because independent clinics provide the majority of abortion care in the U.S. (Madsen et al., 2017; Abortion Care Network, 2020). Another strength is that saturation was reached with 15 interviews, but 25 additional interviews are available to provide further depth and nuance to these results. This study also employed a true constant comparative method because all results were discussed with the primary person who collected this data. Lastly, although some providers' length of experience covered decades, their insight brings a different perspective to a field that has high turnover rates (Janiak et al., 2018).

Results should also be approached in light of certain limitations. The participants in this sample worked in the Midwest and Southern U.S.; their experiences may not extend to areas of the country that have different or more liberal abortion policies. However because clinics and providers in these states face political hostility, it is vital to understand the challenges they face in providing abortion care and how they want to be supported.

Public Health Implications

These findings reflect the importance of hearing and learning from abortion care providers of all levels in their experiences with social support and abortion stigma. Future abortion-related research should aim to include providers of all levels to share their experiences and stories – similar to individuals who have sought or received abortions – to normalize but also recognize that abortion providers have unique work experiences that transcend traditional workspaces. It is important to capture all providers' experiences in abortion research to understand the variety of challenges affecting clinic personnel in providing abortion care. Abortion continues to be a point of contention globally and recognizing the complexity of clinic personnel's experiences is vital in understanding how to support clinics and keep them running.

Secondly, abortion clinics establish a standard of care that is not seen in other medical spaces. Abortion care has traditionally taken a feminist approach that centers justice in which patients are seen as equal partners in their health, compared to other healthcare settings in which physicians are seen as those who know best (Madsen et al., 2017). Aspects of patient-centered care include treating patients with respect and dignity, properly communicating with them, and recognizing their autonomy (Sudhinaraset et al., 2020). To ensure that individuals are empowered to make decisions for their health, independent abortion clinics should serve as a model for other sexual and reproductive healthcare facilities. If similar medical practices follow this model, patients will feel supported and heard by their healthcare providers, hopefully leading to better health outcomes overall.

Lastly, this thesis demonstrates the power communities hold in changing the course of movements and public opinion. Public support for abortion, abortion providers, and independent clinics can influence local governments, which can start to establish systemic change in abortion

policies. This was recently seen in Argentina where abortion was legalized after years of grassroots movements and activism to change public and government attitudes towards abortion. The groundwork laid by these activists allowed for this bill to pass despite anti-choice opposition and a long history of anti-abortion legislation (Politi & Londoño, 2020). While this is not an easy nor quick task to fulfill, establishing community support systems can sustain independent clinics and providers in business as well as maintain places for individuals to seek safe abortion services.

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Appendix A: Codebook

Code	Definition	Example
Perceptions of community support	Participant describes the extent of support from their community, which can be local, professional or personal and/or reasoning for perceived community support.	"Everybody in the family knows what I do, everybody's supportive." "We have people that I think support behind the scenes, but until people really stand up and say, you know, enough is enough then, you know, it's just going to continue to get worse." "...I have to call the police to double check that they're on their way...And that's just the police here."
Desires for community support	Participant gives examples of ways their community can show support for their clinic and/or the larger abortion movement and network.	"...I can just say like, donating pajama pants, scrub pants...having that is helpful...I always direct people to like, NNAF site...if they wanna help the clinic."
Disclosure/non-disclosure	Participant describes telling or not telling family, friends, strangers about their job. Can change over time.	"Like the first week in my neighborhood, I couldn't tell people that I work in an abortion clinic because I remember the old neighborhood that I did, people stop[ped] talking to me... my children were not invited for birthday parties and things like that."
Tension within the abortion provider community	Descriptions of the differences in funding, resources, and focus between independent clinics and/or larger funds and between independent clinics and the larger medical community.	"One of the things that is a clear pattern...is to put independent abortion providers out of business" - On PP "I have been told by funds that they don't trust...they don't trust clinical owners...There's the question back and forth...Where, why do you need this money? What are you spending this money on?"
Violence, harassment, and feelings of	Descriptions of perceived safety,	"But you just never know, you never

safety	threats of violence, protestor experiences and/or steps taken to decrease perceived violence.	know when someone's gonna-what's-what's gonna push someone over the edge...I feel pretty safe because we have our locked doors, so people can't get in here. Um, so there's three doors that they have to go through before they can actually get into the clinic. And then, you know, our windows lock and then we put, um, a safety film on our windows just in case there was a bullet or something."
Elements of abortion care	Descriptions of what makes abortion care unique compared to other medical care.	"Abortion care providers, for the most part, are practicing much more ethical medicine than anyone else…We assure that decision-making is rooted in-in patient desire, it doesn't happen anywhere else."
Self-care	Participant describes personal and/or professional coping mechanisms in response to stressors from working in an abortion clinic.	"We think it's a normal job, but we're dealing with a lot more stressors and a lot more-lot more heavy stuff. So maybe we do need extra care."
Race and racism	Descriptions of how race plays a role in the abortion community and provider network.	"...most funds are run by women of color...and most clinics are owned by white women...so I think there's a lot of you know, patriarchal, systemic issues that still exist." "It's really offensive and-and, you know, and it's hurtful and...folks don't understand what it's like to be a Black man, you know, in-in America, in addition to that, to be a-a-a Black person of color, you know, owning an abortion clinic… They treat us people of color totally different than they do, than they do white folks." - on protestors
Barriers to patient access	Descriptions of barriers that patients face in seeking and receiving abortion care.	"I think money. This is probably the number one [barrier]..transportation...childcare… [if] they don't have a working phone."
Barriers independent abortion clinics	Descriptions of local, state, and	"We don't have the money or the

face in providing care	federal barriers that abortion clinics and providers face in providing care.	resources to fight the, you know, deal with these crazy laws…" - on TRAP laws "Um, and a lot of the residents say they wanna do abortions. But then, um, once- once they finish their residency program and they get their- their job, you know, they don't look into the hospital system that's employing them to find out if they can even do abortions because there's a lot of hospital systems where you [can't] do abortions…"
Roe v. Wade	Participant describes feeling anxiety or fear that Roe will be overturned and they won't be able to provide care.	"...We're still, you know, under attack and that we're, uh, possibly looking at, you know, Roe overturned or being severely restricted...And like I tell people all the time. And so, you know, once an abortion clinic closes, you don't really see another one opening."
Identity	Participant describes their work as inherent to their life and/or synonymous with a sense of self.	"Abortion is 95% of my life." Unlike probably other people...it's my identity." "The work that you do everyday should be done…[as] a way of putting your values and your morals and your ethics into practice."
Background	Descriptions of the participant's personal life and background.	"Like coming from a Muslim father and Dominican Catholic mother, we don't talk about [abortion]. In the neighborhood, people did, you know, on the ground."
Clinic history	Descriptions of the clinic's formation, ownership, prior staff, etc.	"Um, and so as those doctors were, you know, reaching retirement, whatever, they-they went to Jane, and they're like, 'Hey, like, we're getting old. Can you do something? You've got all these connections and you know everything,' and so, um,

		she was able to...bring the Women's Health Organization to North Dakota. So, in 1981, the first clinic-abortion clinic opened in North Dakota."
Participant role and responsibilities	Participant describes their current role and responsibilities, can include past positions and/or responsibilities they have accumulated at work.	"Um, I started out doing front office staff, reception, and then I've done some patient education, and then I was like, the clinic coordinator, which would be like an associate director. And then, our founding director retired in 2008. So then I became the executive director in 2008, July."
Clinic services	Descriptions of the clinic's services and/or day-to-day routine.	"Well, on an abortion day, um, it's never the same. Um, it's unpredictable. Um, sometimes it can be really busy, sometimes...not."
Local/state political landscape	Descriptions of the local or states' overall political inclinations and opinions, including attitudes towards abortion.	"...because you're really dealing with the state as far as these abortion regulations [go]."

Appendix B: Study Participant Demographics

Participant ID	Job Title	Age	Gender Identity	Ethnicity	Religious Affiliation	Length of Employment (years)	Clinic Location
2	Executive Director	63	Female	White	Lutheran	39	Duluth, Minnesota
7	Clinic Director & Owner	47	Female	White	Atheist (raised Catholic)	21	Fargo, North Dakota
10	Physician	42	Female	White	None	7.5	Albuquerque, New Mexico
18	Clinic Owner & Administrator	46	Male	Black	Episcopalian	19	Huntsville, Alabama
23	Floor Supervisor	54	Female	Hispanic	Spiritual	26	Houston, Texas
24	Clinic Director	32	Female	South Asian	Hindu	6	Houston, Texas
25	Physician & Owner	77	Male	White	Jewish	39 -contracted	Houston, Texas
27	Assistant Administrator	66	Female	White	Episcopalian	11	Shreveport, Louisiana
28	Administrator	62	Female	White	None	27	Shreveport, Louisiana
32	Counselor	n/a	Female	Multi-racial (Black, Filipina)	n/a	11	Shreveport, Louisiana
35	Director of Patient Advocacy	27	Nonbinary	Multi-racial (Piaute, Apache,	Spiritual	8	Shreveport, Louisiana

				White)			
46	Director of External Affairs	51	Female	White	Episcopalian	8.5	Memphis, Tennessee
52	Counselor	72	Female	Black	Methodist	23	Jackson, Mississippi
53	Clinic Director	47	Female	Black	Christian	18	Jackson, Mississippi
59	Clinic Administrator	29	Female	White	None	8	Bellevue, Nebraska