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Conceptualising abortion stigma

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Abortion stigma is widely acknowledged in many countries, but poorly theorised. Although media accounts often evoke abortion stigma as a universal social fact, we suggest that the social production of abortion stigma is profoundly local. Abortion stigma is neither natural nor 'essential' and relies upon power disparities and inequalities for its formation. In this paper, we identify social and political processes that favour the emergence, perpetuation and normalisation of abortion stigma. We hypothesise that abortion transgresses three cherished 'feminine' ideals: perpetual fecundity; the inevitability of motherhood; and instinctive nurturing. We offer examples of how abortion stigma is generated through popular and medical discourses, government and political structures, institutions, communities and via personal interactions. Finally, we propose a research agenda to reveal, measure and map the diverse manifestations of abortion stigma and its impact on women's health.

Introduction

Unwanted pregnancies and abortion have existed since time immemorial. The seminal work of George Devereux (1976) on the history of abortion around the world points to the frequency of abortion across cultures and time. Chinese, Greek and Roman cultures all developed systems of dealing with unwanted pregnancies and regulating population growth in their respective societies. The Egyptians were some of the first to create abortion techniques, which were discussed and reported in some of their first, and our oldest, medical texts (Devereux 1976).

Today, abortion is one of the most common gynaecological experiences; perhaps the majority of women will undergo an abortion in their lifetimes (Åahman and Shah 2004). Despite its existence across time and its persistence across geographic location, the impact of abortion on women, families, communities and societies differs drastically across the world. Safe abortions – those done by trained providers in hygienic settings – and early medical abortions (using medication to end a pregnancy) carry few health risks (WHO 2003). However, every year, close to 20 million women risk their lives and health by undergoing *unsafe* abortions (Sedgh et al. 2007). Twenty-five percent of these women will face a complication with permanent consequences and close to 66,500 women will die (WHO 2007, 13). The majority of these women live in the developing world and half of those who die are under the age of 25 years (WHO 2007).

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State and societal control over abortion are manifested in different ways. At least 26% of world citizens live in countries where abortion is prohibited (Centre for Reproductive Rights 2008). The paucity of accessible, quality and affordable services and trained providers is another reason why safe abortions remain out of the reach of many of the world's women. Why have so many countries narrowly defined groups of women who can or cannot obtain legal abortion services? Why is something as common as abortion – experienced by 81 women around the world every minute – silenced and ignored even by organisations dedicated to women's health? Why do women continue to experience severe abortion-related injuries and death despite the existence of safe and simple approaches to prevent unsafe abortions?

While extensive research has investigated the public health consequences of abortion and analysed abortion from a human rights perspective, there is a notable gap in the area of abortion stigma. In this paper, we develop an operational definition of abortion stigma and propose some of the ways it is perpetuated and normalised. We see this as a first step to building a framework for comparative, empirical research on whether and how abortion stigma is produced and how it changes over time and place.

Stigma and abortion research

Social science research suggests that health-related stigma develops across a broad array of cultural and social contexts (Link et al. 2004, Weiss and Ramakrishna 2006). Despite their emergence in many settings, the experience of stigma is played out in a 'local world', that is the context of social relationships and cultural constructs (Yang et al. 2007). In the case of abortion stigma, there is limited understanding of how it takes root in particular communities, what its impact is and how it can be countered.

Although ethnographic accounts of abortion experiences[1] often mention stigma as a dimension of women's experience, there is no research on the origins or mechanics of abortion stigma itself. We therefore turn first to Goffman's (1963) conceptualisation of stigma as an 'attribute that is deeply discrediting' that negatively changes the identity of an individual to a 'tainted, discounted one' (3). This concept has been applied to mental illness (Kleinman et al. 1995), leprosy (Opala and Boillot 1996), tuberculosis (Jaramillo 1999, Kelly 1999, Long et al. 2001), the analysis of cancer-related discrimination (Sontag 1978) and HIV/AIDS (Parker and Aggleton 2003, Castro and Farmer 2005, Ogden and Nyblade 2005).

Link and Phelan (2001) deepen our understanding of the way that stigma can be produced and reproduced through a cascade of consecutive social processes:

> In the first component, people distinguish and label human differences. In the second, dominant cultural beliefs link labelled persons to undesirable characteristics – to negative stereotypes. In the third, labelled persons are placed in distinct categories so as to accomplish some degree of separation of 'us' from 'them'. In the fourth, labelled persons experience status loss and discrimination that lead to unequal outcomes. (367)

Stigmatised behaviours need not be visible to be stigmatised. As Goffman (1963) states, the term is 'applied more to the disgrace itself than to the bodily evidence of it' (2). A stigmatised act or condition can bring shame and stigma to the larger group, as Das (2001) states 'stigma is seen as contagious' (10).

To gather a sense of the geographical boundaries of abortion stigma as a recognised term in popular cultures, we conducted a database search of international mass media sources in seven languages (English, Spanish, French, Italian, Portuguese, Dutch and German). This study yielded 428 news items in 42 countries with references to stigma in

the context of abortion (LexisNexis n.d.). Although media accounts of abortion experiences around the world often evoke abortion stigma as a universal social fact, ethnographic and community-based studies of abortion experiences suggest that while it may share common denominators and shared health outcomes, the social production of abortion stigma can also be profoundly local.

Anthropological research on abortion highlights how the meanings of abortion can change situationally and over time (Roe 1989, Morgan 1989, Hoshiko 1993, Rylko-Bauer 1996, Whittaker 2002). Public health literature tends to focus on abortion or unwanted pregnancy as a health outcome and examines the context that leads to this outcome (Varkey et al. 2000, Ganatra and Hirve 2002, Varga 2002). Social scientists have investigated the anti-abortion movements creation of foetal personhood and their use of foetal imagery as a strategy to taint women who have chosen to end 'innocent lives' (Petchesky 1990, 1997).

Defining abortion stigma

The moral worlds in which abortions take place may or may not include controversies about reproductive physiology (the beginning of life, foetal viability, foetal pain), normative sexuality, policies related to abortion (its legal status, how it should be paid for, who is the ultimate decision-maker – woman, male partner or health professional), cultural and religious norms, demographic and political trends and family dynamics. It is entirely possible that there are situations in which abortion stigma does not exist, is minimal or is less stigmatised than another condition. For instance, in Cameroon, Johnson-Hanks (2002) describes a situation where local beliefs about honour, shame and motherhood make abortion less shameful than a mistimed entry into motherhood.

The following four cases provide glimpses into the moral worlds that often frame decisions to terminate a pregnancy.

Zambia has one of the more liberal abortion laws in Africa, but access to safe services remains limited due to a variety of factors including policy restrictions, distance to health facilities, cost, lack of trained providers and stigma. Koster-Oyekan (1998) describes the secrecy, shame, fear of ridicule and taboos associated with abortion. She also reports a high level of unsuccessful abortions that resulted in health complications. Girls who abort are considered infectious, with the ability to harm others (Webb 2000). The potential contagion also extends to providers, hospitals, medical or nursing schools, pharmacies, family members and others.

In Thailand, abortion is only permitted under limited circumstances, women and providers are prosecuted under the law, health complications are common and religious authorities are opposed to easing restrictions on abortion. Whittaker's (2002) research indicates that abortion is understood by villagers to be potentially a reasonable act, given other social values related to motherhood and poverty. While women acknowledge that Buddhism rejects abortion, reality demands 'situational ethics'. It is unclear whether abortion is stigmatised in this context.

In Vietnam, which at one time had the world's highest abortion rate, abortion was considered to be part of the national project of socialism to bring Vietnam into the 'rational' and scientific world. Despite the relatively easy accessibility of abortion services, young women and men experienced felt stigma and expressed feelings of regret that they had committed a sinful and immoral act based on their ideas of family and religion. These feelings led them to keep their abortion a secret (Gammeltoft 2003).

In the Netherlands, Norway and other Scandinavian countries, where abortion is less legally restricted, public attempts to control pregnant women's actions through guilt or shame are cast as deviant, patronising and inappropriate (Scharwächter 2008), yet women who terminate their pregnancies are expected to be contrite or vaguely apologetic when exercising their rights (Løkeland 2004).

These examples demonstrate that abortion stigma – rather than a universal truth – is a social phenomenon that is constructed and reproduced locally through various pathways. We propose a definition of abortion stigma 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. While definitions of womanhood vary depending on local cultures and histories, a woman who seeks an abortion is inadvertently challenging widely-held assumptions about the 'essential nature' of women. We hypothesise that there are at least three archetypal constructs of the 'feminine' that can be transgressed through an abortion experience: female sexuality solely for procreation, the inevitability of motherhood and instinctual nurturance of the vulnerable. To choose to avert a specific birth, counters prevailing views of women as perpetual life givers and asserts women's moral autonomy in a way that can be deeply threatening. Women, who seek induced abortions, either clandestinely or through established health systems, may be perceived as challenging the inescapability of maternity and defying reproductive physiology (Rylko-Bauer 1996, 480, Erviti, Castro, and Collado 2004, Bradshaw et al. 2008).

Unlike other behaviours that confound expectations of women as mothers (e.g. choosing to remain childless or using contraceptives), a woman who terminates a pregnancy often defies long-held ideals of subordination to community needs. She uses her agency to deem a potential life unwanted and then acts to end that potential life. Like some other forms of stigma, a woman who terminates a pregnancy may challenge a moral order. In the case of abortion, the challenge may be to women's moral capacity to make life or death judgements (Keusch, Wilentz, and Kleinman 2006, Paris 2007).

While its root causes are manifold, activists and social scientists often argue that abortion stigma is perpetuated by systems of unequal access to power and resources, narrow and rigid gender roles and systematic attempts to control female sexuality. In Link and Phelan's (2001) words:

> Finally, stigmatisation is entirely contingent on access to social, economic and political power that allows the identification of differentness, the construction of stereotypes, the separation of labelled persons into distinct categories and the full execution of disapproval, rejection, exclusion and discrimination. (367)

The power dynamics that underline abortion are part of an ideological struggle about the meaning of family, motherhood and sexuality (Petchesky 1990). Power differentials are expressed across women's life spans and play out in a unique way in relation to those experiences unique to women – such as pregnancy, childbirth and abortion – that often do not benefit from sufficient political or financial resources. Sexual activity, specifically female sexuality, is at the core of abortion stigma because it may amplify transgressions of stated norms about who, when, why and how to have sex (Bleek 1981, Gilmore and Somerville 1994). Similarly, suitability for motherhood and acceptability of pregnancy termination is determined by a host of individual characteristics including socio-economic status, occupation, race or ethnicity and age. These in turn are shaped by larger regulating social forces such as medical, economic and political structures (Foucault 1973). The fact that so many women do have abortions, despite powerful barriers, indicates that this is contested space where agency and resistance are dynamic.

Production of abortion stigma

In this section we apply Link and Phelan's (2001) conceptualisation of stigma to the abortion issue. Stigma can only be created by over-simplifying complex situations and abortion is no different. This is especially true in creating the first stage of stigma production: the marking of human differences.

The decision to terminate a pregnancy is highly contextual in terms of culture and community, but also within an individual's life trajectory. The decision to terminate a pregnancy does not take place in a vacuum, instead it is a result of a particular set of often quite complex circumstances. Yet over-simplifying and denying the frequency with which abortion occurs is fundamental to the creation of this marked category. In addition, widespread practices of under-reporting and intentionally misclassifying abortion procedures by women and providers alike results in misconceptions about prevalence (Fu et al. 1998, Jones and Kost 2007). The invisibility of abortion stigma may have an impact on prevalence data. Only 35–60% of actual abortions are reported in surveys (Jagannathan 2001). A mutually reinforcing cycle of silence makes it challenging to know the true prevalence of abortion in a given community (see Figure 1).

Once the exceptionality of abortion is rhetorically established, it is possible to create a category of 'women who abort' as deviant from the norm. In order to assure that an abortion experience expels a woman from the normative category of 'woman', labels and generalisations are applied 'linking her to a set of undesirable characteristics that form a stereotype', the second component of stigma (Link and Phelan 2001, 369). Various labels such as promiscuous, sinful, selfish, dirty, irresponsible, heartless or murderous are applied to women who abort in different contexts (Roe 1989, Koster-Oyekan 1998, Belanger and Hong 1999, Ganatra and Hirve 2002, Whittaker 2002, Schuster 2005).

These negative stereotypes belie the fact that many abortions are undertaken to preserve the health and wellbeing of family members (Alan Guttmacher Institute 1999). Married women with infants are among those most likely to avail abortion services and women who terminate a pregnancy in one instance may often continue subsequent pregnancies (Winikoff 2007). The separation of these marked women from 'normal'
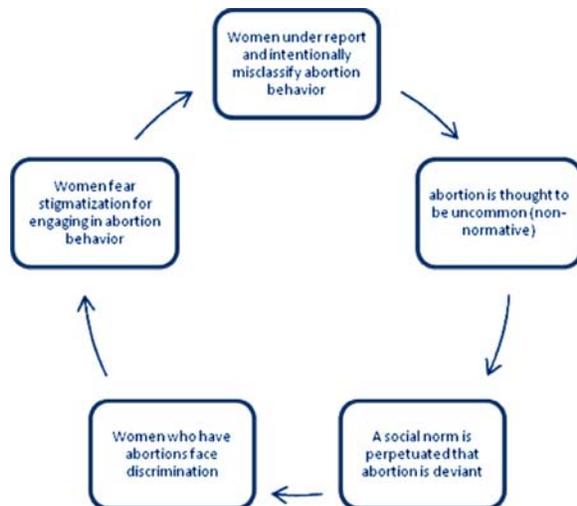

Figure 1.   The prevalence paradox: the social construction of deviance despite the high incidence of abortion.

women achieves Link and Phelan's third component of stigma. Silence and fear of social exclusion keeps women and others from speaking out in support of those who do abort, thus sustaining the negative stereotype. Indeed, women who have had abortions may even take public stands against it (Faundes et al. 2004, Joffe and Cosby 2007).

The final process of abortion stigma is overt discrimination. The manifestations of enacted stigma on an interpersonal level may include: denial of accurate medical information, excessive fees for services, verbal or physical abuse, expulsion from school or employment, public shaming, endangerment of marital prospects, community ostracism, poor quality of services or the use of untrained providers in unsafe conditions (Koster-Oyekan 1998, Varga 2002, Erviti et al. 2004, Lithur 2004, Schuster 2005).

The transience of a safe abortion experience makes abortion stigma potentially different than stigma associated with a chronic or disfiguring illnesses. With abortion stigma there is no contagion, causative agent, diagnosable disease or visible marking. If an abortion is performed safely and early, there is no enduring stigmata to indicate that a woman has had an abortion. The potential invisibility of many women who have safe abortions in relative privacy allows some women to avoid self-identifying or adopting a tainted identity linked to the experience.

Locating abortion stigma

Abortion stigma can be articulated in various spaces and mechanisms. Heijinders and Van der Meij (2006) have outlined a geography of health stigma to draw attention to the many levels where actions are needed. We adapted their model to explore how abortion stigma manifests in (1) framing discourses and mass culture, (2) governmental/structural, (3) organisational /institutional, (4) community and (5) individual levels (Figure 2).

Framing discourse and mass culture

Framing discourses, communication that intends to shape public opinion, link women to a set of undesirable characteristics that form a stereotype (Link and Phelan 2001, 369). Critical analyses of language, framing strategies and discursive elements used by women, communities, religious groups, medical providers, lawyers, anti-reproductive rights activists and the media, are important to understanding how abortion stigma changes over
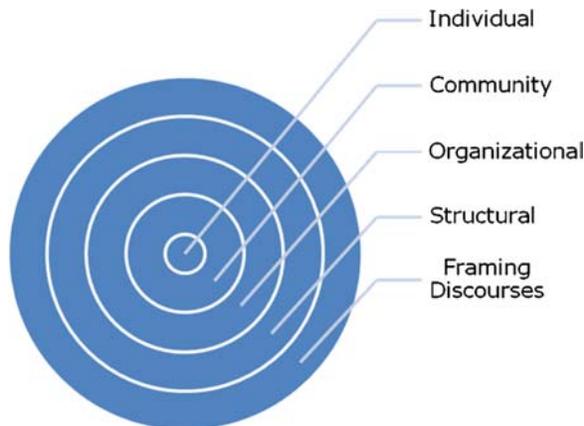

Figure 2.   Levels of abortion stigma.

time (Benford and Snow 2000, Rohlinger 2002, Marx Ferree 2003, Rohlinger and Meyer 2005, Rohlinger 2006, Hipsher 2007).

Many examples of how framing discourse can draw or deflect status loss are found in the global language of pregnancy termination. In many parts of the world, abortion is described by women and communities as a 'delayed' or 'missed' menstrual cycle, a 'dropped' or 'lost' pregnancy, or in terms that communicate the impermanence of pregnancy without assigning agency to anyone (Renne 1996, Sobo 1996, Whittaker 2002, Schuster 2005). In contrast, some medical discourses categorise abortions as spontaneous or induced to locate agency and ascribe responsibility (Rance 1997, Erviti et al. 2004).

Those who provide abortions are often referred to as 'abortionists' and 'murderers' by other providers, those opposed to abortion, the media and others in many places around the world (Mitchell et al. 2004). These are highly stigmatising categories that contribute to the exclusion of pregnancy termination as a legitimate part of reproductive healthcare by equating it to an abhorrent crime. This discursive frame seeks to create a schism between all health providers and those who provide this particular medical intervention. In Bolivia, by contrast, service providers often describe their work as 'saving women' to counter perceived attempts at marginalisation and to deflect stigma (Rance 1997). Across contexts, euphemisms such as 'menstrual regulation' provide linguistic terrain for providers to cast their work in a positive, self-affirming light (Pheterson and Azize 2005).

As the controversy around abortion has intensified and globalised in the past decade, we have seen the popular ascendancy of a discourse of foetal personhood (Franklin 1991, Petchesky 1997, Zechmeister 2001). Feelings, sentience, desires and other facets of autonomy (except actual biological autonomy) have been ascribed to this foetal subject (Mitchell 2001, Gammeltoft 2007). Attributes of innocence, purity, vulnerability and filial love have been rhetorically assigned. By conflating a developing foetus with an actual baby through the popular media, culture and art, abortion stigma becomes embedded in popular discourse (Mitchell 2001, Bashour, Hafez, and Abdulsalam 2005). The destruction of an imagined, fully anthropomorphised being is easier to portray as violent, cruel and unjustified. The proliferation of ultrasound and transvaginal video have helped to give form and dynamism to a heretofore ambiguous 'Other' and have catapulted the foetus into the public imagination as a counterclaimant for space and control over women's bodies (Franklin 1991, Petchesky 1997, Zechmeister 2001).

Governmental/structural factors

In addition to being a social discreditation process, stigmatisation is often an indicator of deep social inequalities (Parker and Aggleton 2003). Policy and law are reflections of ideologies and thus norms that fuel abortion stigma are enshrined in the core structures of many societies. Abortion stigma can be found embedded in economic, educational, legal, health and welfare systems. For instance, in 69 countries, abortion is considered a crime and the criminalising of this very common procedure that only women need is another indication of how gender discrimination can become enshrined in policy and law (Centre for Reproductive Rights 2008).

In foreign policy, abortion stigma has until recently been reflected in US Government international policy. Through what was termed the 'global gag rule', the US Government mandated that non-US organisations receiving US family planning funds cannot perform, advocate for, counsel, refer for abortion services, even when these activities are supported by their own, non-US funds and are lawful under their national sovereign legislation. The gag rule stigmatises in two ways. First, it marginalises abortion services by physically

isolating them from other reproductive health services. Second, the gag rule seeks to silence and forestall abortion advocacy. The gag rule has effectively curtailed the work of groups that used to be outspoken about women's rights (Global Gag Rule Impact Project 2003).

Organisational/institutional influences

Institutions may create or perpetuate abortion stigma through their policies, architecture and norms. Organisations that physically separate abortion services from other medical care in health facilities create missed opportunities for meeting women's other health needs. Where abortion is segregated, women are less likely to receive post-abortion contraception, HIV counselling, STI treatment, cervical cancer screening or other services they may need (Johnson et al. 2002, Gallo et al. 2004, Plotkin, Masepuka, and Vilili 2006).

The lack of systematic training of abortion providers in medical schools is an example of how institutional policies can sustain abortion stigma. In the USA, less than 27% of obstetrics and gynaecology residency programmes require first-trimester abortion training. This has contributed to the 11% decline in abortion providers in the USA between 1996 and 2000. In 2000, 87% of US counties lacked an abortion provider (Guttmacher Institute 2006).

Abortion stigma can also be reproduced by insurance companies who limit the extent of abortion coverage to specific groups or situations. In some countries, public insurance or welfare systems regulate abortion access differently than other gynaecological care. The USA, federal insurance programs for poor women such as Medicaid, and those serving in the military, only cover abortion under narrow circumstances.

Community factors

Abortion stigma and status loss is most often articulated at community and social network levels. Yang et al. (2007) argue that what is at stake for tainted individuals is honour within social networks by suggesting that stigma is 'fundamentally a moral issue in which stigmatised conditions threaten what really matters' (1528). In Indonesia and Ghana, women who seek an abortion before marriage may be labelled 'promiscuous' or worse and this taint can put their chances of marriage at risk (Bennett 2001, Lithur 2004).

Stigma can be dangerous in societies where women's mobility is limited and their access to financial resources is negligible. In contrast, women who benefit from social networks and believe that society supports their decision to terminate a pregnancy, such as women in the UK, may experience less grief and anxiety than those who were unsupported by their communities or the larger environment (Goodwin and Ogden 2007).

Secrecy can also be strategic. Young people in many contexts face the dual challenge of avoiding both the discrediting stigmas of birth out of wedlock and abortion (Bleek 1981, Webb 2000, Mojapelo-Batka and Schoeman 2003). Varga (2002) showed that young women in South Africa felt that they needed to keep their abortions secret. Fear of community rejection often pushes women to take extreme measures and may have fatal consequences. In Zambia, one-third of schoolgirls and two-thirds of women studied reported attempting an abortion entirely alone, often using caustic substances (Koster-Oyekan 1998).

Individual factors

The processes by which women interpret, rationalise and make sense of their abortion experiences are diverse. However, the penetration of abortion stigma into the psyche of

individual women and men is common and perhaps the most destructive locus of abortion stigma. Shame and guilt are the two most common manifestations of internalised abortion stigma (Bleek 1981, Mojapelo-Batka and Schoeman 2003, Lithur 2004). Women themselves may regard their own decisions as rendering them somehow 'unnatural' (Scharwächter 2008). Women may feel that they are selfish or immoral because they perceive themselves to be defying familial expectations, cultural norms or ideas of motherhood. A young woman from Vietnam describes why her abortion experience is stigmatising and how she plans to address the perceived transgression:

> People who make their parents feel sad, who cause their parents worries, they lack filial piety [*hieu*]. I have made my mother sad, but I am going to redeem myself by taking care of her when she gets old. (Gammeltolft 2003, 134)

This framing reflects Yang et al.'s (2007) assertion that stigma diminishes or destroys a lived value and these values vary widely across cultural contexts. Since the mid-1980s, international organisations opposed to abortion have sought ways to essentialise or universalise guilt and shame. They seek to position shame as an organic and necessary physiological response to the medical procedure and not as a consequence of societal scorn and marginalisation of women. The following example from a Kenyan high school textbook alleges an inescapable cause-effect relationship between abortion and self-loathing:

> A girl will always know and live with the reality that she wilfully smothered and killed her unborn child. It is fairly haunting and dauntingly prickly to one's conscience. Hallucinations, dementia and ultimate madness are the likely consequences for the victims. (Otiende, Okello, and Bennaars 2001, 26)

Those opposed to abortion seek to pathologise women through language by introducing a term to capture the alleged mental health impacts: post-abortion syndrome (PAS) (Reardon 2000). Interestingly, Wilson (2007) examines how these activists also attempt to universalise their claims of chronic disability by turning to non-Western traditions. To perpetuate a norm that all women who abort will 'naturally' and perpetually mourn their loss, they invoke ceremonies and traditions outside their cultural milieu to evidence their universality claim (Wilson 2007). Cannold (2002) argues that this should be seen as part of a broader, softer strategy to portray women who abort as unwitting victims, duped into abortions by amoral providers and feminists. This framing may be appealing as it appears to be less overtly hostile to women than the 'foetal centric' rhetoric used in the past by these same individuals and groups. And yet in both these constructions, women continue to be denied moral agency and all women are expected to need motherhood at all times, under all circumstances.

Consequences of abortion stigma

Because abortion stigma is poorly understood and generally not measured, there is little research to indicate what negative consequences (health- or non-health-related) it may have on women's lives. It is important, however, to begin to think about what impacts it may have by drawing on existing health literature. To initiate this thinking, we present a hypothesis of the process of abortion stigma that could lead to negative health outcomes for individual women, acknowledging that the linear nature of the diagram is not suited to stigma (see Figure 3).

Pregnancy termination is a common and simple medical procedure that should be an integral part of any comprehensive reproductive health program (similar to miscarriage management). Instead, however, services are often provided in separate public clinics or by private providers. Both women and providers intentionally misclassify or under-report
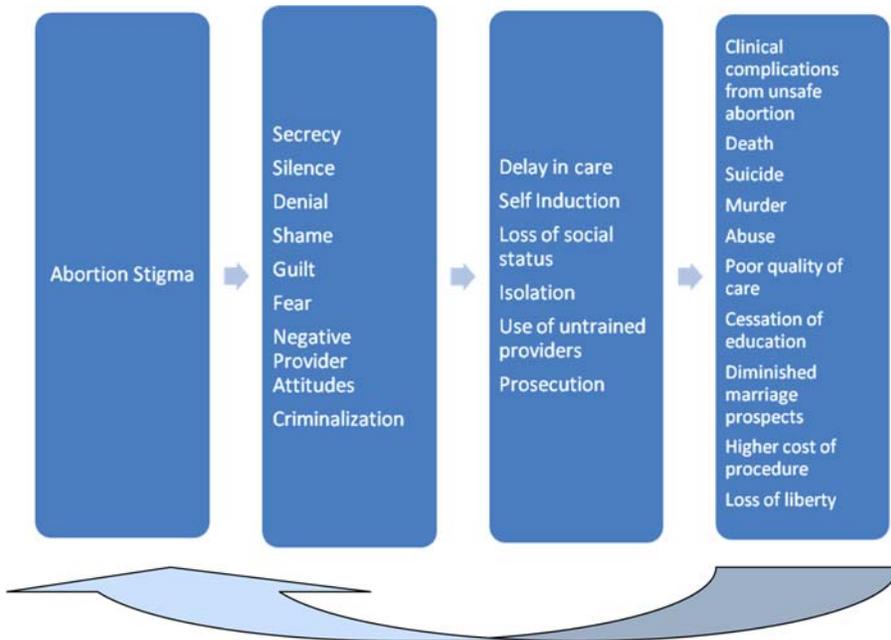
Figure 3.   Hypothesised impact of abortion stigma on women's health.

pregnancy terminations resulting in a paucity of reliable statistics in some countries and the ensuing belief that abortion is uncommon. These occurrences give rise to the creation of social norms that treat the practice of abortion and the women who a have them has deviant and non-normative, which in turn results in death and injury for millions of women globally.

Moving forward

We began this paper with a general discussion about stigma and then, after a brief discussion of the moral world of abortion stigma, provided a definition of abortion stigma that reveals how abortion transgresses traditional norms of womanhood. We then suggest how abortion stigma is created and examine how it is manifested on various levels. We posit that abortion stigma is potentially multi-faceted, multi-directional and its meaning and expression are likely to be context specific.

    We find that abortion stigma is a 'compound stigma', that is, it builds on other forms of discrimination and structural injustices. Stigma is dependent on the appropriation and use of different forms of power. Ultimately, abortion stigma serves to erase and disguise a legitimate medical procedure, discredit those who would provide or procure it and undermine those who advocate for its legality and accessibility. However as Castro and Farmer (2005) caution, we must be careful not to ascribe disproportionate import to stigma and allow it to paralyse us into inaction. Indeed the roots of abortion stigma – narrow gender roles, intent to control female sexuality, compulsory motherhood – are social constructs that can be deconstructed. As in the case of HIV and AIDS, we must empirically determine what role stigma plays, how it is expressed in particular communities and how it can be countered most effectively. Only then can we design meaningful advocacy strategies and clinical interventions to address abortion stigma. There is, therefore, an urgent need for evidence-based and woman-centred knowledge about the impact of

abortion stigma. Along these lines, we have identified three complementary tasks for moving forward the global understanding of abortion stigma.

Firstly, there is an extensive research agenda to be pursued. It is critical to understand abortion stigma better, measure it empirically, deconstruct it in particular contexts and re-construct its contours at a more general level. In order to reflect the fact that abortion stigma is neither natural nor 'essential', research should explore historical periods and country contexts where the role of abortion stigma remains minimal or is declining. While most stigma research has focused on the individual, psychological level, we feel that this would be inappropriate for abortion stigma. We concur with Aggleton, Parker and Mulawa (2003) and Yang et al. (2007) that the community should be the central locus of research and, ultimately, resistance to abortion stigma.

Comparative qualitative and quantitative research on the scope and manifestations of felt and enacted abortion stigma, will help to reveal how ideologies related to gender, female sexuality and motherhood sustain or undermine abortion stigma in specific contexts. Further, research must include both stigmatisers and stigmatised as they share an often-contested social space and struggle to define values and norms (Weiss and Ramakrishna 2006).

The relationship between the law and abortion stigma merits further research. Liberalising abortion laws may help to change abortion-related norms and behaviours or they may heighten stigmatising attitudes. Legal restrictions on abortion jeopardise women's health and lives, but their relationship to societal climates of secrecy, denial and discrimination deserves scrutiny. In countries like Romania and South Africa, liberalisation had a direct and positive impact on maternal mortality (Hord et al. 1991, Jewkes et al. 2005). However, whether the levels of felt and enacted abortion stigma have also declined is an open question. Initial thinking by Burris (2006), especially on the role law plays in the resistance to stigma, deserves further attention.

The relationship between public discourse and abortion stigma also deserves more analysis. Cultural phenomena, such as the rhetorical personification of a foetus in the USA, deserve greater attention as vehicles for solidifying abortion stigma in the linguistic terrain (Morgan 1989).

Secondly, the development of programmes and interventions to reduce abortion stigma and multi-country pilot testing of these strategies are needed. Future interventions should take into account what has been learned about stigma in other fields, decreased life opportunities and increased social inequities. A promising start is the in-depth work on HIV and AIDS-related stigma (Aggleton, Parker, and Mulawa 2003, Nyblade et al. 2003). Participatory research that has the potential for helping women to articulate the steps to dismantling stigma should be a central part of this approach.

Thirdly, there is a need for rigorous evaluation of the abortion stigma reduction interventions that are currently being implemented. While some have been designed to measure and evaluate stigma, most interventions were not designed with the sole objective of reducing stigma so causality may be challenging to attribute.

Re-framing abortion is a complicated and long-term process, but it is not too much to hope that in the future women who terminate unwanted or unhealthy pregnancies and doctors who assist them might not be perceived as tainted or discredited, but rather normal and even respectable within the context of their families, their communities and their lives.

Note

1. The general term 'abortion' refers to induced abortion rather than spontaneous abortion or miscarriage.

References

Aggleton, P., R. Parker, and M. Mulawa. 2003. *Stigma, HIV/AIDS and discrimination in Latin America and the Carribbean*. Sustainable Development Department Technical Paper Series. Washington, DC: Inter-American Development Bank.

Aahman, E., and I. Shah. 2004. *Unsafe abortion: Global and regional estimates of unsafe abortion and associated mortality in 2000*. 4th ed. Geneva, Switzerland: World Health Organisation.

Alan Guttmacher Institute. 1999. *Sharing responsibility: Women, society and abortion worldwide*. New York: Alan Guttmacher Institute.

Bashour, H., R. Hafez, and A. Abdulsalam. 2005. Syrian women's perceptions and experiences of ultrasound screening in pregnancy: Implications for antenatal policy. *Reproductive Health Matters* 13, no. 25: 147–54.

Belenger, D., and K. Hong. 1999. Single women's experiences of sexual relationships and abortion in Hanoi, Vietnam. *Reproductive Health Matters* 7, no. 14: 71–82.

Benford, R., and D. Snow. 2000. Framing processes and social movements: An overview and an assessment. *Annual Review of Sociology* 26: 611–39.

Bennett, L.R. 2001. Single women's experiences of premarital pregnancy and induced abortion in Lombok, Eastern Indonesia. *Reproductive Health Matters* 9, no. 17: 37–43.

Bleek, W. 1981. Avoiding shame: The ethical context of abortion in Ghana. *Anthropological Quarterly* 54, no. 4: 203–10.

Bradshaw, S., A. Criquillion, V.A. Castillo, and G. Wilson. 2008. Talking rights or what is right? Understandings and strategies around sexual, reproductive and abortion rights in Nicaragua. In *Gender, rights and development: A global sourcebook*, ed. M. Mukhopadhyay and S. Meer, 57–68. Amsterdam: Royal Tropical Institute (KIT).

Burris, S. 2006. Stigma and the law. *Lancet* 367: 529–31.

Cannold, L. 2002. Understanding and responding to anti-choice women-centred strategies. *Reproductive Health Matters* 10, no. 19: 171–9.

Castro, A., and P. Farmer. 2005. Understanding and addressing AIDS-related stigma: From anthropological theory to clinical practice in Haiti. *American Journal of Public Health* 95, no. 1: 53–9.

Centre for Reproductive Rights. 2008. *The world's abortion laws*. New York: Centre for Reproductive Rights.

Das, V. 2001. Stigma, contagion, defect: Issues in anthropology of public health. National Institutes of Health. www.stigmaconference.nih.gov/FinalDasPaper.htm

Devereux, G. 1976. *A study of abortion in primitive societies*. New York: International Universities Press.

Erviti, J., R. Castro, and A. Collado. 2004. Strategies used by low-income Mexican women to deal with miscarriage and 'spontaneous' abortion. *Qualitative Health Research* 14, no. 8: 1058–76.

Faúndes, A., D.G. Alves, N.J. Andalaft, and M.H. de Souza. 2004. The closer you are, the better you understand: The reaction of Brazilian obstetrician-gynaecologists to unwanted pregnancy. *Reproductive Health Matters* 12, suppl. 24: 47–56.

Foucault, M. 1973. *The birth of the clinic: An archaeology of medical perception*. London: Tavistock Publications.

Franklin, S. 1991. Foetal fascinations: New dimensions to the medical-scientific construction of foetal personhood. In *Off-centre: Feminism and cultural studies*, ed. S. Franklin, C. Lury, and J. Stacey. New York: Routledge.

Fu, H., J.E. Darroch, S.K. Henshaw, and E. Kolb. 1998. Measuring the extent of abortion underreporting in the 1995 national survey of family growth. *Family Planning Perspectives* 30, no. 3: 128–33.

Gallo, M., H. Gebreselassie, M.T.A. Victorino, M. Dgedge, L. Jamisse, and C. Bique. 2004. An assessment of abortion services in public health facilities in Mozambique: Women's and providers' perspectives. *Reproductive Health Matters* 12, suppl. 24: 218–26.

Ganatra, B., and S. Hirve. 2002. Induced abortions among adolescent women in rural Maharashtra, India. *Reproductive Health Matters* 101, no. 9: 76–85.

Gammeltoft, T. 2003. The ritualisation of abortion in contemporary Vietnam. *Australian Journal of Anthropology* 14, no. 2: 129–43.

Gammeltoft, T. 2007. Sonography and sociality obstetrical ultrasound imaging in urban Vietnam. *Medical Anthropology Quarterly* 21, no. 2: 133–53.

Gilmore, N., and M.A. Somerville. 1994. Stigmatization, scapegoating and discrimination in sexually transmitted diseases: Overcoming 'them' and 'us'. *Social Science and Medicine* 39, no. 9: 1339–58.

Global Gag Rule Impact Project. 2003. 'Access denied: US Restrictions on international family planning.' Population Action International. www.globalgagrule.org

Goffman, E. 1963. *Stigma: Notes on the management of spoiled identity*. Upper Saddle River, NJ: Prentice Hall.

Goodwin, P., and J. Ogden. 2007. Women's reflections upon their past abortions: An exploration of how and why emotional reactions change over time. *Psychology and Health* 22, no. 2: 231–48.

Guttmacher Institute. 2006. Facts on induced abortion in the United States. http://www.guttmacher.org/pubs/fb_induced_abortion.pdf

Heijnders, M., and S. Van Der Meij. 2006. The fight against stigma: An overview of stigma-reduction strategies and interventions. *Psychology, Health and Medicine* 11, no. 3: 353–63.

Hipsher, P. 2007. Heretical social movement organizations and their framing strategies. *Sociological Inquiry* 77, no. 2: 241–63.

Hord, C., H.P. David, F. Donnay, and M. Wolf. 1991. Reproductive health in Romania: Reviewing the Ceausescu legacy. *Studies in Family Planning* 27, no. 4: 231–40.

Hoshiko, S. 1993. *Our choices: Women's personal decisions about abortion*. Harrington Park Press.

Jagannathan, R. 2001. Relying on surveys to understand abortion behavior: Some cautionary advice. *American Journal of Public Health* 91, no. 11: 1825–31.

Jaramillo, E. 1999. Tuberculosis and stigma: Predictors of prejudice against people with tuberculosis. *Journal of Health Psychology* 4: 71–9.

Jewkes, R., H. Rees, K. Dickson, H. Brown, and J. Levin. 2005. The impact of age on the epidemiology of incomplete abortions in South Africa after legislative change. *BJOG: An International Journal of Obstetrics and Gynaecology* 112: 355–9.

Johnson, B.R., S. Ndhlovu, S.L. Farr, and T. Chipato. 2002. Reducing unplanned pregnancy and abortion in Zimbabwe through postabortion contraception. *Studies in Family Planning* 33, no. 2: 195–202.

Johnson-Hanks, J. 2002. The lesser shame: Abortion among educated women in southern Cameroon. *Social Science and Medicine* 55: 1337–49.

Joffe, C., and K. Cosby. 2007. The loneliness of the abortion patient. Alternet. www.alternet.org

Jones, R.K., and K. Kost. 2007. Underreporting of induced and spontaneous abortion in the United States: An analysis of the 2002 National Survey of Family Growth. *Studies in Family Planning* 38, no. 3: 187–97.

Kelly, P. 1999. Isolation and stigma: The experience of patients with active tuberculosis. *Journal of Community Health Nursing* 16: 233–41.

Keusch, G., J. Wilentz, and A. Kleinman. 2006. Stigma and global health: Developing a research agenda. *Lancet* 367: 525–7.

Kleinman, A., W.-Z. Wang, S.-C. Li, X.-M. Cheng, X.-Y. Dai, K.-T. Li, and J. Kleinman. 1995. The social course of epilepsy: Chronic illness as social experience in interior China. *Social Science and Medicine* 40: 1319–30.

Koster-Oyekan, W. 1998. Why resort to illegal abortion in Zambia? Findings of a community-based study in Western province. *Social Science and Medicine* 46, no. 10: 1303–12.

LexisNexis. n.d. LexisNexis Academic NL. http://www.lexisnexis.nl/dutch/.

Link, B.G., L.H. Yang, J.C. Phelan, and P.Y. Collins. 2004. Measuring mental illness stigma. *Schizophrenia Bulletin* 30, no. 3: 511–41.

Link, B., and J.C. Phelan. 2001. Conceptualizing stigma. *Annual Review of Sociology* 27: 363–85.

Lithur, N.O. 2004. Destigmatizing abortion: Expanding community awareness of abortion as a reproductive health issue in Ghana. *African Journal of Reproductive Health* 8, no. 1: 70–4.

Løkeland, M. 2004. Abortion: The legal right has been won, but not the moral right. *Reproductive Health Matters* 12, no. 24: 167–73.

Long, N.H., E. Johansson, V.K. Diwan, and A. Winkvist. 2001. Fear and social isolation as consequences of tuberculosis in VietNam: A gender analysis. *Health Policy* 58: 69–81.

Marx Ferree, M. 2003. Resonance and radicalism: Feminist framing in the abortion debates of the United States and Germany. *American Journal of Sociology* 109, no. 2: 304–44.

Mitchell, L.M. 2001. *Baby's first picture: Ultrasound and the politics of fetal subjects*. Toronto, Canada: University of Toronto Press.

Mitchell, E.M.H., K. Mwaba, S. Makoala, and K. Trueman. 2004. *A facility assessment of termination of pregnancy (TOP) services in Limpopo Province, South Africa*. Chapel Hill, NC: Ipas.

Mojapelo-Batka, E.M., and J.B. Schoeman. 2003. Voluntary termination of pregnancy: Moral concerns and emotional experiences among black South African adolescents. *South African Journal of Psychology* 33, no. 3: 144–53.

Morgan, L.M. 1989. When does life begin? A cross-cultural perspective on the personhood of fetuses and young children. In *Abortion rights and fetal 'personhood'*, ed. E. Doerr and J.W. Prescott, 97–114. Long Beach, CA: Centerline Press.

Nyblade, L., R. Pande, S. Mathur, K. MacQuarrie, R. Kidd, H. Banteyerga, K. Aklilu, G. Kilonzo, J. Mbwambo, and V. Bond. 2003. *Disentangling HIV and AIDS stigma in Ethiopia, Tanzania and Zambia*. Washington, DC: International Center for Research on Women.

Ogden, J., and L. Nyblade. 2005. *Common at its core: HIV-related stigma across contexts*. Washington, DC: International Center for Research on Women.

Opala, J., and F. Boillot. 1996. Leprosy among the Limba: Illness and healing in the context of world view. *Social Science and Medicine* 42: 3–19.

Otiende, J., G. Okello, and G. Bennaars. 2001. *Peak revision Kenya certification secondary education social education and ethics exam review book*. Nariobi, Kenya: East African Educational Publishers.

Parker, R., and P. Aggleton. 2003. HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action. *Social Science and Medicine* 57: 13–24.

Paris, G. 2007. *The psychology of abortion*. 2nd ed. Putnam, CT: Spring Publications.

Petchesky, R.P. 1990. *Abortion and women's choice: The state, sexuality and reproductive freedom*. Boston, MA: Northeastern University Press.

Petchesky, R.P. 1997. Fetal images: The power of visual culture in the politics of reproduction. *Feminist Studies* 13, no. 2: 263–92.

Pheterson, G., and Y. Azize. 2005. Abortion practice in the northeast Caribbean: 'Just write down stomach pain.' *Reproductive Health Matters* 13, no. 26: 44–53.

Plotkin, M., P. Masepuka, and G. Vilili. 2006. Family planning after PAC for selected clients in Malawi. *PAC in Action* 10: 7.

Rance, S. 1997. Medical discourses on abortion: Case studies in hospitals belonging to the Bolivian public health and social security systems., Executive Summary of the Research Report, unpublished manuscript.

Reardon, D. 2000. The complexity and distortions of post-abortion research. Project Rachel. http://www.hopeafterabortion.com

Renne, E.P. 1996. The pregnancy that doesn't stay: The practice and perception of abortion by Ekiti Yoruba women. *Social Science and Medicine* 42, no. 4: 483–94.

Roe, K.M. 1989. Private troubles and public issues: Providing abortion amid competing definitions. *Social Science and Medicine* 29: 1191.

Rohlinger, D.A. 2006. Friend and foe: Media, politics and tactics in the abortion war. *Social Problems* 53, no. 4: 537–61.

Rohlinger, D.A., and D.S. Meyer. 2005. Framing abortion globally: Transnational framing of access to abortion in the United States, England and Ireland. In *Women's movement in a dynamic and global perspective*, ed. L.A. Banaszak, 197–214. New York: Rowan and Littlefield.

Rohlinger, D.A. 2002. Framing the abortion debate: Organizational resources, media strategies, and movement-countermovement dynamics. *Sociological Quarterly* 43, no. 4: 479–507.

Rylko-Bauer, B. 1996. Abortion from a crosscultural perspective: An introduction. *Social Science and Medicine* 42, no. 4: 479–82.

Scharwächter, P. 2008. Abortion decision making by focusing: A preliminary study. *European Journal of Contraception and Reproductive Health Care* 3, no. 2: 191–7.

Schuster, S. 2005. Abortion in the moral world of the Cameroon grassfields. *Reproductive Health Matters* 13, no. 26: 130–8.

Sedgh, G., S. Henshaw, S. Singh, E. Ahman, and I.H. Shah. 2007. Induced abortion: Estimated rates and trends worldwide. *Lancet* 370: 1338–45.

Sobo, E.J. 1996. Abortion traditions in rural Jamaica. *Social Science and Medicine* 42, no. 4: 495–508.

Sontag, S. 1978. *Illness as metaphor and AIDS and its metaphors*. New York: Anchor Books.

Varga, C.A. 2002. Pregnancy termination among South African adolescents. *Studies in Family Planning* 33, no. 4: 283–98.

Varkey, P., P.P. Balakrishna, J.H. Prasad, S. Abraham, and A. Joseph. 2000. The reality of unsafe abortion in a rural community in South India. *Reproductive Health Matters* 8, no. 16: 83–91.

Webb, D. 2000. Attitudes to 'kabonya mafumo': The terminators of pregnancy in urban Zambia. *Health Policy and Planning* 15, no. 2: 186–93.

Weiss, M., and J. Ramakrishna. 2006. Stigma interventions and research for international health. *Lancet* 367: 536–8.

Whittaker, A. 2002. 'The truth of our day-by-day lives': Abortion decision making in rural Thailand. *Culture, Health and Sexuality* 4, no. 1: 1020.

Wilson, J.T. 2007. Mourning the unborn dead: American uses of Japanese Buddhist post-abortion rituals. Unpublished thesis (PhD), University of North Carolina at Chapel Hill.

Winikoff, B. 2007. Abortion stories. *Lancet* 370: 1305–6.

World Health Organization. 2007. *Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003*. 5th ed. Geneva, Switzerland: World Health Organization.

World Health Organization. 2003. *Safe abortion: Technical and policy guidance for health systems*. Geneva, Switzerland: World Health Organization.

Yang, L.H., A. Kleinman, B.G. Link, J.C. Phelan, S. Lee, and B. Good. 2007. Culture and stigma: Adding moral experience to stigma theory. *Social Science and Medicine* 64: 1524–35.

Zechmeister, I. 2001. Foetal images: The power of visual technology in antenatal care and the implications for women's reproductive freedom. *Health Care Analysis* 9: 4387–400.

Résumé

La stigmatisation de l'avortement est largement admise dans de nombreux pays mais faiblement théorisée. Bien que les médias l'évoquent souvent comme un fait social universel, nous suggérons que sa production sociale est profondément locale. La stigmatisation de l'avortement n'est ni naturelle ni « essentielle » et sa formation repose sur les disparités et les inégalités de pouvoir. Dans cet article, nous identifions les processus sociaux et politiques favorables à l'émergence, au maintien et à la normalisation de la stigmatisation de l'avortement. Nous émettons l'hypothèse de la transgression par l'avortement, de trois idéaux chéris de la « féminité » : la fécondité perpétuelle, l'inévitabilité de la maternité et l'instinct d'élevage des enfants. Nous donnons des exemples de modes d'émergence de la stigmatisation de l'avortement, dans les discours populaires et médicaux, les structures gouvernementales et politiques, les institutions, les communautés et les interactions personnelles. Enfin nous proposons un programme de recherche qui dévoile, mesure et cartographie les diverses manifestations de la stigmatisation de l'avortement et son impact sur la santé des femmes.

Resumen

El estigma que representa el aborto está ampliamente reconocido es muchos países pero se ha teorizado muy poco al respecto. Aunque las interpretaciones de los medios de comunicación muchas veces evocan el estigma del aborto como un hecho socialmente universal, aquí sugerimos que la producción social del estigma en torno al aborto está profundamente arraigado a nivel local. El estigma del aborto no es ni natural ni "esencial" y depende de desigualdades y diferencias de poder para que ocurra. En este artículo identificamos qué procesos sociales y políticos favorecen la aparición, perpetuación y normalización del estigma del aborto. Suponemos que el aborto viola los tres ideales "femeninos" más preciados: la fecundidad eterna, la inevitabilidad de la maternidad y el instinto de crianza. Presentamos ejemplos de cómo surge el estigma del aborto a partir de discursos populares y médicos, de estructuras gubernamentales y políticas, de instituciones, comunidades y a través de interacciones personales. Para terminar, proponemos un programa de investigación para revelar, medir y situar las diversas manifestaciones del estigma del aborto y su repercusiones en la salud femenina.