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Abortion stigma in a pro-choice world: A mixed methods study of abortion stigma in Australia

By

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ABSTRACT

Stigma is a fundamental driver of health inequities. International evidence shows that abortion stigma is pervasive and has a range of health and social impacts. However, in Australia there is a dearth of abortion stigma research to inform stigma prevention and management efforts. To address this critical research gap, this doctoral thesis presents the first Australian – and largest global - study of the extent, predictors, drivers, and experiences of abortion stigma.

This sequential mixed methods research commenced with a comprehensive critical review of literature pertaining to abortion stigma and stigma theory. This informed the development, validation, and implementation of a cross-sectional national survey (tool), named The Australian Abortion Stigma Survey (TAASS), to measure anticipated and perceived abortion stigma among the Australian community. The survey went viral on social media, garnering 57,999 valid responses. TAASS found that most participants have abortion-supportive beliefs and perceive other Australians to be similarly pro-choice. However, most participants also anticipate abortion seekers and providers are likely to experience stigma and discrimination. Abortion-related attitudes and knowledge, as well as age, were found to be primary predictors of abortion stigma.

The survey was followed by a qualitative interview study to explore why young people are most likely to anticipate social consequences associated with abortion, as identified by the survey. Twenty young people, who had and had not experienced abortions, participated in semi-structured interviews. Thematic analysis identified that exposure to American media content, a lack of education about abortion in educational settings, and awkwardness around abortion in the media teach young Australians that abortion is contested and socially risky. While young people commonly resist and reject negative abortion narratives, and despite differences according to gender, religion, and class, abortion related stigma and discrimination are seen to be inevitable.

Building on stigma and abortion stigma research and theory, this thesis makes original theoretical and empirical contributions to knowledge. It provides the first comprehensive Australian dataset regarding perceived and anticipated abortion stigma and identifies the population groups most impacted. It proposes a more nuanced conceptualisation of anticipated and perceived abortion stigma than has been offered to date. Finally, this research informs a conceptualisation of abortion stigma as a social process that is primarily enacted and maintained via socio-political structures, systems, norms, and narratives. It offers an agenda for future abortion stigma research in Australia that focuses on understanding and addressing the socio-political, rather than individual and interpersonal, elements of abortion stigma. It is hoped the findings of this research will support the establishment of evidence-based policies and interventions to address abortion stigma. Addressing abortion stigma is likely to support the Australian Government's commitment to achieve universal access to all reproductive health services, including abortion care, by 2030.

DECLARATION

I certify that this thesis:

1. does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university

2. and the research within will not be submitted for any other future degree or diploma without the permission of Flinders University; and

3. to the best of my knowledge and belief, does not contain any material previously published or written by another person except where due reference is made in the text.

Signed Kari Vallury

Date 10th November 2023

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PUBLICATIONS AND AWARDS

Publications:

As per the Flinders University thesis guidelines, this includes publications I have authored throughout the duration of my PhD candidature that have both been a part of and separate to my PhD research.

- Vallury, K.., Kelleher, D., Mohd Soffi, A.S., Mogharbel, C. and Makleff, S. (2023). Systemic delays to abortion access undermine the health and rights of abortion seekers across Australia. *Aust N Z J Obstet Gynaecol,* 63(4), 612-615.
- Bowler. S., Vallury, K., & Sofija, E. (2023). Understanding the experiences and needs of LGBTIQA+ individuals when accessing abortion care and pregnancy options counselling: a scoping review. *BMJ Sexual & Reproductive Health*, 49, 192-200.
- Sheeran, N., Vallury, K., Sharman, L. S., Corbin, B., Douglas, H., Bernardino, B., Hach, M., Coombe, L., Keramidopoulos, S., Torres-Quiazon, R., & Tarzia, L. (2022). Reproductive coercion and abuse among pregnancy counselling clients in Australia: trends and directions. *Reproductive health*, *19*(1), 170.
- Vallury, K., Baird, B., Miller, E., & Ward P. (2021). Going Viral: Researching Safely on Social Media. *J Med Internet Res*, 23(12), e29737.

Conference presentations:

- Vallury, K. (2022, August). Australia's next generation of abortion seekers: Shamed if they do and shamed if they don't [Rapid fire presentation]. 2022 Joint Australasian HIV&AIDS and Sexual Health Conferences, Sunshine Coast, Queensland, Australia.
- Vallury, K. (2022, July). Qualitative and Quantitative findings from the Australian Abortion Stigma Study [Oral presentation]. Brisbane, Queensland, Australia.
- Ratcliffe, S. & Vallury, K. (2022, July). An evidence-based agenda for addressing abortion stigma in Australia [Oral presentation]. Brisbane, Queensland, Australia.
- Vallury, K. (2022, May). Findings from the Australian Abortion Stigma Study [Oral presentation]. 2022 CHASS PA Conference. Adelaide, South Australia, Australia.
- Vallury, K. (2021). Findings from the Australian Abortion Stigma Survey [Oral presentation]. 2021 Joint Australasian Sexual Health + HIV&AIDS Conferences. September 2021. Online.
- Vallury, K. (2016, November). The Impact of Abortion Attitudes and Stigma on Access in Developed Countries: Findings of a Systematic Review [Rapid fire presentation]. 2016 Australasian Sexual Health Conference. Adelaide, South Australia, Australia.

Awards:

- Flinders University Thesis Write-Up Stipend, Awarded June 2023.
- Best Higher Degree by Research Student Publication, College of Humanities, Arts and Social Sciences, Flinders University. For, "Going Viral: Researching Safely on Social Media". Awarded June 2023.
- DocFest 2020 Best HDR Student Poster Presentation. College of Medicine and Public Health, Flinders University. Awarded September 2020.
- 3MT Competition 2020 Final Runner Up. *Understanding Perceived Abortion Stigma in Australia.* Flinders University. Awarded August 2020.

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CHAPTER ONE: INTRODUCING THE PROBLEM, SIGNIFICANCE, AND STUDY OF ABORTION STIGMA

My own two abortion experiences - in my late teens and twenties - were largely stigma and judgment free. This was partly because I am enthusiastically pro-abortion, as are those in my immediate and extended social and professional networks. It was also thanks to the local, timely, compassionate, and free abortion care available to me. And yet, while experiencing a miscarriage several years after my second abortion I had a frustratingly persistent thought: “perhaps this is punishment for my abortions”.

Abortion stigma is an “understanding that abortion is morally wrong and/or socially unacceptable” (Cockrill et al., 2013, p.3). My internalisation of abortion stigma, despite my own beliefs and experiences, reflects the pervasiveness of negative social narratives about abortion. How and from where do these narratives derive such power?

This doctoral thesis addresses a dearth of Australian abortion stigma research through the implementation of a sequential mixed methods research project. It describes the development and implementation of the first quantitative survey of felt abortion stigma ever to be validated and implemented among a sample of the Australian public. Addressing questions raised and trends identified by the survey, it then presents a qualitative interview study in which the understandings, experiences, and perceived drivers of abortion stigma among young people in Australia are explored. This research offers conceptual and empirical original contributions to the abortion stigma evidence base, including a new measurement tool and insights into the mechanisms by which abortion stigma establishes and maintains its power, even in pro-choice settings.

This introductory chapter establishes the case for the significance and importance of this doctoral research in the context of Australian and global abortion stigma research and practice. Section 1.1 argues for the significance and relevance of this research, introducing the abortion stigma concept and evidence base, and the research gaps this thesis addresses. Section 1.2 situates this research in the Australian context in regard to abortion prevalence, provision, and politicisation. Section 1.3 sets out the aims and objectives of this research, followed by an exploration of the theoretical foundations in Section 1.4. Section 1.5 describes my positionality and identity in relation to the research design, process, and outcomes. Section 1.6 sets out the content and focus of each chapter, and the language used throughout the thesis pertaining to ‘abortion seekers’ and ‘abortion’ is explained in Section 1.7.

1.1 Abortion stigma: the research and the relevance

Research has established an undeniable and concerning link between abortion stigma and abortion accessibility in Australia. Studies have found that the anticipation of abortion stigma is a primary deterrent to abortion provision among health professionals, education among health educators, and of sexual and reproductive health (SRH) service expansion, especially in rural and remote communities (Dawson et al., 2017; De Moel-Mandel et al., 2021; Hulme-Chambers, Clune, et al., 2018; Keogh et al., 2017; Kruss & Gridley, 2014; Millar, 2023). However, there is little Australian research explicitly measuring and describing abortion stigma, particularly beyond the rural health context.

Expanding the evidence base regarding the extent, forms, drivers, salience, and thus power of abortion stigma in the Australian context, with its diversity of human experiences, systems, and beliefs, is critical and urgent. Without it, health practitioners, advocates, policy makers, researchers, citizens, and abortion seekers will unnecessarily struggle to effectively disrupt processes of abortion stigmatisation and address resulting health and social inequities. In turn, this will likely undermine our capacity to meet Australia's reproductive health commitments, including to achieve universal access to all reproductive health services (including abortion care) made in the National Women's Health Strategy 2020-2030 (Commonwealth of Australia, 2018). It remains unclear whether international abortion stigma research findings and interventions are relevant to the Australian context. "To effectively contend with abortion stigma, it is crucial to consider how stigma manifests differently across locations" (Strong et al., 2023, p. 6). Limited local research also means the Australian experience is to date not reflected in abortion stigma theory.

1.1.1 The (abortion) stigma concept

Stigma has been described as a "fundamental cause of health inequalities", given its significant impacts on population health and life outcomes (Hatzenbuehler et al., 2013, p. 819; also see Phelan et al., 2014; Stangl et al., 2019). Despite the potential impact on the many millions of abortion seekers and health professionals involved in abortion provision globally every year, abortion stigma has been under-researched and under-theorised compared with many other health stigmas (Guttmacher Institute, 2016; Kosenko et al., 2019; Millar, 2020).

Since Kumar and colleagues' foundational conceptualisation of abortion stigma, multiple forms of abortion stigma experiences have been identified and described (Kumar et al., 2009). As described in Chapters 2 and 3, these range from individual level internalisation, perceptions, and anticipation of stigma(tisation) to direct and indirect judgment, harassment, and discrimination enacted interpersonally and via laws, policies, systems, and discourse. Abortion stigma experiences can result in shame and guilt, secrecy and social isolation, healthcare avoidance, (attempted) unsafe

abortion, psychological distress and depressive symptoms, barriers to abortion access, and the exceptionalism of abortion in education and health systems (Hanschmidt et al., 2016; Millar, 2023; Sorhaindo & Lavelanet, 2022). Abortion stigma influences and is influenced by the quality, effectiveness, and efficiency of abortion care (Sorhaindo & Lavelanet, 2022), as defined by the World Health Organization (World Health Organization, 2022). "Felt" abortion stigma, which includes perceptions of others' abortion beliefs, abortion norms, and the anticipation of judgment and discrimination, particularly impacts health-seeking behaviours, disclosure, and wellbeing (Aiken et al., 2018; Astbury-Ward et al., 2012; Cockrill & Nack, 2013; Harris, 2012; Harris et al., 2011; Hoggart, 2017; McCoyd, 2010; Tsui et al., 2011).

There has been a recent shift towards understanding abortion stigma at a macro level (Strong et al., 2023). This conceptual shift has been articulated and driven by Millar (2020) and informed by the work of key stigma theorists, including Scambler (2018), Parker and Aggleton (2003), and Tyler and Slater (2018). With this change, abortion stigma is increasingly understood as, "a social process that functions to reproduce and legitimate modes of differential power relations", rather than a primarily individual-level and interpersonal phenomenon (Millar, 2020, p. 1). Abortion stigma is therefore not a universal or inevitable experience. Rather, it is contested and variable (in prevalence and salience) across socio-cultural and geographical contexts. Individual, community, organisational and structural factors affect whether individuals or groups are likely to be affected by abortion stigma (Bommaraju et al., 2016; Coleman-Minahan et al., 2020; Coleman-Minahan et al., 2021; Cowan, 2017; Love, 2018; Rice et al., 2017; Sackeim et al., 2022; Shellenberg & Tsui, 2012)[1]. Developing a comprehensive evidence base regarding the nature, drivers, and impacts of abortion stigma in Australia is vital to improving abortion access and outcomes and for stigma prevention.

In this thesis I argue that abortion stigma exists and operates beyond the individual and interpersonal levels. Global stigmatising and discriminatory narratives and practices are integrated into and perpetuated by systems, norms, and social narratives which have taught, and continue to teach, generations of Australians that abortion is socially taboo. Beliefs that abortion is socially problematic appear to be salient and impactful in the lives of Australia's youth even when individuals' beliefs, values, and experiences of abortion are positive and normalising. I argue that abortion stigma is a powerful form of reproductive control and oppression that is enabled by and perpetuates gender inequity and has been effectively weaponised by the global anti-abortion movement (Ross, 2017). In drawing these conclusions, I build on the work of current leading stigma theorists and align this research with intersectional structural conceptualisations of health and stigma.

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[1] For more details, examples, and references see Chapter 3 Section 3.4.1 and Section 3.4.5.

1.2 Abortion in Australia

The exceptionalism of abortion is undeniable in the Australian health, education, and political/legal systems[2] (Millar, 2023; Sifris & Belton, 2017). The exceptionalism of abortion "at the level of medical institutions, law and policy stems from and reiterates the view that abortion is ancillary, rather than integral, to health care practice and delivery" (Millar, 2023, p.10). Despite this, abortion is not an exceptional or uncommon experience. It is one of the most common and safest gynaecological procedures (Fehlberg et al., 2019; World Health Organization, 2022). Approximately one in four Australian women will experience an abortion in their lifetimes, and over 85,000 abortions are undertaken in Australia annually (Keogh et al., 2021). Transgender, non-binary and gender expansive people also experience abortions (Moseson et al., 2021), although there is a dearth of data indicating the proportion who experience abortions (Jones et al., 2020).

1.2.1 The politicisation, provision, and accessibility of abortion

Studies over the last 20 years have consistently shown majority support for legal abortion in Australia. Over 80% of Australian adults have been found to be 'pro-choice' in that they support abortion legality and/or access in all or some circumstances (Betts, 2004, 2009; de Crespigny et al., 2010). Total opposition to abortion appears only among a small minority of religious groups and among people aged over 75 years (Betts, 2009). Over 85% of obstetrician gynaecologists have been found to hold abortion-supportive views, and 92% support abortion provision in public hospitals (Cheng et al., 2020; de Costa et al., 2010). Abortion as a public or moral 'issue' has been described as (historically) less 'politicised' in Australian than in other countries[3]. In the United States of America (US), for example, abortion beliefs are more divided, more strongly associated with partisanship, and more central to political debate and outcomes (Blazina, 2022; Ratcliff, 2019; Sides, 2022). In line with widespread support for abortion legality, abortion has been decriminalised in the 21st Century in almost all Australian states and territories, with further decriminalisation efforts underway in Western Australia. Melville (2022) has suggested, perhaps optimistically, that decriminalisation indicates the 'depoliticisation' of abortion in Australia.

Most abortions in Australia are provided by private health services. Few states and territories routinely offer publicly funded abortion care (Baird 2023; Srinivasan et al., 2022). Decriminalisation has been found to have variable impacts on the accessibility and provision of abortion and significant barriers to affordable, timely and inclusive abortion care remain (Baird, 2017; Baird 2023; Cleetus et al., 2022; Doran & Hornibrook, 2014; Keogh et al., 2017). These include a lack of political commitment to expanding the public provision of abortion care and a reliance on

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[3] Even so, the politicisation of abortion to achieve anti-abortion policy interests, such as in influencing the availability of early medication abortion drugs, has been significant (Penovic, 2022).

overburdened private providers, an insufficient number of abortion providers and dispensing pharmacies, inconsistent requirements regarding conscientious objection among health professionals, and the ongoing exceptionalism of abortion care in the health care system and medical education curriculum (Children by Choice, 2022b; Cleetus et al., 2022; Commonwealth of Australia, 2023; Doran & Hornibrook, 2014; Melville, 2022; Millar, 2023; Sifris & Penovic, 2021). Early medication abortion (EMA) “has revolutionised access to quality abortion care globally” (World Health Organization, 2022, p.xx). Even when seeking EMA, abortion seekers in Australia are often required to attend several appointments with multiple health services to secure an abortion (Mazza et al., 2020). Abortion access in Australia is commonly described as a ‘post-code lottery’ (Children by Choice, 2022b; Commonwealth of Australia, 2023; Mazza, 2023). This ‘lottery’ is rigged: it disadvantages abortion seekers experiencing inequality and marginalisation due to their location, Medicare or visa status, English language and health literacy, experiences of violence, and socio-economic status (Choice, 2022b; Ireland et al., 2020).

1.3 Aims, objectives, and hypotheses

Given significant gaps in the extant global and local abortion stigma research and theory, this research aims to describe the extent and predictors of perceived and anticipated abortion stigma among the general population. Furthermore, it seeks to elucidate the experiences and drivers of abortion stigma among young people, who are identified as a priority population group in the first phase of this research. The goal is to present a baseline understanding of abortion stigma in Australia on which future research and practice can be built.

Based on previous research, it is hypothesised that a range of individual characteristics, beliefs, and experiences will predict abortion stigma. This research assesses whether anti-abortion beliefs and attitudes, religiosity, political preferences, and traditional gender role beliefs predict abortion stigma in Australia. It also explores associations between abortion stigma and geographical location, abortion experience, pregnancy and parenting experiences, sex, age, educational background, and knowledge.

The specific research objectives include:

- constructing a relevant and validated tool to measure felt (perceived and anticipated) abortion stigma among a sample of the Australian public;
- identifying the extent of felt abortion stigma among people living in Australia (Herein referred to as ‘Australians’) aged 16 years and over;
- identifying the predictors of felt abortion stigma in Australia, including;

    - identifying and describing the population groups that are most likely to be impacted by perceived abortion stigma; and
    - identifying and explaining the experiences and drivers of abortion stigma among a sample of young Australians; and
- offering an interpretation and conceptualisation of abortion stigma that more fully aligns with the scope of abortion stigma experiences and drivers than previous theoretical and conceptual abortion stigma work has done.

1.4 Theoretical foundations

Given the scope and relevance of the research aims, objectives, and potential implications of this thesis I approached the research with a multi-disciplinary lens. I have incorporated the abortion stigma literature's evolving conceptualisations of abortion stigma, described above. This research began with an attempt to measure abortion stigma quantitatively, through a largely positivist paradigm, and with a focus on largely individual-level predictors. In undertaking the interview study, I began to explore and embed understandings of abortion stigma as a social process and issues of power and oppression. As a result, in the qualitative and integrated (quantitative and qualitative) phases of the analysis and interpretation, the research incorporates a critical ontological perspective, and incorporates influences from critical realism, feminist, intersectional, and justice focused scholarship. Critical ontological and theoretical perspectives are central to the conduct of socially transformative and justice-focused research (Mertens, 2010). Such an approach fits with calls for contemporary global public health to centre feminist and intersectional understandings of the influence of power differentials on health outcomes (Davies et al., 2019; Heidari & Doyle, 2020).

Elements of critical realism influence my approach to the concepts of power and resistance. Combining constructivist and realist analytic techniques enable me to test, reflect and build on existing abortion stigma theory. Notable stigma researchers have employed critical realist approaches to understanding stigma (Parker & Aggleton, 2003; Scambler, 2009). These authors and others have demonstrated its value in informing/enabling a shift from individual to power and class focused interpretations of stigma (for example, see Bonnington & Rose, 2014; Monaghan, 2017; Parker & Aggleton, 2003). Critical realism incorporates constructivism and realism and encourages a focus on understanding the interactions among agency, socially constructed realities, and 'real' structures to explain phenomenon such as stigma (Maxwell, 2012; Sims-Schouten & Riley, 2019; Stutchbury, 2022).

My approach to the qualitative component of this research, the joint synthesis, and the development and prioritisation of recommendations for theory, policy, and practice are particularly

informed by intersectional and feminist theory and frameworks. Abortion stigma is firmly rooted in gendered norms and experiences, and in patriarchal systems that disproportionately harm women and gender-diverse people and populations (Abrams, 2015; Kumar et al., 2009). Furthermore, stigma is inseparable from oppression more broadly, such as that related to gender, class, race, and poverty (Scambler, 2009). Feminist and intersectional theories, at their core, prioritise the identification and amplification of marginalised voices and diversity, including but not limited to those of women, in research and knowledge production (Evans, 2019; Lykke, 2010). Trans-disciplinary research has been described as inherently feminist, as it makes porous traditional disciplinary boundaries of traditional positivist (social) sciences (Rayaprol, 2016, p. 378). The implementation of an inclusive intersectional approach to research necessitates prioritising the consideration of, “how individuals and groups, who are situated by multiple social locations and whose social identities may overlap or conflict in specific contexts, negotiate systems of privilege, oppression, opportunity, conflict, and change across the life course and geography” (Few-Demo, 2014, p. 170). Thus, particularly in the later parts of this thesis, I have attempted to centre social and political context, inequities, power relations, and their intersections, in my approach to and interpretation of the research (findings) (Macleod, 2019, p. 47; Bailey, 2011). An exploration of difference and stratified reproductive norms is incorporated into this thesis through explorations of gender, class, and religion.

1.5 Statement of positionality

My positionality and identity as a white, middle-class, Australian PhD student, woman, abortion-seeker, and mother have undeniably influenced the research questions, design, data collection and data analysis processes. As a researcher and advocate, I weave into this thesis my evolving understandings of and increasing commitment to feminist and intersectional research paradigms. Prior to my role as a PhD candidate, I studied and worked in international sexual and reproductive health policy and programming, and rural health research. It was through these professional experiences that my commitment to integrated, preventive, and equity driven approaches to sexual and reproductive health solidified.

During the final three years of this research, I have been working with a leading Australian feminist, pro-choice non-profit organisation, Children by Choice. The organisation provides non-directive pregnancy options and post-abortion counselling, reproductive rights training for health and social sector professionals, and individual, systemic, and political advocacy. My research and advocacy work, and professional and practice communities I have become a part of, have informed my understanding of reproductive rights and justice frameworks and my ability to contextualise this research. I have always been ‘pro-choice’: I am now explicitly ‘pro-abortion’. My hopes for this

research – that it will be academically rigorous and practically valuable – underpin the decisions made at all stages of the research process.

I began to reflect on my own abortion experiences, and experiences of abortion stigma, only in the latter half of the PhD process. I did not explicitly position myself as an 'insider' throughout the entirety of the research process, though neither can I truly be considered an 'outsider' (Wilson et al., 2022). Throughout the interviews, my identity as an abortion seeker became relevant as I chose to share my personal abortion stories with some interviewees as a form of trust building – a benefit of insider positioning - and power distribution (more about this in Chapter 8 Section 8.3.2). My positionality in this regard also came to the fore in my discomfort and hesitance around recruiting and speaking with young people with anti-abortion views (see Chapter 5 Section 51). Making an explicit decision to move into an insider position for the interview process was vital in ensuring I paid sufficient attention to the potential benefits and challenges associated with situating myself in this way (Holmes, 2020; Wilson et al., 2022). Of note, while I moved between insider and outsider status throughout the research in relation to my identity as an abortion seeker, I never left my insider status as a pro-abortion advocate.

1.6 Thesis outline

In the following eight chapters I present a body of research that meets the aims and objectives described above.

In Chapter 2 I introduce, describe, and define the history and evolution of the stigma concept, broadly, and abortion stigma specifically, along with theory and key terms relevant to and used throughout this thesis. Furthermore, I define the domains of abortion stigma and outline the conceptual frameworks that informed the design and conduct of this research.

In Chapter 3 I present a comprehensive overview and critique of the evidence base pertaining to abortion stigma in high-income countries, contextualising this research and identifying local and global research gaps. The review findings are organised thematically, according to the elements of stigma outlined in the Health Stigma and Discrimination Framework (Stangl et al. 2019).

In Chapter 4 I describe and justify the use of a sequential mixed methods research design to address the aims of this doctoral research. I also describe the methodological choices made, and methods used to conduct the quantitative components (Phases 1A and 1B) of this research. This includes an outline of the processes I used to develop and validate a survey tool, named The Australian Abortion Stigma Survey (TAASS), to measure perceived and anticipated abortion stigma

in Australia. It also includes a detailed description of the implementation of the validated survey tool, including participant recruitment, data collection, and analysis methods.

In Chapter 5, I describe the methodology employed in Phase 2, the qualitative component, of the research. I set out the processes of study design, recruitment, data collection and analysis used to undertake an interview study with 20 young Australians. I conclude this chapter by outlining the methods I used to synthesise the quantitative and qualitative findings in the final stage of data analysis and interpretation.

In Chapter 6 I present the findings of TAASS, which elucidate the extent and predictors of, and thus the population groups most impacted by, perceived abortion stigma in Australia. Descriptive, bivariate, and multiple linear regression results are provided, culminating in two multivariable models that describe the primary predictors of anticipated and perceived abortion stigma in Australia. I then discuss the implications of the findings to the research aims and beyond this research, the potential use of TAASS tool in future abortion stigma research, and the role of TAASS findings in guiding the focus of the qualitative component of this research.

In Chapter 7 I provide and discuss the findings of a qualitative interview study undertaken with 20 young Australians to elucidate *why* young people are most likely to anticipate abortion stigma, as identified by TAASS. Results are presented thematically and describe interviewees' experiences of abortion and abortion-related stigmatisation, their perceptions of the extent and drivers of abortion stigma in Australia, and their beliefs about the social stratification of abortion stigma experiences among young people. I discuss these findings in the context of the wider literature and extrapolate four meta-themes related to systemic and structural elements and drivers of abortion stigma.

In Chapter 8 I synthesise the findings of the quantitative and qualitative components of this research and situate them in the context of abortion (and) stigma theory and global literature. I demonstrate the potential implications of the research findings for abortion stigma theory, systemic and structural level intervention design, and future Australian and global research.

In Chapter 9 I present the conclusions of this research. I summarise the original contributions to knowledge and the implications for future research. I provide an overview of the limitations of the doctoral project and offer concluding remarks about the potential of this research and the nature of abortion stigma.

1.6 A note on the overdue evolution of, and language used in this thesis

I have sought to use language that is non-discriminatory, inclusive, intentional, and accurate to the greatest extent possible (Children by Choice, 2022a; MSI, 2020). Most abortion and pregnancy related research and evidence to date has been undertaken with cisgender women, and primarily reflects their experiences. However, "transgender men, nonbinary, gender-fluid and intersex individuals with a female reproductive system and capable of becoming pregnant [also] require abortion care" (World Health Organization, 2022, p. 4). The use of gender neutral and/or gender inclusive language is becoming more accepted in pregnancy and abortion-related research and care (MacKinnon et al., 2021; Moseson et al., 2021). Millar (2023), however, notes the slow uptake of inclusive language in various Australian settings, such as medical education. I attempt to contribute to the normalisation of gender inclusive language in abortion research through intentional inclusive language use. Whenever possible I use the term 'abortion seekers', as recommended by the World Health Organization (2022). When referring to pregnant people who may seek or consider abortion, I primarily use the terms 'pregnant people', again in line with the World Health Organization (2022). I neither seek to underplay nor erase the role of gender-based oppression in the stigmatisation of abortion. Nevertheless, I believe this can be acknowledged concurrently with the use of language that includes all people who may seek abortion services (IPAS, 2018). There are two key exceptions. Given the long history of women-only abortion and pregnancy related research, when referring to prior research findings I use the word 'women' when it most accurately reflects research participants and findings. When developing the survey tool in 2019 I engaged an expert panel to select and develop survey items (detail in Chapter 4). While the panel supported me to avoid assumptions of cis heteronormativity in phrasing survey items, it was agreed that use of the term 'women who have abortions' was appropriate as it aligned with prior abortion stigma literature.

I have also actively chosen to use the term 'abortion' as opposed to 'termination of pregnancy', 'induced abortion' and other variations throughout this thesis. This term is preferred by many abortion seekers (Kaller et al., 2023; Kavanagh & Aiken, 2018). Some medical practitioners argue that use of the term abortion can confuse experiences of induced and spontaneous abortion (Millar, 2023; Steer, 2018). 'Abortion' is nevertheless most widely used and preferred by leading abortion and pregnancy-related services and organisations and journals, and unlikely to be misinterpreted (ACOG, 2022; Kavanagh & Aiken, 2018). Frequent use of the term, despite its historical association with a range of negative stereotypes, may itself serve as a tool of de-stigmatisation (Kavanagh & Aiken, 2018; Kavanagh et al., 2018; Millar, 2023).

Throughout this thesis the terms 'pro-choice' and 'anti-abortion' are used at times for the sake of simplicity and to categorise levels of support for abortion. I recognise that this binary is in itself problematic, both in English language characterisations of abortion attitudes and in other

languages where similar terms alluding to binary beliefs are not present (Valdez et al., 2022). These terms do not capture the nuanced and contextually variable beliefs most people hold about abortion (Pew Research Centre, 2022). The simplicity of the binary of the pro-choice and anti-abortion/pro-life frame risks obfuscating the complex, intersectional nature of reproductive politics and silencing subjugated knowledges (Pew Research Centre, 2022; Ross, 2017). Thus, despite use of the terms at times throughout this thesis, I have attempted to ensure this research otherwise recognises these complexities and avoids falling prey to simplistic conceptualisations of abortion beliefs, justice, and rights.

1.7 Conclusion

In this chapter I have described the scope and socio-political context of this research, the research gaps it addresses, and its significance. I have explained my ontological, epistemological, and theoretical perspective, and outlined the structure of the thesis, grounding subsequent chapters practically and intellectually. There have been substantial conceptual and political shifts in the time I have been completing this research. As a result, this thesis is more relevant than ever, particularly given the Australian (federal) Government's commitment to achieving universal access to reproductive healthcare by 2030 (Commonwealth of Australia, 2023; Department of Health, 2018).

CHAPTER TWO: CONCEPTUALISING ABORTION STIGMA

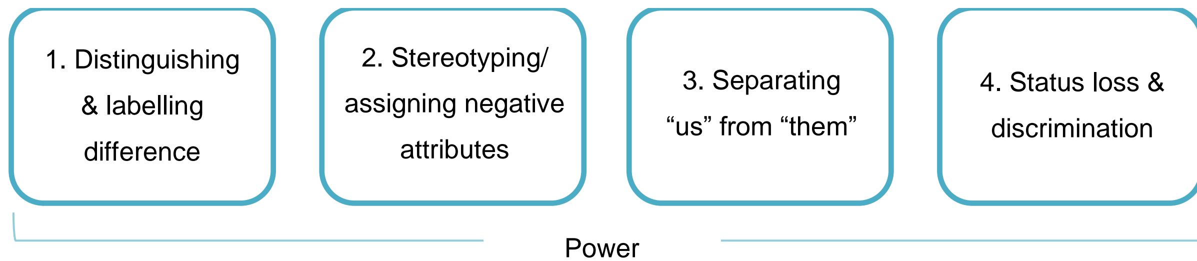
Since Goffman's 1963 book *Stigma,* arguably the most influential account of stigma to date, a plethora of stigma research and theory has emerged in relation to myriad health and social conditions, experiences, and identities (Earnshaw et al., 2022; Stangl et al., 2019; Tyler & Slater, 2018). The stigma concept is continually contested and evolving, following sociological and broader social trends, priorities, and movements. Over the seven and a half years in which I have undertaken this research, conceptualisations of stigma, broadly, and of abortion stigma specifically have evolved substantially. In this chapter the stigma process and evolution of the stigma concept are described, setting the basis for the remainder of this thesis. Section 2.1 provides an overview of the stigma concept and theory, and explores how our understanding of stigma has evolved, particularly in relation to stigmatised health conditions and experiences. Section 2.2 outlines the recent history of abortion stigma theory, while Section 2.3 defines key terms and the conceptual frameworks on which this thesis is grounded. Throughout this chapter I outline a number of assumptions about the nature of stigma that this research adopts, tests, and challenges. These assumptions have implications for the research design and analysis choices described in the subsequent chapters in this thesis, and for the body of work to which this thesis contributes.

2.1 Stigma

2.1.1 The evolution of the stigma concept

Goffman's foundational study defined stigma as "an attribute, behaviour, or reputation which is socially discrediting", resulting in the social exclusion and assumptions of deviance attributed to and of people who experience stigmatised conditions or identities (Goffman, 1963, p. 3). In sociology and social science, stigma has been characterised as socially created and maintained, and thus localised rather than universal (Crocker et al., 1998; Goffman, 1963; Link & Phelan, 2001). Stigmatisation occurs when dominant cultural beliefs and taken-for-granted assumptions drive the identification and labelling of human differences, some of which are then linked to undesirable characteristics and negative stereotypes (themselves linked to 'problems of knowledge' – specifically ignorance). This results in 'othering', status loss and discrimination (Goffman, 1963; Link & Phelan, 2001; Thornicroft et al., 2007). This process can only occur in contexts of power inequities, and thus stigma has been described as following "the fault lines of existing social marginalisation or social exclusion" (Deacon, 2006, p. 422). Figure 1 offers a visual representation of this process, based on the conceptualisation by Link and Phelan (2001).

Figure 1: The stigma process as described by Link & Phelan (2001)



Goffman's characterisation of stigma alluded to its inherently relational nature and role in social control. It has been suggested, however, that Goffman primarily positioned stigma – due to his own epistemological priorities – as a concern of micro-social interactions (Tyler, 2018). Scambler (2009, p. 443) described that for Goffman, "the structure of face-to-face interaction in the lifeworld is what steadies and sustains the social order". Tyler (2018, p. 749) suggested that Goffman explicitly argued for the "'bracketing off' of the economic and political imperatives that structure behavioural settings" and avoided acknowledging racism and the role of power in stigma, thus presenting a "politically anaesthetised" version of the stigma concept. This is despite Goffman's work coming after many decades of contextually situated stigma scholarship among black theorists (Tyler, 2018). Smith et al. (2022, p. 892) argued that Goffman was, instead, "attempting to shift the attention from the study of 'deviants' to an understanding of situated rule-breaking which, again, is grounded in an understanding of the rules, demands and obligations that hold in each social setting". Irrespective of the interpretation of Goffman's intentions, theorists have indicated that interpretations and applications of the stigma concept since Goffman have focused largely on individuals and micro-level experiences, manifestations, drivers, and management of stigma, often failing to address its relational character, and particularly the ways interpersonal relations are governed by power, including financial and political structures and institutions (Aranda et al., 2023; Kosenko et al., 2019; Link & Phelan, 2014; Smith et al., 2022; Tyler, 2018). A lot of this micro-social and individual-level stigma work has occurred in the field of psychology (Kosenko et al., 2019).

Over the last two decades, there has been a shift towards increasingly contextualised conceptualisations of stigma. Researchers and theorists have been calling for "re-situating", "rethinking", "re-framing", and thus developing "post-individualistic account[s] of stigma" that consider macro-level structures and processes as inseparable from the stigma concept and individuals' experiences (Monaghan, 2017, p. 182; Tyler, 2018; Tyler & Slater, 2018). It has been argued that the focus of stigma research on stigmatised populations and individual level stigma management strategies, "runs the danger of reifying stigma or of making stigma appear a concrete and objective evaluation rather than a subjective and contextual evaluation by audiences" (Aranda et al., 2023, p. 2). (Re)focusing stigma research on stigma's function as a form of social power and

control is vital to developing comprehensive and usable conceptualisations that are both likely to inform effective interventions. Furthermore, it is essential if future stigma research is to avoid perpetuating individualistic accounts of health and thus “neoliberal ideology and scapegoating” (Monaghan, 2017, p. 182; Tyler, 2018; Tyler & Slater, 2018). Such accounts in turn uphold racist, classist, ableist and patriarchal norms and priorities. While “stigma and deviance have always been deployed – ‘weaponised’ – for social and political ends” (Scambler, 2018, p. 773), it is relatively recently that this has been explicitly acknowledged in (popular/ mainstream sociological) stigma literature (Tyler, 2018)[4].

Key to post-individualistic accounts of stigma is the characterisation of stigma as a classificatory form of political, cultural, and economic power, and of (symbolic) violence and oppression (Lindell, 2022; Link & Phelan, 2014; Owen, 2022; Tyler, 2018; Tyler & Slater, 2018). Stigma has been described as intentionally enacted to control “individuals who do not adhere to socially defined norms” (Smith et al., 2016, p. 73). Recent stigma theorists advocate for an increased focus on the way stigma is used to marginalise, and justify the marginalisation of certain population groups, elucidating its relationship to social order and dominant ideologies. It is within such framing that we have come to understand stigma as local, contested, resisted, and salient for different individuals in different contexts based on historical, geographical, political, economic, and cultural factors (Crocker et al., 1998; Link & Phelan, 2001; Tyler & Slater, 2018).

2.1.2 An overview of health stigma

> Stigma is a useful idea in healthcare. It helps make clear the social impact of illness, or, in other words, how the experience of an illness may coincide with a range of negative social events, such as discrimination, judgement, social exclusion, vilification, ostracism, labelling, status-loss, prejudice, unfair treatment, among others. (Dolezal, 2022, p. 855).

Health stigmas have become a primary focus of stigma scholarship. Within the “rich conceptual landscape” of health stigma research (Dolezal, 2022, p. 855), disability, mental health, HIV, and weight stigma scholarship is particularly prolific, and these stigmas are thus relatively well understood in relation to their prevalence and impacts (Goldberg, 2017; Sickel et al., 2014; Stangl et al., 2019; Tyler, 2018). Nelkin and Gilman (1998, pp. 362-363, in Deacon 2006, p. 422) have described how both categories of blame, which produce notions of deviance and stigma, and the experience of illness itself, are “frequently associated with the ‘other’, be it the other race, the other class, the other ethnic group”, and with poverty, sexual practices and identities. Health related stigma is subsequently inherently socio-political in nature. Across a range of health conditions,

[4] Tyler (2018) argues that there is, in fact, a significant body of work that applies the stigma concept in a political and emancipatory framework among Black American scholars, though this, they argue, was systematically sidelined throughout the 20th Century.

stigma has been shown to be a "barrier to health seeking, engagement in care and adherence to treatment" (Stangl et al., 2019, p. 1), and a fundamental determinant of mental and physical health, economic, and social inequities (Dolezal, 2022; Hatzenbuehler et al., 2013; Sharac et al., 2010).

The beliefs related with, and experiences, magnitude, and salience of particular health stigmas, are mediated by their nature as either concealable or visible, controllable or uncontrollable, and direct or associative/courtesy stigma (Quinn & Earnshaw, 2013). Concealable stigmatised identities are those that can be hidden, often in some situations and not in others, such as having (had) an abortion experience, or mental illness, whereas other stigmatised identities may be visible or obvious, such as physical disability (Quinn & Earnshaw, 2013). The level of control a person with a stigmatised health condition or experience is perceived to have over their stigmatised identity can also impact their experience of stigma. For example, stigmas deemed to be the result of individual fault or flaw are more likely to result in a stronger sense of blame towards stigmatised persons (Hegarty & Golden, 2008). Furthermore, stigma is described as experienced by both people with stigmatised identities, and those associated and who interact with them, the latter known as 'courtesy' stigma or stigma by association (Goffman, 1963; Phillips et al., 2012). As with direct stigma, courtesy stigma has been found to interact with other dimensions of identity and social positioning and power (Bachleda & El Menzhi, 2018; Kotova, 2020; Phillips et al., 2012).

Health stigma is widely understood to manifest in a range of stigma experiences, including internalised, anticipated/felt/perceived, and enacted stigma. Internalised stigma, internalisation of stigma, or self-stigma refers to a form of individual-level stigma involving fear or acceptance of negative messaging, assumptions and stereotypes about a stigmatised identity, and application of these negative attributes to oneself (Drapalski et al., 2013; Hoggart, 2017; Kane et al., 2019). Anticipated stigma refers to the anticipation or expectation of experiencing "discrimination, stereotyping, and/or prejudice" as the result of one's stigmatised status (Earnshaw et al., 2013, p. 2). Enacted stigma involves direct and often interpersonal experiences of stigmatisation and discrimination (Earnshaw et al., 2013). Stigma researchers variably use, often synonymously, the terms felt, perceived, and anticipated stigma. Hanschmidt et al. (2016, p. 169) refer to perceived abortion stigma as, "a woman's awareness of devaluing attitudes of others concerning her abortion and her own expectation that these attitudes might result in discriminatory actions". Cockrill and Nack (2013, p. 974) define felt abortion stigma as "assessments of others' abortion attitudes, as well as expectations about how attitudes might result in actions" in their abortion stigma conceptualisation. The first part of Hanschmidt et al. (2016) and Cockrill and Nacks' (2013) definitions align with the definition adopted by Biggs et al. (2020, p. 2), who describe perceived abortion stigma as "people's perceptions of how others judge them for seeking or obtaining an abortion". The second parts of their definitions, however, speak to the anticipation of enacted stigma. Other researchers have drawn clear distinctions between anticipated and perceived stigma. Stangl et al. (2019, p. 2) define perceived health stigma as more general perceptions about

"how stigmatised groups are treated in a given context", and anticipated stigma as specific "expectations of bias being perpetrated by others if their [stigmatised condition] becomes known". In order to facilitate consistency and comparability with previous abortion stigma research (outlined in more detail in Chapter 3), I chose to use a conflated conceptualisation of perceived, felt, and anticipated abortion stigma in the literature review and survey development components of this research (reflected in Chapters 3 and 4). The distinction between the terms and thus experiences, however, becomes central to the data analysis and interpretation stages of the quantitative study in particular, and is described in more detail in Chapter 6 Section 6.6.1. As a result, in later chapters of this thesis, necessary distinctions between perceived and anticipated stigma are made.

A fourth domain of stigma, structural level stigma, has been described and defined as, "societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and wellbeing of the stigmatised" (Hatzenbuehler, 2016, pp. 1-2). While there is relatively limited research and even fewer interventions that address structural stigma, it is gaining increasing research attention among scholars focused on understanding the political role and power of stigma. Structural stigma reflects the outer-most levels of a socio-ecological model, of the macro-social, comprising ideology, institutions, and social norms (Hatzenbuehler, 2016)[5].

In the following section, I describe how theory and core concepts from the wide-ranging stigma research, and health stigma research more specifically, has been applied to abortion stigma and used in this study.

2.2 Abortion stigma theory: A recent history

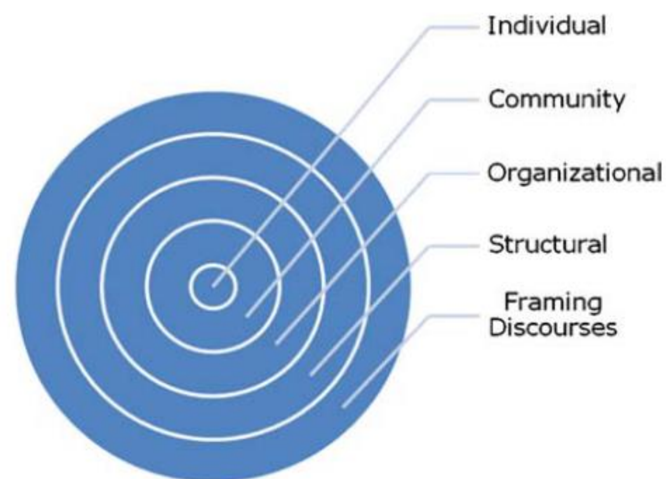
Abortion stigma has been described as one of the least understood and most poorly defined and theorised forms of health stigma (Kosenko et al., 2019; Norris et al., 2011). Nevertheless, there are a number of conceptual articles which underpin the extant abortion stigma literature and this research. As with the broader stigma literature this conceptual work has increasingly moved from relatively individual level to more recent macro-social and political characterisations of abortion stigma.

Kumar et al. (2009) drew on research findings from both developed and developing countries to develop the first explicit conceptualisation and most cited and influential definition of abortion

[5] The socio-ecological model of health frames health as multifaceted and mediated by a range of individual, interpersonal, organisational/institutional, community and structural level/public policy factors (See Figure 2). Health stigma researchers apply the framework to support an understanding and the conceptual organisation of the interrelated determinants and mediators (or 'levels') of stigmatised health conditions/experiences, and thus to draw attention away from purely individual and interpersonal level elements of stigma (Ratcliffe, 2023; Williams et al., 2023; Stangl et al., 2019).

stigma to date (Millar, 2020). They defined 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” (Kumar et al., 2009, p. 628). In doing so, they established a basis for the research of abortion stigma as a distinct component of abortion seekers’ social lives and experiences, characterised by its invisibility (post-abortion), and locating it within a socio-ecological understanding of health (see Figure 2).

Figure 2: Levels of abortion stigma (Kumar et al. 2009, p. 630)



Kumar and colleagues (2009) suggested that abortion stigma emerges because abortion challenges assumptions about the ‘nature’ of women as nurturers and inevitability of motherhood, the idea of female sexuality linked solely to procreation, and the perceived moral capacity of women to make life and death judgments. Importantly, Kumar and colleagues (2009) explicitly recognised abortion stigma as a social and local phenomenon that is influenced by gender-based inequities in access to power and resources and rigid gender roles. For example, a woman’s perceived suitability for motherhood, determined by a range of personal and social factors, would impact the acceptability and thus stigmatisation of abortion, and therefore be experienced differently for women in varying contexts. Thus, their work set a foundation for subsequent abortion stigma research that rejected purely micro-level characterisations of stigma. It did, however, propose a relatively narrow interpretation of stigma as primarily an issue of gender norms.

In 2011, two articles offered expanded characterisations of abortion stigma. O'Donnell et al. (2011) researched abortion stigma experiences and stigma resistance among North American abortion providers, expanding the focus of abortion research, which was previously focused on women who have abortions. In the same year, Norris et al. (2011) provided a further expanded conceptualisation of abortion stigma as impacting three key groups: women who have abortions, abortion facility staff (and clinics more broadly), and partners, supporters, and advocates. While

subsequent research into abortion supporters, advocates, researchers, and partners of abortion seekers remains limited, experiences of the stigmatisation of abortion providers has been an ongoing focus of stigma research to date (described in more detail throughout Chapter 3). Norris and colleagues (2011) also presented a wider conceptualisation of the norms and values underpinning abortion stigmatisation. They posited the stigmatisation of abortion is driven by the attribution of personhood to the fetus, legal restrictions on abortion care, stereotypes about and beliefs that abortion is dirty or unhealthy, and the explicit use of stigma as a tool by anti-abortion advocacy groups. Norris and colleagues' (2011) expanded conceptualisation offered new categories of analysis to stigma researchers.

In 2013, Cockrill and Nack published a social-psychological framework of individual level abortion stigma that has underpinned most subsequent abortion-stigma research. Adapting a framework of sexual stigma (Herek et al., 2009), they described their framework as the first "grounded theory of women's experiences of abortion stigma in the contemporary United States" (Cockrill & Nack, 2013, p. 974). They proposed that individual level abortion stigma occurs across the three domains described above: internalised, felt, and enacted abortion stigma (these domains, and the literature exploring them, is described in detail in Chapter 3 Section 3.4.3). Furthermore, they identified three strategies of stigma management that women who have abortions engage in: management of a damaged self, that is taking actions and framing abortions in ways that avoided negative stereotypes and labels; maintenance of good reputations, such as through secrecy about an abortion experience, and; management of damaged reputations, including attempts to normalise abortion or condemn condemners (Cockrill & Nack, 2013). There has been a subsequent and increasing body of work that recognises abortion stigma as contested, managed, and rejected, drawing on this framework of stigma management.

Key conceptual articles after Cockrill and Nacks' (2013) influential work demonstrate a distinct shift in focus from the individual and interpersonal level to the level of social systems and structures in considering the formation, drivers, experiences, and outcomes of abortion stigma. Kosenko et al. (2019, p. 4), who like Cockrill and Nack were based in the US, proposed a conceptualisation of abortion stigma as "constituted in messages that separate and label something [in this case abortion] as physically, behaviourally, morally, or socially deficient". This communication focused definition was hypothesised to "locate stigma outside of the individual and to emphasize its discursive nature" (Kosenko et al., 2019, p. 4). In positioning abortion stigma *as* a mode of communication, constituted in individual messages or more broadly in social discourse, they argued the definition shifted the focus from attributes held by individuals to the nature and role of communication (Kosenko et al., 2019). Furthermore, their definition allows stigma to be understood as operating in a range of contexts, not all of them relational, such as in the media.

In 2020 Millar published the first explicitly structural and power-focused conceptualisation of abortion stigma. This work is based on a Foucauldian interpretation of abortion stigma and power, calling for it to be "reframed as a classificatory form of power that works through designating relations of difference" (Millar, 2020, p.1). Millar describes abortion stigma as a "social process that functions to reproduce and legitimate modes of differential power relations" (Millar, 2020, p. 1). Framing abortion stigma as a tool of social and political control necessitates a focus on the stratification of abortion stigma along axes of gender, race, class, ability, and sexuality. Millar, as other stigma theorists had previously done, claimed that a lack of recognition of the role of power in stigmatisation, and the individual and interpersonal foci of abortion stigma conceptualisations, were largely to blame for ineffective stigma interventions that have inherently placed "the burden of alleviating stigma" on the stigmatised (Millar, 2020, p. 4). Individualistic characterisations of abortion stigma - as a stigmatised identity or attribute that an abortion seeker gains or becomes – are seen to strengthen "the anti-abortion claim that abortion forever damages a woman's sense of self" (Millar 2020, p. 4). While Millar recognised her conceptualisation as broad and thus potentially undesirable to interventionists, she described this as intentional and vital: The simplification of abortion stigma definitions and conceptualisations both results in artificially simple responses to a complex social problem and fails to allow for cultural and contextual variability.

Developing a class-based conceptualisation of abortion stigma, Love, a UK based sociologist, has also been instrumental in demonstrating the role of abortion stigma as a classed form of bio-political regulation (Love, 2018, 2021). Contextualising her findings in current and historical class politics in the United Kingdom (UK), Love has situated the existence and salience of abortion stigma in middle-class values and norms around restraint and responsibility, themselves underpinned by neoliberalism. Love therefore positions abortion stigma as a tool of dominant group interests, used to generate and legitimise inequity.

This recent history of abortion stigma theory therefore demonstrates its increasing alignment with broader shifts in stigma scholarship towards more structural and critical conceptualisations and increasing alignment with intersectional and justice-focused sexual and reproductive health scholarship and practice. Strong, Coast and Nandagiri (2023), for example, apply frameworks of intersectionality and reproductive justice to further expand the conceptualisation of abortion stigma as structural, intersectional, and a driver of reproductive injustice. Interestingly, Millar and Love who have to date been leading the shift in reimagining abortion stigma as an intersectional, classed experience and social problem, are both based outside of the US, where most of the abortion stigma scholarship has occurred to date. In Chapter 3, I briefly describe the way empirical Australian abortion literature differs in focus from US-based research: together, these discussions highlight the importance of cultural and disciplinary diversity in abortion stigma research, particularly if stigma theory is to become inclusive and increasingly relevant to sexual and reproductive health practice, and beyond the US.

2.3 Frameworks and terminology

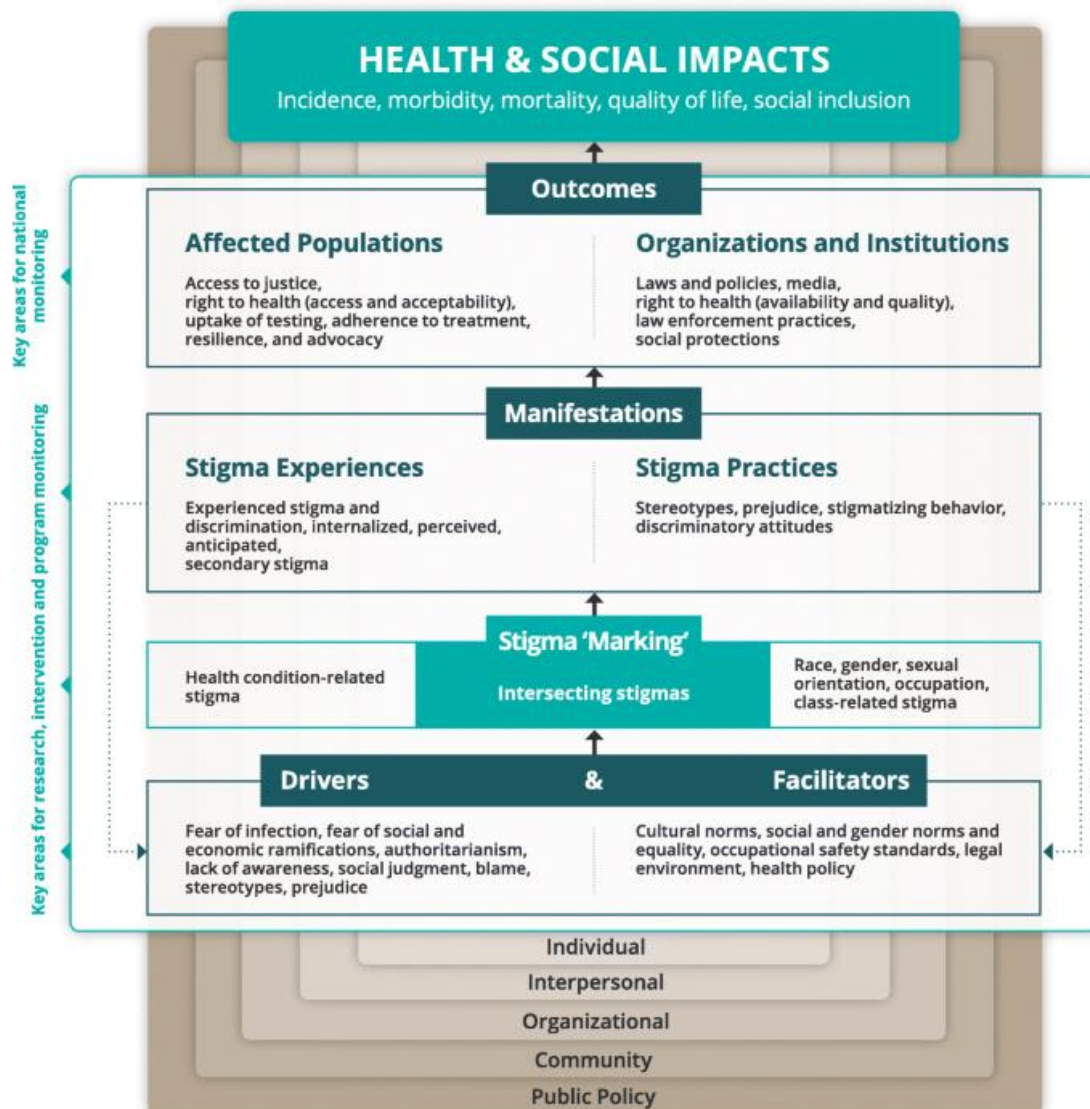
Thus far throughout this chapter I have worked to define and interrogate "the concept of abortion stigma, [which] is not a priority in the majority of abortion research, where stigma is generally defined briefly and, sometimes, not at all" (Millar, 2020, p. 4). In this section, I describe the specific conceptualisations of stigma and abortion stigma on which the remainder of this thesis is grounded, making explicit the assumptions and definitions used herein.

2.3.1 Conceptual frameworks applied throughout this thesis

I draw on three main conceptualisations of stigma to guide the various components, assumptions, and conclusions of this research. The first of these is Cockrill and Nack's (2013) framework of individual level abortion stigma, described above. This framework defined the domains of internalised, felt, and enacted abortion stigma, described the interactions between these domains and the stereotypes of 'good' women versus deviant or 'bad girls', and described a typology of stigma management. This conceptualisation explicitly informs the organisation of the findings of the literature review in Chapter 3 and the design of the survey tool used in the quantitative component of this work, including its focus on measuring felt abortion stigma specifically, as distinct from other stigma experiences.

I also draw on Stangl and colleagues' (2019) Health Stigma and Discrimination Framework to ground much of the research presented in this thesis (see Figure 3). Stangl and colleagues (2019) propose that the use of their framework, which is applicable to health stigmas broadly, can facilitate the comparison of stigma research and interventions across stigmatised health conditions. I anticipate that adopting a stigma framework built on the vast health stigma literature will support the comprehensiveness and comparability of this current abortion stigma research by moving beyond the limitations of the relatively less comprehensive abortion stigma conceptualisations.

Figure 3: The Health Stigma and Discrimination Framework (Stangl et al., 2019, p. 3)



The Health Stigma and Discrimination Framework incorporates a socio-ecological understanding of health (demonstrated in the layers at the bottom of Figure 3) alongside “a series of constituent domains” which interact and intersect to reflect both the stigmatisation process, along with its causes and consequences (Stangl et al., 2019, p. 2). It is intended for use across a range of stigmatised conditions and identities, and incorporates stigma drivers, intersections, manifestations, outcomes, and impacts. The framework does not require researchers to differentiate between stigmatisers and the stigmatised, which enables exploration of the structural dimensions of abortion stigma beyond interpersonal interactions (Stangl et al., 2019). Furthermore, previous abortion stigma conceptualisations, such as Cockrill and Nack’s (2013) three domain model, can be incorporated into this more holistic framework.

In Chapter 3, the literature review, I draw upon this framework explicitly to structure the presentation of the results. Furthermore, a number of key terms used throughout the thesis are based on the definitions provided by Stangl and colleagues (2019), including:

- ‘drivers’, used to refer to primarily negative causes or enablers of abortion stigma; “facilitators”, used to refer to both positive and negative factors that determine whether or not a person or group experiences or is impacted by abortion stigma;
- Stigma ‘experiences’, including internalised, anticipated, perceived, and enacted abortion stigma and discrimination; and
- Stigma ‘practices’, used to describe stereotypes, behaviours, and discriminatory attitudes that constitute the practice of stigmatisation.

Thirdly, Millar’s conceptualisation of abortion stigma as a form of power was particularly influential in the later phases of this research. Millar’s (2020) work is specifically reflected in Chapters 7, 8 and 9, informing the analysis and interpretation of the qualitative study, and the integrated analysis of quantitative and qualitative findings. I draw on Millar’s conceptualisation of abortion stigma, alongside the work of influential stigma theorists - including Link and Phelan (2014), Scambler (2018), Parker and Aggleton (2003), and Tyler and Slater (2018) - to frame my analysis of the way abortion stigma functions in Australian social life.

Finally, for the purposes of this thesis I draw upon a recent definition proposed by Ratcliffe et al. (2023), which aligns with Millar’s (2020) conceptual work on structural abortion stigma. Ratcliffe and colleagues define abortion stigma as,

> the socio-cultural process of labelling the termination of pregnancy as deviant, along with individuals and organisations associated with abortion, devaluing them across multiple, interrelated levels to gain, maintain, or strengthen social power (Ratcliffe et al., 2020, p. 1).

This definition is useful as it situates abortion stigma outside of the individual, recognises multiple targets of abortion stigma, and incorporates the socio-ecological interpretation of abortion stigma. Of the few published definitions, it is most closely aligned with my own conceptualisation of abortion stigma, reflected throughout this thesis.

2.3.2 Defining shame and deviance

While not central conceptual foci of this research, the terms ‘shame’ and ‘deviance’ emerge throughout the thesis. ‘Shame’ is commonly referred to, often synonymously with ‘stigma’, in stigma research and dialogue, although its distinctions and interactions with stigma remain under-researched (Dolezal, 2022). Shame has been described as “an emotional response to stigma” (Hutchinson & Dhairyawan, 2018, p. 225) and a negative feeling experienced in response to

internalising, perceiving, or anticipating that others (will) see you as, deeply flawed, inadequate or immoral (Dolezal, 2022, p. 856). Scambler (2009) describes stigma as a violation of 'norms of shame', shame the result of a (perceived) 'ontological deficit'. Shame thus forms a core element of experiences of internalised and felt/perceived/anticipated stigma (Dolezal, 2022; Scambler, 2018). For the purposes of this study, shame is broadly conceptualised as a negative, self-conscious emotional response to, and reflected in, internalised, experienced, or perceived stigma (Dolezal, 2022). The concept of shame emerges primarily in the qualitative phase of this research, wherein interviewees used the term to refer to their own experiences and perceptions of abortion stigma. In contrast to shame, Scambler (2018) defines deviance as a violation of norms of blame, and thus a perceived moral deficit. The concepts of deviance and blame are thus used to refer to the breaking of social rules and norms throughout this thesis (Scambler, 2009).

2.4 Conclusion

In this chapter I have provided an insight into the history, priorities, and advancement of stigma, and abortion stigma, theory, and research since Goffman's foundational 1963 conceptualisation, situating this doctoral work historically and conceptually. I have argued for the importance of macro-social understandings of abortion stigma that recognise it exists at a range of social levels and impacts a range of people who experience, provide, advocate for or support abortion provision or abortion seekers. Furthermore, I have defined a range of key terms that are used throughout this thesis. In the following chapter (3), an in-depth review of abortion stigma research is provided which expands on and describes the empirical literature related to these core concepts and terms, and their implications for those affected by abortion stigma.

CHAPTER THREE: LITERATURE REVIEW

3.1 Introduction

This chapter provides an overview and critique of empirical literature regarding abortion stigma in high-income countries, expanding on the theoretical literature described in Chapter 2. The scoping review presented herein provides context to this thesis by identifying local (Australian) and global research gaps and elucidating key knowledge in the field.

Several prior literature reviews have consolidated specific segments of the research on abortion stigma (Brown et al., 2022; Hanschmidt et al., 2016; Sorhaindo & Lavelanet, 2022). Sorhaindo and Lavelanet synthesised qualitative evidence pertaining to the "role of stigma in the quality of abortion care" (2022, p. 1), characterising the range of impacts abortion stigma has on the availability and nature of abortion care. Brown et al. (2022) explored the role of race on abortion stigma in the US specifically, finding a lack of research contextualising abortion stigma in the context of race, while also identifying literature that points to racial differences in abortion stigma experiences. Hanschmidt and colleagues (2016) conducted the first formal review of abortion stigma literature, identifying abortion stigma experiences among abortion seekers and providers, and a lack of abortion stigma interventions. Together, these reviews identified strong evidence of the stigmatisation of abortion across countries and social groups, experienced primarily by abortion seekers and providers, and described research (and interventions) on abortion stigma as limited and lacking in quality and generalisability.

In comparison, this current review is broad and exploratory. It aims to expand on the findings of the prior reviews, to update, consolidate, explain, and critique abortion stigma research (findings), and to identify key gaps that warrant further research attention. I elected to confine the review to high-income countries given the focus of this research in a high-income setting in which abortion has been almost entirely decriminalised, as it has similarly been in most economically comparable countries (Women and Foreign Policy Program Staff, 2022). Furthermore, the apparent links between stigma, unsafe abortion, and beliefs about 'contagion' in abortion stigma research conducted in lower income countries do not appear to be relevant to the Australian context (Kumar et al., 2009; Shellenberg & Tsui, 2012). The review aim and strategy are intentionally broad, intended to facilitate the identification of studies that have both focused on abortion stigma explicitly and that have identified abortion stigma as research finding (for example, as a barrier to abortion access in studies focused on exploring access to abortion care). Further, in this review I have analysed the included literature in line with Stangl et al.'s (2019) comprehensive Health Stigma and Discrimination Framework. As described in Chapter 2, this framework is more comprehensive than existing abortion stigma-specific frameworks and conceptualisations, and its

use is intended to facilitate consistency and comparison within and across health stigmas and health stigma research (Stangl et al., 2019).

In section 3.2 the search strategy, study selection and data extraction and analysis processes are described. Characteristics of the included studies – both of the entire sample of included citations and of a sub-sample of Australian citations – are described in Section 2.3. The review results are presented in Section 2.4, organised within sub-sections that align with the five elements of the Health Stigma and Discrimination Framework (Stangl et al., 2019), including: 1. drivers and facilitators of abortion stigma; 2. intersections of abortion stigma with other personal characteristics, stigmas, and aspects of marginalisation; 3. stigma experiences and practices, and; 4 and 5. outcomes and impacts of abortion stigma. Within Section 2.4, sub-bodies of literature pertaining to Australian research, and to abortion stigma experiences among young people, are described separately, given their particular relevance to the geographical context and populations of primary interest in this thesis. Finally, the research gaps pertaining to abortion stigma in high-income countries and the relevance of key findings to the aims and design of this study are described in Sections 2.5, the discussion, and 2.6, the conclusion.

3.2 Methods

The methods used to undertake this review align with the PRISMA guidelines for scoping reviews (Tricco et al., 2018). The PRISMA guidelines and checklist outline a set of 20 minimum criteria for scoping reviews, intended to enhance the consistency and quality of scoping review reporting. A PRISMA checklist describing how this review addressed the associated criteria is provided in Appendix A. The scoping review methodology enables the identification, mapping and exploration of concepts and characteristics of an evidence base, and the identification of knowledge gaps, particularly when research questions are broad (Munn et al., 2018; Tricco et al., 2018).

3.2.1 Search strategy

The search was first conducted in 2016 at the commencement of this doctoral work, at which time 10 years of literature was identified with the inclusion of citations published between 2005 and early 2016. Given the contextually dependent nature of stigma, and ever-changing legal and social environment and norms surrounding abortion, 10 years' worth of literature was deemed appropriate. The search was then updated in April 2018 and again in November 2022 as the project progressed. At each update a consistent review methodology was used to identify, sort and extract data from included studies. Therefore, the literature presented in this chapter include all eligible identified research studies published between 2005 and 2022.

The search strategy was designed, with input from experienced research librarians, for high sensitivity and low specificity: aiming to be as comprehensive as is feasible, while ensuring appropriate focus to facilitate a meaningful answer to the review/research question, is key to ensuring quality in a scoping review (McKenzie, 2022; Munn, 2022). The search strategy was designed to represent key elements of the research question, including: the population of interest, in this case various population groups in high-income countries broadly, and the concept(s) of interest, being any element of the abortion stigma process. While search strategies often account for outcome variables and specific participant groups, this was not appropriate given the exploratory and general nature of the research/review question. A range of search terms related to population and concept were identified via examination of existing systematic reviews and abortion stigma research papers. Individual search terms were trialled in the Medline database to explore the scope and relevance of the citations they resulted in. The final search strategy included three groups of search terms; one pertaining to 'abortion' and synonyms, one to 'stigma', 'attitudes', and 'discrimination', and the third to country. A full copy of the search strategy can be found in Appendix B.

Limits were applied to date of publication (2005 onwards) and English language. While introducing limits can introduce biases and result in the exclusion of relevant literature, date limits are commonly applied to support a focus on recent evidence, and both date and language limits can be applied if necessitated by time and resource constraints (Helbach et al., 2022). Transparency around date limits and the reasons for such limits can ensure quality in review reporting (Helbach et al., 2022). Of note, some of the most general terms used in the earlier searches, such as 'belief', 'culture', and 'religion', were excluded from the 2022 search as the quantity of relevant literature had increased substantially and these terms thus became too sensitive (general), identifying a large quantity of citations that were not relevant to the review question. This aligns with the often-iterative nature of scoping reviews (Munn, 2022).

The search was run in seven health and social science databases: Medline, CINAHL, Emcare, Scopus, Proquest, Informit and Cochrane.

Studies were included in the review if they were: a peer-reviewed journal article or conference abstract; provided an analysis of primary data; measured or explored abortion stigma as either a research aim or incidental finding; published between 2005 and 2022; and reported research conducted in at least one high-income country. A list of high-income countries was generated based on the UN DESA 'developed countries' list (UNDESA, 2014) and High Gross National Income country list (The World Bank Group, 2020). The included countries can be found in the search strategy provided in Appendix B. Studies were excluded if they were focused solely on conscientious objection or attitudes to abortion without explicit measurement of or reference to stigma.

3.2.2 Data extraction and synthesis

All citations identified from the database searches were sorted in Endnote 20 for duplication and then against the inclusion and exclusion criteria in three rounds: by title, abstract and full text. I undertook this process independently.

Data pertaining to the country and setting of the study, study design and methods, population characteristics, study aims, key (relevant) outcomes measured, and key (relevant) results and quotes were extracted from each included study into a pre-developed table, in line with best-practice scoping review data collection processes (Tianjing, 2022). These data were then explored and analysed using a process informed by a mixed-methods synthesis paradigm and integrative review methodologies, where qualitative and quantitative findings considered sufficiently similar are grouped and analysed together (Peters, 2020). Firstly, included studies were organised by population, study location and methodology, which facilitated an initial exploration of trends and gaps. Study results were then grouped thematically based on whether they reflected a particular domain of abortion stigma (such as internalised, perceived, enacted, or structural stigma), the impacts or drivers of abortion stigma, stigma resistance, or 'other'[6]. Multiple results from a single study could be coded to multiple thematic groups, similarly to a deductive qualitative data coding process. Within each thematic group, data were then assessed for similarities and differences, facilitating an interpretation of areas of agreement and inconsistencies across studies, locations, and population groups. Finally, the data (study findings) in each theme were grouped according to and analysed and reported in reference to Stangl et al.'s (2019) Health Stigma and Discrimination Framework.

3.3 Study characteristics – all included studies

A total of 3179 citations were identified via the systematic searches: 2056 citations during the 2018 search and a further 1123 in the 2022 update. The full texts of 298 citations were included in a full-text analysis, along with five articles identified via hand-searching. A total of 136 studies, 71 from the 2018 search and 65 from the 2022 search, met the inclusion criteria and were included in the final review.

[6] Stangl and colleagues' (2019) Health Stigma and Discrimination Framework had not been published when this review process began, which is why results were not immediately coded to the five components of this framework.

Table 1: Characteristics of all included studies

Category	Sub-category	# of included studies (n=136)
Country/ region of data collection	US	74
	UK	22
	Europe	11
	Canada	12
	Australia	16
	Japan	1
Research method(s)	Qual	82
	Quant	36
	Mixed	18
Population	Abortion seekers/ people who have had abortions	59
	Abortion providers/ clinic staff	22
	Public	10
	Other/ Mixed	45

Table 1 describes the characteristics of the studies included in this review. Over half of the included studies employed qualitative research methods, and over half were from the US. Abortion seekers were the most common participant group, followed by abortion providers. The 'other' population category included studies with participant groups that included subgroups of women who had not had abortion experiences, health professionals who weren't involved in abortion provision, medical students, and those assessing content/documents or state, national or service-based datasets.

3.3.1 Characteristics of Australian studies

As shown in Table 2, most of the 16 Australian studies included in this review employed solely qualitative research methods. As shown in Table 3, four of the five Australian studies with abortion seekers as participants focused on experiences of abortion seeking in rural areas. Only four studies explored stigma as a primary research aim, none of which included abortion seekers as participants.

Table 2: Characteristics of Australian studies

Category	Sub-category	# of included studies (n=16)
Research methods	Qualitative	14
	Quantitative	1
	Mixed methods	1
Participants	Abortion seekers	5
	Pregnant people (who sought pregnancy options counselling)	1
	Health professionals (abortion providers)	3
	Health professionals (not involved in abortion provision)	4
	Online/parliamentary content/ dialogue/ texts	3

Table 3 outlines the characteristics and key findings of the included Australian studies. It demonstrates that research exploring experiences, barriers, and enablers of abortion (access) were the most common among the Australian literature, among which stigma was frequently identified to be a barrier to abortion care provision and accessibility.

Table 3: Characteristics & findings of included studies from Australia

Citation	Methods	Population	Focus	Key Findings
Baird and Millar (2019)	Qual: Narrative analysis	Websites - abortion clinic and feminist.	Trend of abortion celebratory and de-stigmatising content online.	- Websites address misinformation, provide accurate information; indicate growing trend in feminist, pro-choice commentary. - Primarily represent white, middle class abortion seekers. - Academic work focusing on abortion stigma can reinforce stigma.
Cashman et al. (2021)	Qual: Semi-structured in-depth interviews	11 abortion Seekers – early medication abortion (EMA). 6 months post-abortion. Rural.	Experiences of women accessing EMA through regional sexual health service.	- Women experienced judgment, discrimination by sonographers and GPs: conscientious objection, refusal of care and referral. - Women described feeling guilt over abortion seeking/ pregnancies.
Cleetus et al. (2022)	Qual: Content analysis	1933 pregnant people – pregnancy options counselling clients.	Barriers and facilitators of abortion access post-decriminalisation.	- Stigmatisation and conscientious objection by health providers was a key barrier to abortion access. - Health providers commonly told women they don't do "social abortions", gave misleading or incorrect information to abortion seekers.
Dawson et al. (2017)	Qual: Semi-structured in-depth interviews & focus groups.	32 GPs - 8 EMA providers, 24 not abortion providers.	Impact of stigma on abortion provision.	- Some GPs interested in EMA provision were concerned about stigmatisation, especially by colleagues. - Abortion providers felt professionally isolated.
De Moel-Mandel et al. (2021)	Quant: Delphi surveys	24 health professionals	Factors influencing implementation of nurse-led model of care for EMA provision in primary healthcare.	- Stigma and "conservative social attitudes" hindered implementation of nurse-led abortion provision & access. Providers feared stigma and harassment in rural communities. Lack of support from other health providers.

Doran and Hornibrook (2014)	Mixed: Service data & semi-structured in-depth interviews	7 health professionals at women's health centres, 13 abortion seekers. Rural.	Factors associated with access to abortion care among women in rural New South Wales.	- One woman saw 5 GPs before offered a referral. GPs blocked access. - Fear of judgment led to lack of disclosure, social isolation.
(Doran & Hornibrook, 2016)	Qual: Semi-structured in-depth interviews	13 abortion seekers. Rural.	Factors impacting rural abortion access.	- Internalised stigma led to shame, secrecy, isolation. - Protestors exacerbated perceived and enacted stigmatisation. - Doctors delayed access with unnecessary tests, inadequate information. - Lack of access led to attempted self-induction by two participants.
Evans and O'Brien (2015)	Qual: Discourse analysis	150 online news articles.	How language shapes stigma and how attitudes are portrayed through language.	-Pro-life language used shapes abortion as stigmatised and deviance, misrepresents majority opinion. -Language used to humanise fetus, stereotype mothers, 'other' abortion seekers, draw distinctions between acceptable and less acceptable abortions
Hulme-Chambers, Clune, et al. (2018)	Qual: Semi-structured in-depth interviews	6 training providers, 13 health professionals. Rural.	Factors that enabled and challenged decentralisation effort to increase rural EMA service provision.	-Health providers feared stigma, privacy breaches and reputational damage from community and profession. Didn't want to be known as the 'abortion doctor'. -Stigma seen as risk to decentralisation as likely to dissuade health professionals from providing abortion.
Hulme-Chambers, Temple-Smith, et al. (2018)	Qual: Semi-structured in-depth interviews	18 abortion seekers – EMA. Rural.	Rural women's experiences obtaining EMA in a rural primary healthcare service.	-Women very satisfied with care from abortion clinic staff. Care from others – GPs, sonographers, pharmacists – at times helpful, at times distressing/ stigmatising: conscientious objection, delays, being 'berated'. - Enacted stigma led to women lying about pregnancy intentions, distress.
Keogh et al. (2017)	Qual: Semi-structured in-depth interviews	"Experts in abortion provision".	Perceived intent and impact of Victorian law reform.	-Providers felt stigma not meaningfully addressed by decriminalisation. -Felt that stigma limits disclosure and provision.

Kruss and Gridley (2014)	Qual: Semi-structured in-depth interviews	11 family planning health professionals. Rural.	Perceived facilitators and barriers to rural family planning accessibility and mental health impacts.	-Examples of doctors refusing to refer, threatening young patients with unwanted disclosure to families. -Conservative values and rural culture perceived barriers to SRH service development.
LaRoche et al. (2020b)	Qual: Semi-structured in-depth interviews	22 abortion seekers (women, non-binary and trans people) – EMA.	Patient experiences of accessing EMA through different health service delivery formats and geographical areas.	- Many women reported unhelpful and stigmatising interactions with GPs – misinformation, attempts to dissuade from choosing abortion. This exacerbated internalised stigma. - Overregulation of mifepristone seen to prevent EMA provision in primary care.
LaRoche et al. (2021b)	Qual: Semi-structured in-depth interviews	22 abortion seekers (women, non-binary and trans people) – EMA.	Effect of criminalisation of abortion on patients' experiences of accessing care.	- US television content drove anticipated stigma and harassment. - Criminalisation felt like moral judgment, drove 'silence' about abortion. - Abortion seekers had to fit their stories into legally mandated narratives of 'acceptable' abortions, creating a hierarchy of deservedness and judgment.
Newton et al. (2016)	Qual Semi-structured in-depth interviews	15 abortion providers – EMA.	Factors influencing abortion method choices.	- Abortion seekers didn't know abortion available as providers not willing to promote service. - Women chose EMA to avoid protestors and stigmatisation.
O'Rourke (2016)	Qual: Content analysis	Parliamentary texts - federal and state - re. abortion reform debates	Assumptions and constructions that maintain dominant narratives about women who seek abortions.	-Debate (by 'conservative' politicians) deliberately promoted stereotypes about abortion seekers - constructed as deviant women, sexualised, irresponsible, dumb - to prevent availability of EMA and public abortions and justify continued state oversight of abortion.

3.4 Results – thematic analysis

The findings of the analysis of all of the included articles are presented thematically below, organised according to the five key components of Stangl et al.'s (2019) Health Stigma and Discrimination Framework. In Figure 4 I have applied key findings from this review to the framework to demonstrate its relevance and value in shaping how we understand and conceptualise abortion stigma. Within these themes, the extent and locations of abortion stigma are also described.

Given that many of the drivers and facilitators of abortion stigmatisation are also consequences of stigma, and vice versa, the exploration of themes in this way results in some arbitrary separation of concepts and experiences, necessitating some repetition.

3.4.1 Drivers and Facilitators of abortion stigma

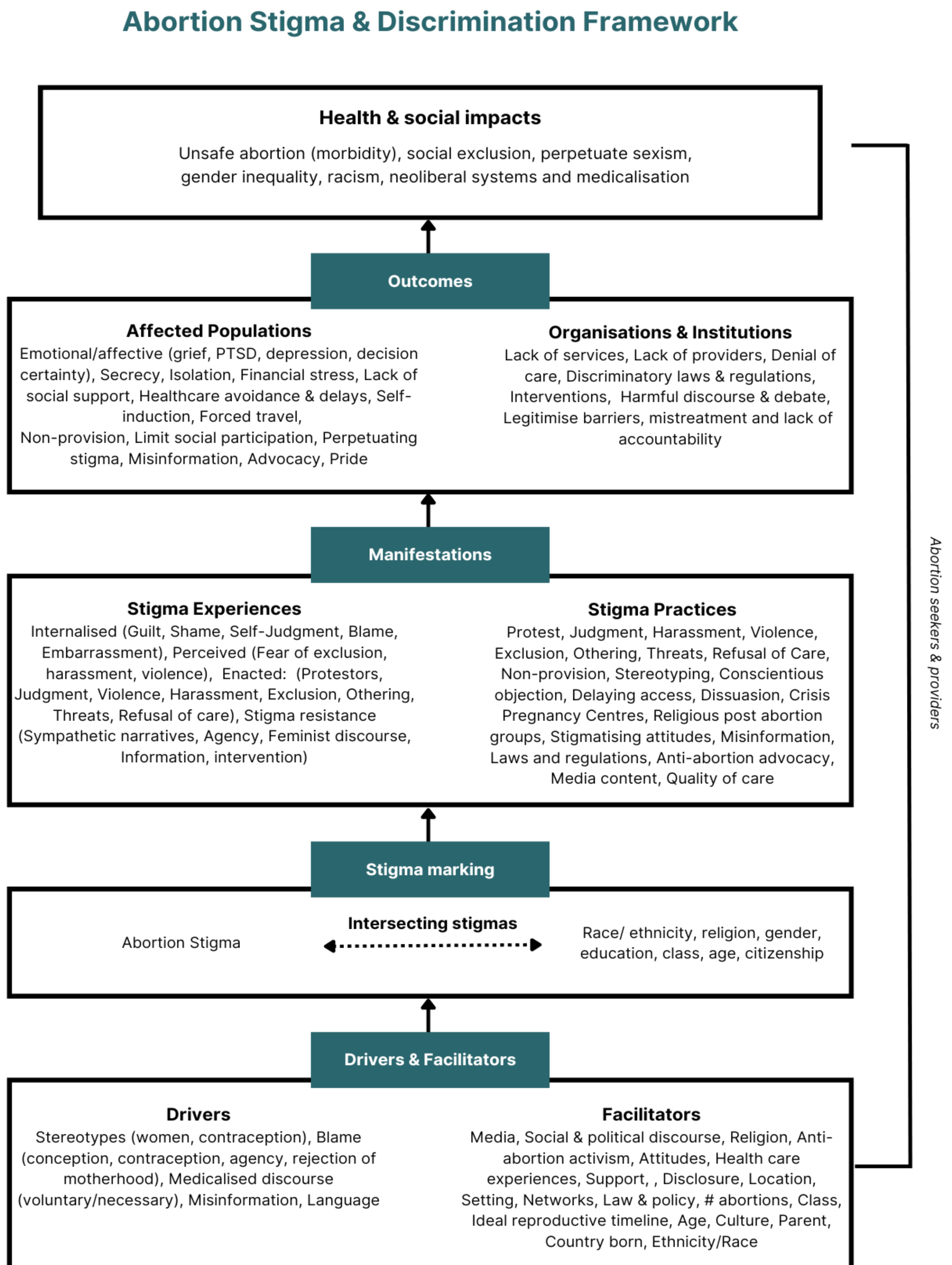
Findings presented here pertain to Stangl and colleagues' (2019) definitions of stigma drivers and facilitators. Drivers, which are "conceptualised as inherently negative", and facilitators, which can be positive or negative, together determine whether stigma marking occurs (Stangl et al., 2019, p. 2).

3.4.1A Social judgment, blame and stereotypes

Facilitated and enabled by gendered norms, abortion laws and policies, stereotypes, judgment, and blame are primary drivers of the stigmatisation of abortion. The assignment of blame to, and the stigmatisation of, abortion seekers depend on the circumstances in which their pregnancies were conceived, and how, why, and with which accompanying emotions they made their abortion decisions (Gelman et al., 2017; Love, 2018). Abortion seekers have been described as being aware of a hierarchy of legitimacy in relation to reasons for seeking abortions (Love, 2021).

Abortions perceived to be necessary or 'medically indicated', abortion as a result of rape, or abortion sought for an unplanned pregnancy that occurred in a context of contraceptive use are generally considered most acceptable, or 'good abortions' (Love, 2018, 2021; Norris et al., 2011). Furthermore, abortion seekers who express decision difficulty, feelings of shame or regret, carefully considering all of their pregnancy options, or experiencing their first abortion are seen to be most 'justified' in their decisions and most likely to elicit sympathetic (rather than blame) responses (Cockrill & Weitz, 2010; McCoyd, 2010; Nickerson et al., 2014; O'Donnell et al., 2011; Ralph, 2022; Shellenberg et al., 2011).

Figure 4: Application of review findings to the Health Stigma & Discrimination Framework



Under such circumstances, abortion seekers may discursively situate their experiences within sympathetic narratives thus be more easily able to avoid or resist stigmatisation (Baird, 2014; Beynon-Jones, 2017; Gelman et al., 2017; Love, 2021; Ralph, 2022). For example, Ralph (2022, p. 211) found that cultural framings of abortion as non-normative mean that abortion seekers who expressed some regret and framed their abortion as a "means of securing the ideal of middle-class motherhood in the future", were able to position their abortions as enablers of responsible parenting, and thus as symbols of responsibility. Love (2021) and Beynon-Jones (2017) in the UK and Ekstrand et al. (2005) in Sweden have described how abortion decisions that enable women to pursue education and career goals can facilitate the avoidance or resistance of stigma as they enable the achievement of middle-class goals and norms.

In contrast, abortions perceived to be 'voluntary' or for 'social' reasons, that occur at 'later' gestations, and sought by people who have experienced previous abortions are seen to be least acceptable, or 'bad' abortions (Love, 2018, 2021; McLeod et al., 2022; Norris et al., 2011; Smith et al., 2018). Multiple studies have found that women are considered to be primarily responsible for birth control, and thus 'irresponsible' when it isn't used or fails (Aiken et al., 2018; Ekstrand et al., 2005; Gelman et al., 2017). Negative references to abortion being used 'as birth control' position women and abortion seekers who have more than one abortion as failing to learn from 'their mistakes', abortion as exceptional, and thus not legitimate family planning health care (Hoggart, 2017; LaRoche & Foster, 2018; Shellenberg et al., 2011).

This hierarchy of abortion acceptability and the notion of responsibility have historically been reflected in global abortion laws, which have most frequently allowed abortion "to preserve a woman's health" and least frequently allowed abortion for "economic or social reasons" or "on request" (Berer, 2017, p. 17). Research in Australia has found that laws criminalising abortion result in abortion seekers feeling they are "required to fit their abortion story into a state-mandated narrative" (LaRoche et al., 2021, p. 1).

The impacts of hierarchies of acceptability appear to be particularly salient in healthcare settings. Abortion seekers perceive and experience pressure to present 'respectable' abortion narratives and 'justify' abortion choices in order to secure abortion access (Love, 2021b, p. 325; De Zordo, 2018b; Love, 2018). An abortion seeker in an Australian study described,

> … her only frame of reference for abortion was that it was illegal and she thought her experience would mimic what she had seen on American television shows. She expected there to be protestors and to experience harassment when she went for her abortion...She described herself as being "terrified" to give the wrong answer and feared that she would be forced to continue with her pregnancy if she said the wrong thing (LaRoche et al., 2021, p. 4).

Medicalised classifications of abortions as either ‘necessary’ or ‘voluntary’ have been found to proliferate among healthcare providers and medical students in a range of settings, impacting their beliefs, practices, and abortion-provision decisions (De Zordo, 2018; Love, 2021; Rivlin et al., 2020; Smith et al., 2018). Medically indicated abortions are positioned as more deserving, there are more providers and services willing to offer them, and less judgment by (future) health professionals towards patients who seek them, in comparison with abortions categorised as ‘voluntary’ (Rivlin et al., 2020; Smith et al., 2018). Some medial students reported accepting that some abortion related discrimination is “normal and ethical” as a result (Smith et al., 2018, p. 26). Healthcare providers involved in first trimester abortion care, which is most often for abortions that are (problematically) described as ‘voluntary’, are also more likely to experience harassment than those providing primarily ‘medically indicated’ abortions (Mcleod et al., 2022; De Zordo, 2018).

3.4.1B The media is a driver and facilitator of abortion stigmatisation

Several studies described that abortion seekers and providers believe the media plays a pivotal role in the stigmatisation of abortion (Ekstrand et al., 2005; Evans & O’Brien, 2015; Gallagher et al., 2010; Littman et al., 2009; Purcell et al., 2014). In both Australia and the UK, abortion-related media content has been found to utilise “emotive language that aligns with a pro-life ideology …which has the power to shape perceptions of deviance and stigma surrounding abortion”, despite majority support for abortion in these settings (Evans & O’Brien, 2015, p. 255; Purcell et al., 2014). Similarly, the media has been described as a key source of misinformation (Gallagher et al., 2010; Littman et al., 2009). O'Rourke (2016, p. 37) found stereotypes perpetuated in media and parliamentary texts were “successful in terms of perpetuating the stigma surrounding abortion and in justifying continuing state oversight or intervention”.

3.4.1C Religion

While abortion stigma appears to exist across cultural and religious contexts, religiosity has nevertheless been consistently found to be correlated with abortion stigma practices and experiences. In the US, people who identify as ‘religious’ or attend religious services at least once a month have been found to have higher levels of internalised stigma and stigmatising attitudes, and to be less likely to support abortion-supportive policies, than their less or non-religious counterparts (Cockrill & Nack, 2013; Cutler et al., 2021; Janiak et al., 2018). Research participants, including both abortion seekers and health professionals, have also described religiosity as a barrier to abortion accessibility. Research participants described religion as driving conscientious objection among General Practitioners (GPs) which, particularly in rural and remote communities where there are limited health professionals, can limit or prevent abortion provision and access (De Moel-Mandel et al., 2021; Heller et al., 2016). Studies have also found that religious individuals and organisations in the US, including anti-abortion Crisis Pregnancy Centres and an evangelical post-abortion support group, constructed abortion as dangerous, convinced abortion seekers they were

traumatised, and intentionally stigmatised abortion, at times with direct reference to Christian religious teachings (Husain & Kelly, 2017; Kimport, 2019).

3.4.2 Facilitators of abortion normalisation and stigma resistance

Along with drivers and facilitators of abortion stigmatisation, a suite of facilitators of abortion normalisation have been identified, including abortion-supportive attitudes, social and partner support, sexual and reproductive health literacy and information, and abortion storytelling.

3.4.2A Abortion-supportive attitudes facilitate abortion normalisation

Abortion attitudes and beliefs - held by abortion seekers, providers, future providers (i.e., medical students), and the public - were found to mediate abortion stigma experiences. For example, holding abortion-supportive attitudes and perceiving a community (broadly) to be supportive of abortion was found to enable abortion provision and intent to provide abortion among medical students in Canada (Myran et al., 2015). In rural New South Wales, Australia, women who sought abortion and abortion providers described abortion supportive attitudes as a necessary condition for abortion accessibility and reductions in stigma experiences (Doran & Hornibrook, 2014). Believing in the principles of reproductive rights and autonomy have also been found to protect abortion seekers subjected to anti-abortion protestors from feelings of shame and internalised stigma (Carroll et al., 2022). Book club interventions in the US, wherein groups of women read stories that included abortion seeking, found groups with more abortion-supportive attitudes encouraged abortion disclosures by abortion seekers' and improved the stigma-reducing effects of the intervention (Cockrill & Biggs, 2018).

3.4.2B Other facilitators of abortion stigma resistance among abortion seekers

For abortion seekers at the interpersonal level, several factors have been identified as playing a role in facilitating de-stigmatising abortion-related interactions and experiences. Several US studies described how having support people in their lives, and partners with them at abortion appointments, helped abortion seekers to mitigate potential practical and mental health impacts of stigmatisation (Altshuler et al., 2021; Hanschmidt et al., 2017; Herold et al., 2015). In particular, attending abortion appointments accompanied by their partners can help to protect abortion seekers against the internalisation and anticipation of stereotyping related to notions of promiscuity and irresponsibility (Altschuler et al., 2021). Having interactions with supportive health providers was also found to improve patient experiences of abortion, with some providers reporting they used interactions with patients to actively correct and resist abortion-related stereotypes (Altshuler et al., 2017; Hanschmidt et al., 2017; J. O'Donnell et al., 2011). For women who seek abortion for fetal abnormality, a strong association between perceived and internalised stigma has been

identified (Hanschmidt et al., 2017). Minimising perceived stigma through interactions, such as with health professionals, that normalise abortion appear to reduce experiences of internalised stigma, in turn mediating grief and depressive symptoms (Hanschmidt et al., 2017).

Knowledge and experience of pregnancy and abortion and knowing a close friend or family member who has had an abortion have been found to be protective against internalised and perceived abortion stigma (Kavanaugh et al. 2019; Zareba et al. 2017), likely due to combating the salience or acceptance of abortion-related stereotypes. Interventions that have helped abortion seekers feel 'less alone' appear to mitigate abortion-related stigma. For example, a participant in a US trial describing seeing a video of others talking about their abortion experiences as, "empowering! You don't see it, don't hear it. That was good stuff!" (Littman et al., 2009, p. 427). In contrast, however, showing abortion stories to members of the public in a US-based intervention appeared to be less impactful, resulting in immediate reductions in stigma that were lost at 3-month follow up (Cutler et al., 2022).

For abortion seekers who talk about their abortion experiences with others, stigma-mitigating effects have been identified as a result of the frequency of positive and supportive responses received, connections made through disclosure and attitudinal changes resulting from storytelling (Woodruff et al., 2020). Receiving positive responses to an abortion disclosure can encourage further disclosure, thus interrupting cycles of shame, non-disclosure and perceived rarity of abortion (Kumar et al., 2009; Woodruff et al., 2020). Among abortion advocates, publicly speaking about their activism has been found to help them to resist internalised stigma related to their public support for abortion (Giovannelli et al., 2022).

At the individual level, framing their abortion stories within sympathetic narratives and as morally sound facilitates stigma resistance among abortion seekers (Hoggart, 2017). Several studies have found that abortion seekers distance themselves and their circumstances from 'other women' to avoid stigmatisation, thus simultaneously avoiding stereotypes associated with selfishness and irresponsibility while perpetuating stigmatising discourses (Hoggart, 2017; Nickerson et al., 2014). In contrast, studies have found that some abortion seekers explicitly reject abortion-related stereotypes and stigma through positive and rights-based framings of abortion (Purcell et al., 2020; Ralph, 2022). However, even when women perceive their abortion experiences positively and resist the often assumed 'awfulness' of abortion, they often situate their positive interpretations within inherently negative or moral abortion frames (Purcell et al., 2020). Explicitly positive and feminist abortion narratives are primarily used by pro-choice activists and organisations (Baird & Millar, 2019).

3.4.2C Facilitators of stigma resistance among health professionals who provide abortion care

Geographical location, organisational setting, professional networks, and pride in their abortion work have been found to enable abortion stigma resistance and abortion normalisation among health professionals who provide abortion care. Geographically, abortion providers working in urban environments more commonly report supportive professional environments and less frequent experiences of stigma and discrimination, and subsequently fewer barriers to provision, in comparison with abortion providers working in rural areas (Jennifer Dressler et al., 2013; Hulme-Chambers, Clune, et al., 2018; Norman et al., 2013). Health professionals who provide abortion care have also described abortion-specific facilities, facilities that have been providing abortion for longer periods of time, and university-based health services as safe spaces that protect workers from stigmatisation by colleagues and enable professional bonding and support (Harris et al., 2011; O'Donnell et al., 2011; Summit et al., 2020). In Ireland, working in general practice, compared with hospital settings, has been found to lead to lower levels of provider stigma (Dempsey et al., 2021). Professional networks and discussing their work experiences with other abortion providers have been found to be supportive and normalising for health professionals who provide abortion care (Martin et al., 2017; O'Donnell et al., 2011). Positioning abortion as routine healthcare, as well as considering themselves as working for an important cause, can help health professionals who provide abortion care to find pride in their work, counter stigmatising narratives, and to resist stigmatisation more broadly (Martin et al., 2014; Maxwell et al., 2020; O'Donnell et al., 2011).

3.4.2D Community and structural-level facilitators of abortion normalisation

Relative to facilitators of stigma and abortion normalisation at the individual level, fewer included studies described structural level facilitators of abortion normalisation, stigma resistance and mitigation. Several studies that have explored the impacts of abortion related laws on abortion stigmatisation and normalisation, including harassment and violence against abortion seekers, providers and clinics, didn’t identify meaningful impacts (Keogh et al., 2017; Pridemore & Freilich, 2007). Nevertheless, restrictions imposed on abortion via laws and policies create opportunities for the stigmatisation of abortion (Broussard, 2020; De Moel-Mandel et al., 2021; Lee et al., 2022). Institutional avoidance of engaging in ‘abortion politics’ places responsibility (perceived and/or actual) for ensuring and enabling abortion accessibility on individual health providers, significantly impacting individuals’ careers and wellbeing, and alienating them from their colleagues (Chowdhary et al., 2022). Addressing legal and organisational restrictions complicating and undermining abortion accessibility may therefore be critical for the de-stigmatisation of abortion.

The limited studies that have explored the relationship between pro-choice activism and abortion stigma have found positive representations of abortion play an important role in its normalisation.

Baird and Millar (2019) identified a trend in increasingly positive – feminist and pro-choice – commentary on Australian abortion clinic and feminist websites and called for an increased (academic) focus on positive representations of abortion. In Poland and Ireland, researchers found that feminist, pro-choice and political activists, and abortion advocates effectively used narratives framing abortion as normal and common in order to combat stigmatisation and prevent (further) restriction of sexual and reproductive health care (Cullen & Korolczuk, 2019).

3.4.3 Manifestations: Stigma experiences and practices

Experiences of abortion stigma(tisation), and the impacts of these, are the most well addressed aspects of Stangl and colleagues' Health Stigma and Discrimination Framework among the studies identified and included in this review. As described in Chapter 2, in Stangl et al.'s (2019, p.3) framework, stigma experiences are described as including internalised, perceived, anticipated and secondary stigma and discrimination. Based on the state of abortion stigma research and theory, however, in the following section I have categorised 'stigma experiences' according to Cockrill and Nack's three domain model of individual-level abortion stigma, referring to internalised, felt, and enacted stigma. 'Felt' stigma includes references to perceived and anticipated stigma. Stigma practices are referenced as described by Stangl et al. (2019, p.3) and include stereotyping, prejudice, and enactments of stigmatising behaviours and discriminatory attitudes.

3.4.3A Internalised stigma

Cockrill and Nack (2013) describe that internalised stigma manifests among women who have had abortions when they believe negative discourses about abortion seekers, and that such discourses apply to themselves. Even abortion seekers who disagree with the stereotypes associated with abortion stigmatisation, however, have described stigmatising narratives as "getting under their skin" (Love, 2021, p. 327).

Among the included studies, the belief that women are primarily responsible for contraception, and thus perceptions that they are irresponsible and 'to blame' in cases of unplanned pregnancy that result in abortion, was the most commonly identified cause of internalised stigma, guilt, and shame (Allen, 2014; Cockrill & Nack, 2013; Ekstrand et al., 2009; Hoggart, 2017; Kimport et al., 2011; Love, 2018). Abortion seekers described themselves as "stupid" (Cockrill & Nack, 2013), but did not hold similar feelings of blame towards their sexual partners (Ekstrand et al., 2009; Kimport et al., 2011). In contrast, abortion seekers who were able to position their abortions as 'not their fault' were more easily able to distance themselves from contraception-related (self)judgment and (self)blame (Allen, 2014; Hoggart, 2017; Hoggart et al., 2017). A 30-year-old abortion seeker in Love's (2018, p. 760) study in the UK explained,

> The internal pressure to make an excuse for why you were pregnant in the first place is really intense. For a while I was like, of course I had an IUD [intrauterine device] and it was completely a mistake, and I would think, why am I doing that? I would never expect someone else to explain an abortion to me, so why do I feel the need to explain my abortion to people who don't even care?

Internalised stigma, and a heightened sense of embarrassment, failure, and shame, has been found to be particularly salient when someone has more than one abortion experience (Hoggart et al., 2017; LaRoche & Foster, 2018). As one research participant from Canada explained,

> I guess, for me the thing that I felt sort of weird about was the fact that I had three [abortions]…I have some shame around that, sort of like, you think that I could get it together better on the birth control front (LaRoche & Foster, 2018, p. 330).

In these accounts internalised stigma appears to be related to gendered contraceptive norms wherein women are held primarily responsible for pregnancy prevention. Social norms, beliefs, and stereotypes about the inevitability of and women's responsibility to prioritise motherhood, and about abortion seekers as single, "unintelligent, naive, uneducated, promiscuous, irresponsible, cruel, and/or selfish" have also been found to drive internalised stigma among abortion seekers (Altshuler et al., 2017, 2021; Cockrill & Nack, 2013, p. 979). That said, Cockrill and Nack (2013), in their seminal work on individual level abortion stigma in the US, also found that not all women seeking abortion internalised such beliefs, some women who had abortions alternately altering their previous beliefs about abortion seekers as a result of their experience. In the US, race, religion, anti-abortion attitudes, and having ever given birth have been found to predict experiences of internalised stigma (Altshuler et al., 2021; Cockrill & Nack, 2013; Cutler et al., 2021; Sackeim et al., 2022; Shellenberg & Tsui, 2012; Tsui et al., 2011; Wiebe et al., 2011).

Overall, there was limited evidence in the included studies that abortion providers commonly experience internalised abortion stigma. Martin et al. (2018) found that only 3% of the 315 providers they surveyed felt 'shame' about their work. Christian faith and burnout were identified in included studies as increasing the likelihood of providers experiencing internalised stigma (Dempsey et al., 2021; Martin et al., 2017; Martin et al., 2018).

3.4.3B Felt stigma

The extant literature suggests felt (including anticipated and perceived) abortion stigma is common among both abortion seekers and providers across settings and countries (Aiken, Johnson, et al., 2018; Biggs et al., 2020; Carroll et al., 2022; Chor et al., 2019b; Cockrill & Nack, 2013; Coleman-Minahan et al., 2020; Coleman-Minahan et al., 2019; Doran & Hornibrook, 2016; Gelman et al., 2017; L. H. Harris et al., 2011; Kimport et al., 2011; Lee et al., 2022; Martin et al., 2014; Martin et

al., 2018; Maxwell et al., 2020; McLeod et al., 2022; Shellenberg & Tsui, 2012; Zaręba et al., 2017). Several large quantitative studies exploring the prevalence and correlates of abortion stigma in the US have found that between one half and two thirds of abortion seekers perceive and anticipate judgment from people close to them and their wider communities related to their abortions (Biggs et al., 2020; Shellenberg & Tsui, 2012). A study in Germany found 37% of abortion seekers feared (perceived) stigma (Killinger et al., 2022).

Felt abortion stigma presents as fears about the potential social consequences that can result from having or providing abortions. These commonly include the fear of receiving negative or judgmental reactions from friends, family, healthcare providers, co-workers, or strangers on disclosure of/in the case someone finds out about an abortion experience or work (Aiken et al., 2018; Altshuler et al., 2017; Astbury-Ward et al., 2012; Cockrill & Biggs, 2018; Cockrill & Nack, 2013; Doran & Hornibrook, 2014; Doran & Hornibrook, 2016; Ekstrand et al., 2009; Herold et al., 2015; Kimport et al., 2011; Martin et al., 2018; Nickerson et al., 2014; Smith et al., 2016; Weitz & Cockrill, 2010). They also include the fear of encountering anti-abortion protestors outside an abortion service, social or religious exclusion and physical harassment or violence (Astbury-Ward, 2018; Harris et al., 2011). For health professionals involved in abortion provision, fears related to targeted harassment or social exclusion of family members and of career impacts have also been described (Dawson et al., 2017; Dressler et al., 2013; Martin et al., 2017). Women in the US military also feared career repercussions should people in their workplace learn about their abortion experiences (Grindlay et al., 2017).

As with internalised stigma, certain sub-populations of abortion seekers and providers have been found to be more likely than others to perceive high(er) levels of abortion stigma. This includes people living in small/rural communities (Altshuler et al., 2017a, 2017b), white women compared with Hispanic and black women (in the US) (Bommaraju et al., 2016; Shellenberg & Tsui, 2012), young people (Killinger et al., 2022), people living in states with particularly restrictive abortion laws or conservative social values (Shellenberg & Tsui, 2012), and people with higher levels of religiosity (Martin et al., 2017; Shellenberg & Tsui, 2012; Zaręba et al., 2017). While having had one, multiple or a recent abortion(s) was been found to lead to lower felt abortion stigma scores in some quantitative studies (Rice et al., 2017; Shellenberg & Tsui, 2012), qualitative research alternately indicates many abortion seekers have particularly acute fears of judgment related to (and driven by the frequency of) their second and subsequent abortions (Doran & Hornibrook, 2016; Hoggart, 2017; LaRoche & Foster, 2018). Pregnant women who have sought and received abortion care, versus those denied abortion care, have also been found to score higher on measures of felt abortion stigma (Biggs et al., 2020).

3.4.3C Enacted stigma and discrimination

Given the scope of research regarding enacted stigma, the findings in this section are separated into three sections. The first section includes research pertaining to enacted stigmatisation of and discrimination against abortion seekers. The second describes enacted stigmatisation of and discrimination against health professionals who provide abortion care. Thirdly, structural stigma practices and experiences of enacted structural stigma, including via laws, policies, institutions, and social discourse, are explored.

Abortion seekers' experiences of enacted abortion stigma and discrimination

Quantitative studies indicate that harassment and discrimination of abortion seekers by family and friends may be less common than abortion seekers and providers anticipate (Shellenberg et al., 2011; Tsui et al., 2011). Several included studies quantitatively measured abortion stigma enacted by friends, family and strangers. Cowan (2017) found that less than a third of participants in the US who told others about their abortion experiences were met with reactions that were perceived to be negative, while most abortion seekers received responses that they perceived to be supportive and sympathetic (Chor et al., 2019; Cowan, 2017). Even so, negative responses to abortion disclosures from friends, family members and acquaintances have been described in numerous studies. Such responses range from unsupportive replies, shaming, and refusal of support to the loss of friendships and relationships, being called 'murderers' by partners, receiving distressing images, death and physical threats, and overt harassment and violence from intimate partners and family members (Gelman et al., 2017; Nickerson et al., 2014; Ostrach & Cheyney, 2014).

The positivity of reactions to an abortion disclosure have been found to vary by the reason for disclosing an abortion experience, who a disclosure is made to and in what setting (Cowan, 2017; Woodruff et al., 2020). Abortion disclosures and storytelling to more general audiences online elicit more negative responses. A US study of the responses to publicly shared abortion stories identified higher rates of enacted stigma online, over 53% of abortion seekers having negative experiences online compared with 36% experiencing negative reactions in person (Woodruff et al., 2020).

In contrast to the minority of abortion seekers who have reported negative responses to abortion disclosures to family and friends, experiences of discrimination and judgment enacted by health professionals in relation to abortion seeking appear to be relatively common. Abortion seekers have described health professionals refusing to provide information about or referrals to abortion related services, attempting to dissuade patients from choosing abortion, refusing to conduct vital surgeries that could endanger a fetus, and selective provision of abortion services, including informing patients that they do not provide 'social' abortions (Cashman et al., 2021; Cleetus et al., 2022; Kavanaugh et al., 2019; Kruss & Gridley, 2014). Abortion seekers have also described experiencing judgmental comments, misinformation about their rights, options and pathways,

health practitioners threatening unwanted disclosure to family members and berating them, and health practitioners making assumptions and comments about sexual behaviour and contraceptive use (Aiken, Guthrie, et al., 2018; Altshuler et al., 2017; Astbury-Ward et al., 2012; Deeb-sossa & Billings, 2014; Kruss & Gridley, 2014). Enacted stigma by health professionals is particularly common in ultrasound appointments and in services that do not specialise in abortion care, whereas it appears to be uncommon in private and specialist abortion clinics (Cashman et al., 2021; Hulme-Chambers, Temple-Smith, et al., 2018; Love, 2018). Crisis pregnancy centres (CPCs) and religious 'help' lines in the US have also been found to be key sources of such stigmatisation. Staff in these services have been found to routinely provide inaccurate information about abortion and contraception, use bible passages to shame and persuade patients, use stigmatising language, such as referring to fetuses as 'children' or 'babies', diagnose false disorders (such as 'post-abortion distress disorder'), refuse care to those not continuing pregnancies, and even to physically block abortion-seekers from leaving their services (Kavanaugh et al., 2019; Kimport, 2019; LaRoche & Foster, 2015).

Laws that require young people to seek judicial approval to access abortion when they do not have parental consent (known as 'judicial bypass'), present in some US states, facilitate the stigmatisation of abortion seekers by judges and court staff. Judges in judicial bypass cases have been found to actively shame abortion seekers, particularly in regard to their sexual behaviour and contraceptive use, and to refuse to try cases involving abortion (Deeb-sossa & Billings, 2014). The judicial bypass process itself has been described as "a form of punishment" based on paternalistic claims that young women need protecting from their own 'immaturity' (Coleman-Minahan et al., 2021; Deeb-sossa & Billings, 2014). One research participant described, "I think she [the judge] laughed in the courtroom. She was kind of making fun of me for not knowing that condoms were considered birth control" (Coleman-Minahan et al., 2019, p. 23). Maturity, tied to stereotypes about 'good girls' and 'deserving abortions', is a legal basis on which judges may grant or deny young people abortion access (Coleman-Minahan et al., 2021; Deeb-sossa & Billings, 2014).

Protestors have been identified as another common source of enacted stigma towards abortion seekers. A US study of 956 women seeking abortions found that half (46%) had seen protestors when entering abortion clinics (Foster et al., 2013). Most (85%) of clinics that participated in the same study reported regular protests outside of their facilities (Foster et al., 2013). In Contrast, a Canadian study found 10% of participants, who included 305 women who had sought abortions in the previous five years, had seen anti-abortion protestors when attending their abortion appointments (Foster et al., 2020). Specialist abortion clinics and facilities doing higher numbers of abortion procedures are most likely to experience (particularly aggressive) protestors (Foster et al., 2013; Janiak et al., 2018).

Research participants have described protestors as holding distressing and offensive signs, shouting insults at abortion seekers and providers, sounding horns every time clinic doors open, attempting to stop people from entering clinics, offering abortion seekers money, adoption, and pamphlets, following people to and from their cars, taking photos of peoples' number plates, 'witnessing', and threatening staff (Carroll et al., 2022; Carroll & White, 2020; Doran & Hornibrook, 2016; Foster et al., 2020; Joffe & Schroeder, 2021; Lowe & Hayes, 2019). Over a third of clinics in a US study categorised protestor behaviour as primarily aggressive, a further 44% indicating protestors engage in a combination of passive and aggressive behaviours (Foster et al., 2013). Anti-abortion protestors have been described as indiscriminate in their targeting of people entering abortion clinics:

> Antonia became pregnant in her late teens after an acquaintance raped her. When she went to a clinic in New Brunswick to obtain her abortion, she encountered a group of protesters. Antonia explained, "I still had the bruises and I still had black eyes. And I had protesters screaming at me, 'you dirty whore, baby killer'. It was awful." (Foster et al., 2020, p. 310)

Religion has been found to be central to anti-abortion protestors' activism (Altshuler et al., 2017). An abortion seeker in the US described how a protestor approached her outside of an abortion clinic with signs containing distressing images, raised a cross to her head and declared,

> "May God forgive you for murdering your child." Nobody at any time did or said anything that made me feel like [having an abortion] was okay, like other women go through this, like you're not a bad person. It was just the opposite. I felt judged … felt like everything I was doing was wrong. (Altshuler et al., 2017, p.112)

Anti-abortion protesters don't necessarily perceive their behaviour to be harassing or negatively received (Lowe & Hayes, 2019). Abortion seekers' accounts contrast this as they describe how anti-abortion protestors cause fear and grief, researchers surmising this exacerbates the systematic stigmatisation of abortion (Cockrill & Nack, 2013; Altshuler et al., 2017).

Abortion providers' experiences of enacted abortion stigma and discrimination

Similarly to abortion seekers, providers and clinic staff have been found to experience a range of enacted stigma perpetrated by patients, strangers, and anti-abortion protestors. Harassment and violence against abortion providers, particularly in the US, has been found to be common. Abortion providers frequently report experiencing negative comments from community members and patients regarding their work (Gallagher et al., 2010; Martin et al., 2017; O'Donnell et al., 2011). A national study found that 84% of abortion clinics had experienced at least one form of harassment (Jerman & Jones, 2014), while other US studies have found that between a third and half of abortion providers report having experienced targeted verbal and/or physical harassment (Martin et

al., 2018; McLeod et al., 2022b). In Canada, nearly 12% of providers report having experienced threats to themselves or their families, and 23.5% report experiencing property vandalism (Norman et al., 2013). Online harassment, in the form of anti-abortion activists publishing providers' personal information, was seen to increase providers' vulnerability to violence and social exclusion (McLeod et al., 2022b; Rosen & Ramirez, 2022b). Studies have also found abortion providers are significantly impacted by disapproval and marginalisation within the medical profession itself (Harris et al., 2011; J. O'Donnell et al., 2011). One study found that more than half of US abortion providers surveyed felt they were marginalised within healthcare at least sometimes (Martin et al., 2014).

As noted above, standalone women's health/abortion clinics are considered by many practitioners as 'safe spaces' due to supportive colleagues and environments (Dressler et al., 2013; Gallagher et al., 2010). Even so, health professionals providing abortion care in such facilities are more prone to experiencing harassment and anti-abortion protestors than those providing abortion in more general medical settings (Jerman & Jones, 2014). In contrast, abortion providers who work in general hospitals commonly report having to manage stigmatisation and negative interactions with other health providers, resulting in strained collegial relationships, lost learning opportunities, and logistical barriers to abortion provision, as well as the complete prevention of abortion provision (Dawson et al., 2017; Dressler et al., 2013; Harris et al., 2011; O'Donnell et al., 2011). Abortion providers working in rural communities report particularly significant challenges in regard to professional opposition, including refusal to participate in abortion cases by other health staff, impacting their ability to provide abortion services and a perceived need not to publicise their abortion work (De Moel-Mandel et al., 2021; Jennifer Dressler et al., 2013; Norman et al., 2013; Summit et al., 2020).

3.4.3D Other stigmatising practices

Along with the myriad interpersonal enactments of abortion stigma, studies have described aspects of social discourse, laws, policies, and health systems as both enabling and enacting abortion stigma and discrimination. Often these were not explicitly described as enacted stigma or stigma practices. Abortion-related stereotypes and narratives positioning abortion as non-normative appear to be intentionally invoked and perpetuated by anti-abortion activists and religious institutions and (unintentionally/ subliminally) accepted and spread by the public via the media and social and political discourse (Duerksen & Lawson, 2017, 2018; Kruss & Gridley, 2014; Littman et al., 2009).

Language use

News coverage related to abortion uses language that shapes and perpetuates stigma and reinforces negative stereotypes about women and their reasoning around abortion choices. News coverage has been found to be more supportive when referring to women adhering to 'sympathetic abortion' narratives (Evans & O'Brien, 2015; Purcell et al., 2014). Parliamentary debate in Australia has similarly been found to be a source of such enactments of abortion-related discrimination, during which stigmatisation has been found to be used as a tool arguing for anti-abortion legislation (O'Rourke, 2016). Several studies have indicated that such public and polarising discourse and debate in the US are sources of pain and isolation for both women and providers (Harris et al., 2011; McCoyd, 2010).

Laws and regulations

Laws that criminalise and separate abortion from mainstream healthcare reflect and enact stigmatisation, legitimising the stigmatisation and 'othering' of abortion care, abortion seekers and providers. Criminalisation of abortion in Ireland prior to 2018, for example, resulted in forced travel, negative health outcomes, and financial hardship (Aiken et al., 2018). A 24-year-old woman described her experience of criminalisation, saying,

> The worst part was when I got to the airport and had to wait five hours to get a plane home when I really needed be in bed and resting. I was sitting there bleeding and it was really tough. I felt like a criminal. But even when I got home the real sense of shame doesn't leave. I had problems looking people in the eye because an experience like that basically says: we don't care about you enough in this country, you should leave (Aiken et al., 2018, p.183).

In Australia, LaRoche and Foster (2021, p. 4) found that, for many of their research participants, the criminalisation of abortion, "felt like a moral judgment and contributed to the feeling that abortion was something that should not be talked about".

Laws and policies that treat abortion as distinct from other sexual and reproductive healthcare similarly alienate health professionals who provide abortion care from the wider health and medical communities, legitimising professional 'othering' and driving a lack of abortion provision (De Moel-Mandel et al., 2021; Harris et al., 2011; Keogh et al., 2017). Providers in the US have described how such restrictions lead to them being labelled 'abortion doctors' who find themselves constantly defending their work, losing medical privileges, and exclusion from institutions and credentialing processes (Chowdhary et al., 2022). Judicial bypass laws, described above, similarly facilitate the stigmatisation of abortion seekers, while stigma enables and legitimises judges' flouting of their legal obligations and preventing access to abortion based on personal beliefs (Coleman-Minahan et al., 2021b; Deeb-sossa & Billings, 2014). Furthermore, even supportive attorneys have been found to incidentally shame their clients as they worked to create narratives around their clients'

pregnancies that would be more likely to secure them abortion access: "Stratifying legitimate abortions and bypasses are actions attorneys use to protect successful judicial bypasses at a population level" (Coleman-Minahan et al., 2021, p.6), thus enacting stigmatising stereotypes to secure individuals' access to care.

Findings regarding the correlation of state level laws regarding reproductive rights with abortion violence and harassment in the US are variable. While one study found no association between laws and anti-abortion violence and harassment (Pridemore & Freilich, 2007), another found more restrictive abortion-related laws are associated with an increase in minor anti-abortion harassment and vandalism (Russo et al., 2012).

3.4.4 Outcomes

The included studies describe a suite of emotional, behavioural, abortion access, and stigma-reinforcing outcomes from the stigmatisation of abortion, abortion seekers and providers. The impacts and outcomes of abortion stigmatisation appear to be the least well addressed element of the Health Stigma and Discrimination Framework Stangl et al.'s (2019) framework. Of note, all the outcomes described were identified by studies with people who had sought or were accessing, or who provided abortion and abortion-related services. There is a dearth of research exploring the impacts of abortion stigma on pregnant people prior to abortion seeking.

3.4.4A Emotional/ affective outcomes

Guilt, shame, and secrecy appear to be the most commonly described manifestations and impacts of internalised and felt abortion stigma (Hoggart, 2017; Tsui et al., 2011). As an abortion seeker in Cashman et al. (2021, p. 235) described, "you go there [to get an abortion] already you think with some guilt, and you're blaming yourself". Internalised abortion stigma has also been found to be associated with higher levels of grief, PTSD, and depression (Hanschmidt et al., 2017). In contrast, studies have found mixed results about the relationship between perceived stigma and mental health (Kerns et al., 2022; Littman et al., 2009; O'Donnell et al., 2018). Difficulty making pregnancy outcome decisions and choosing to continue pregnancies has also been described as an outcome of perceived/anticipated and internalised stigma (Hoggart, 2017).

3.4.4B Secrecy

Abortion stigma has also been commonly found to result in secrecy and careful disclosure management among both abortion seekers and providers. Studies indicate that abortion seekers who perceive abortion-related stigma and negative attitudes towards abortion in their community are less likely to disclose their abortions to others, in attempts to avoid embarrassment or judgmental reactions (Aiken, et al., 2018; Astbury-Ward et al., 2012; Cockrill, 2013; Cowan, 2014; Doran & Hornibrook, 2014; Ekstrand et al., 2009; Nickerson et al., 2014). Limiting disclosure, while reducing opportunities for experiencing enacted stigma, can result in social isolation and a lack of social support. This in turn has been found to lead to delays in accessing care and social isolation post-abortion (Astbury-Ward et al., 2012; Harris et al., 2011; McCoyd, 2010). Non-disclosure can also result in financial stress: abortion seekers describe they have avoided accessing funding (insurance or public) to which they are entitled, for fear it will lead to unwanted disclosure of their abortions (Cockrill & Weitz, 2010; Grossman et al., 2010; Nickerson et al., 2014). For abortion providers, a lack of opportunities to express and talk through the complexities of their emotions surrounding their abortion work can mean they feel unable to live 'authentically' or 'be themselves' (Martin et al., 2017; O'Donnell et al., 2011).

3.4.4C Health care accessibility

Attempts to avoid unwanted disclosure of an abortion, anticipated negative reactions from healthcare providers, internalised stigma, and prior experiences of stigmatisation during abortion-seeking have been shown to drive avoidance of formal, safe abortion care and follow-up (Aiken et al., 2018; Harris, 2012). Health care avoidance can also be a response to and enable avoidance of anti-abortion protestors (Bras et al., 2021; Ireland et al., 2020; Kerestes et al., 2021). A desire to avoid judgment and discrimination during the abortion-seeking process motivates some women to choose medication abortion via telemedicine, including in contexts where abortion is legal and relatively accessible (Aiken et al., 2018; Aiken, Johnson, et al., 2018; Kerestes et al., 2021; Killinger et al., 2022). Other pregnant people attempt self-induction of (unsafe) abortion as a result of perceived stigma and anticipated judgment and/or violence (Grossman et al., 2010; Harris, 2012).

Perceived abortion stigma, including fear of negative reactions and social isolation, is also linked to a lack of abortion provision, limited service availability, delays in receiving abortion care, and a lack of promotion of available services (Dawson et al., 2017; Heller et al., 2016; Silvia De Zordo, 2018;). Health practitioners eligible for but not providing abortion services have cited anticipated risks to their families as a key reason for their lack of provision (Shellenberg et al., 2011). For health practitioners who do choose to provide abortion services, many feel they have to manage disclosure of their work and worry at least some of the time about how they will be perceived if people find out about their work (Martin et al., 2018). As a result, perceived stigma can limit

providers' social participation, and is particularly impactful for those working in small or rural communities and who have children (Astbury-Ward, 2018; Dressler et al., 2013; Harris et al., 2011; O'Donnell et al., 2011).

The decisions of some health providers not to provide abortion services due to the anticipation of stigma and discrimination, and inequitable and complicated regulations that make the provision of care unnecessarily difficult, contribute to a dearth of abortion services and significant barriers to access for abortion seekers in high-income countries and communities around the world (De Moel-Mandel et al., 2021; LaRoche et al., 2021; Lee et al., 2022). In Australia some rural women have described having to see as many as five doctors before finding one willing to make an abortion referral (Baird, 2014; Doran & Hornibrook, 2014; Grossman et al., 2010; Kruss & Gridley, 2014).

3.4.4D Stigma drives stigmatisation

The drivers, manifestations, practices and impacts of abortion stigma intersect, with certain practices – such as stereotyping - operating both as a cause and consequence of stigmatisation (Stangl et al., 2019). This is particularly evident in accounts of abortion seekers' attempts to distance themselves from other abortion seekers in efforts to resist stigmatisation and stereotyping, noted above (Allen, 2014; Gelman et al., 2017; Nickerson et al., 2014). For example, Nickerson and colleagues described how, "without prompting, women drew stark contrasts between the circumstances leading up to their own abortion and 'other women's' abortions" (2014, p. 681). McCoyd (2010, p. 146) described how women who sought abortion for foetal abnormality tried, "to disassociate themselves from the stereotype of women-who-have-abortions… Most do not envision women who elect to terminate for 'casual' reasons having the same kind of experience", namely feelings of loss and decision-making difficulty.

Several authors have described the way in which secrecy surrounding abortion results in women believing abortion to be 'uncommon' and reinforces the internalisation of negative stereotypes about the type of 'women who have abortions', thus resulting in more secrecy (Allen, 2014; Harris, 2012). Known as the 'prevalence paradox' (Kumar et al., 2009), abortion stigma becomes self-fulfilling. Studies have found that approximately half of US adults report not knowing anyone who has had an abortion, and those who are supportive of abortion are more likely to hear about others' abortions (Cowan, 2014; Frankovic, 2021). Health providers report being less likely to share their (pro-) abortion views in areas perceived to have a higher proportion of people with anti-abortion views (Mollen et al 2018). The prevalence paradox may thus be particularly impactful in more conservative communities as it works to silence pro-abortion voices, creating further space for stigmatising discourses to flourish and increases their relative visibility. As Ralph reflected,

> where women remain silent about their abortions—as well as all the boyfriends, husbands, partners, family members, friends, medical practitioners and others who helped those

women organise it— those hostile to abortion rights are adept at filling the vacuum. (Ralph, 2022, pp. 216-217).

3.4.5 Intersecting stigmas & compound marginalisation

There has been some exploration of the intersections of social marginalisation, class, and abortion stigma. The included studies indicate complex interactions between class and income, race, age, culture, and the law that create unique circumstances in which different abortion stigma experiences, practices and outcomes may be more or less salient for individuals and sub-populations.

Several US studies have found race is associated with internalised and perceived abortion stigma. US-based quantitative research has commonly though not uniformly (see for example Cutler et al., 2021) found black women to be less likely to perceive and internalise abortion stigma, in comparison with white women (Bommaraju et al., 2016; Rice et al., 2017; Sackeim et al., 2022). Race has identified as mediating the influence of factors like income, education, and religion on internalised abortion stigma (Shellenberg & Tsui, 2012). Nevertheless, the marginalisation of particular racial and migrant communities may also exacerbate abortion-related stigma experiences. Some Black and Latina research participants in qualitative studies have described their fear of abortion-related judgment as exacerbated by stereotypes of their communities related to sexuality, contraceptive use, and motherhood (Altshuler et al., 2021; Deeb-sossa & Billings, 2014). Deeb-Sossa and Billings (2014, p. 416) concluded that, “poor immigrant women's reproduction continues to be perceived as a major social problem” in the US. In Italy and Spain, De Zordo (2018) found some obstetrician-gynaecologists felt particular groups of immigrant women were particularly likely to seek multiple abortions due to ‘irresponsibility’, along with cultural norms that prevented contraceptive use.

Being poor and seeking abortion has been described as a ‘double stigma’ (Cockrill & Nack, 2013). A number of studies have explored abortion stigma experiences among samples of low-income women in the US, all indicating participants were acutely aware of, internalised and perceived abortion stigma and related stereotypes related to motherhood, irresponsibility, and deservedness (Gelman et al., 2017; Nickerson et al., 2014; Ostrach & Cheyney, 2014; Smith et al., 2016; Tsui et al., 2011). Gelman et al. (2017) described how perceived limited opportunities for upwards (financial and class) mobility may increase the benefits and perceived value of motherhood among low-income women, subsequently increasing the salience of gender and motherhood related norms and stereotypes among this group. In contrast, having sufficient wealth to access private abortion clinics may be protective against enacted abortion stigma (Love, 2018). Quantitative research in the US identified people in the middle-income bracket as most likely to (perceive they)

receive positive reactions to their abortion disclosures (Cowan, 2017). Nevertheless, the interaction of class and stigma received limited attention in the included studies. Love (2018, 2021) described stigmatising stereotypes as perpetuated by neoliberal, middle-class notions of 'self-control', while middle-class positioning also enabled abortion seekers to resist stigmatisation by drawing on classed narratives that value the prioritisation of educational and career goals. Whether class-based explanations explain the lower levels of stigma experienced among some marginalised groups, such as Black women in the United States, requires further exploration. It is likely that while lower income abortion seekers may be protected from elements of stigma and narratives that stigmatise abortion seekers based on classed beliefs and norms around reproduction, they are likely to be simultaneously facing the impacts of compound stigmas and marginalisation.

3.4.6 Abortion stigma in Australia

This review identified 16 Australian studies that have explored abortion stigma. Only three of these were explicitly focused on abortion stigma, and none of these three included abortion seekers as participants.

Australian research has focused primarily on stigma as a barrier to abortion care provision and access. Widespread conscientious objection and stigma and discrimination enacted by health providers against abortion seekers has been identified and described as a key barrier to abortion access (Cashman et al., 2021; Cleetus et al., 2022; Doran & Hornibrook, 2014; Doran & Hornibrook, 2016; Hulme-Chambers, Temple-Smith, et al., 2018; Kruss & Gridley, 2014; LaRoche et al., 2020). Cashman and colleagues (2021) identified GPs and sonographers as particularly common sources of judgmental and discriminatory treatment. Health professionals have been described as creating distinctions between 'social' as opposed in 'medically indicated' abortions, impacting providers' willingness to participate in abortion care (Cleetus et al., 2022). Felt (perceived and anticipated) stigma is commonly believed to undermine abortion provision, service development and accessibility, particularly in rural areas (Dawson et al., 2017; De Moel-Mandel et al., 2021; Hulme-Chambers et al., 2018; Keogh et al., 2017; Kruss & Gridley, 2014). Health professionals describe the anticipation of social and professional consequences related to abortion provision as limiting service provision, the expansion or implementation of new SRH services, and undermining the implementation of innovative models of abortion care, particularly in rural areas (Dawson et al., 2017; De Moel-Mandel et al., 2021).

Australian studies exploring factors influencing abortion access and choices have also identified stigma as resulting in women choosing medication rather than surgical abortion (Newton et al., 2016) and lying about their pregnancy intentions (Hulme-Chambers et al., 2018) to facilitate avoidance of stigmatising interactions. The accounts of rural abortion seekers in Doran and

Hornibrook (2016) indicate that internalised stigma can lead to shame, stigma, social isolation, and self-induction of (unsafe) abortion attempts. Of note, however these accounts were garnered in studies focused on abortion access. Studies of abortion seekers focused explicitly on abortion stigma were missing from the Australian research identified.

3.4.7 Abortion stigma among young people

Nine of the (entirety of the) included studies were conducted with participant groups comprised largely or entirely of young people, primarily young women, while a number of others explored or identified relationships between age and abortion stigma. They, along with research in Kenya and India, have found that young women are most likely to experience internalised abortion stigma, relative to older women (Cockrill & Nack, 2013; Makleff et al., 2019). Furthermore, they indicate that in the US, abortion-related stereotypes are particularly common and impactful among young people (Coleman-Minahan et al., 2020; Rice et al., 2017; Smith et al., 2016). Young people who don't have access to social or familial support and financial resources have been found to be particularly impacted by secrecy resulting from anticipated stigma, limited disclosure exacerbating legal and logistical barriers to abortion access, internalised stigma and social isolation (Coleman-Minahan et al., 2020; Coleman-Minahan et al., 2021; Killinger et al., 2022; Smith et al., 2016). Young people in Sweden have been described as being aware of, "an illusion of power with regard to their reproductive lives", whereby they are held responsible for their contraceptive use but have their pregnancy choices constrained by external people, norms, and socio-economic conditions (Ekstrand et al., 2009, p. 177).

As with older abortion seekers, health care and judicial systems are primary settings in which young abortion seekers experience enacted stigma and discrimination. Young people have reported experiencing judgment from health providers around their failure to 'take care of themselves' and use birth control effectively, and threats to disclose pregnancies or abortions to their families without consent (Deeb-sossa & Billings, 2014, p. 412; Ekstrand et al., 2009; Kruss & Gridley, 2014). The judicial bypass system, described above, enacts, and enables stigmatisation, directly impacting abortion accessibility (Coleman-Minahan et al., 2019, 2020, 2021; Deeb-Sossa & Billings, 2014). Abortion stigma(tisation) has also been found to lead to coerced contraceptive use among young people (Ekstrand et al., 2009). Young age and associated material and emotional reliance on guardians and others thus appears to exacerbate the risks of abortion stigma for young people. However, there are limited studies describing the immediate and life-course impacts of abortion stigma on young people.

Cowan (2017) found that young people - in their US study of enacted stigma - were least likely to perceive only positive reactions when disclosing their abortions to others, compared with older participants. This is likely in part due to young people having lower levels of control over their

disclosures, particularly in locations and (social and legal) contexts where young people are likely to require support, and as such forced to disclose their pregnancies and abortion seeking, to access abortion services. For example, Cowan (2017) found that the context of an abortion disclosure, including to whom and why abortion stories were being shared, was associated with the likelihood of experiencing negative responses to abortion disclosure. For example, disclosures made to close friends were more likely to receive positive responses than those made to close family, as were those made because of shared experiences versus for other reasons (Cowan 2017).

While young age appears to facilitate abortion stigmatisation and salience for many young abortion seekers, studies have also described a tendency among many young people to position abortion within frames of equity and bodily autonomy. This has been shown to counter the impacts of stigma on abortion care and help-seeking, and possibly the salience of abortion stigma to their own experiences and identities (Hoggart, 2019; Mohamed et al., 2018; Ushie et al., 2019). While young people have been found to acknowledge and at times essentialise abortion stigma, some young women have been described as positioning themselves in dominant narratives of motherhood or responsibility, explicitly rejecting the need for shame or secrecy and indicating abortion for them is normalised (Hoggart, 2019). Nevertheless, rights-based and explicitly positive framings of abortion, as shown in the UK,) appear to be less common than other narrative frames (Purcell et al., 2020).

3.5 Discussion

Empirical research on abortion stigma in high-income countries has burgeoned over the last decade, contributing to an increasingly nuanced understanding of its drivers and facilitators, experiences, practices, impacts and outcomes. In particular, between 2018 and 2022 the number of published studies meeting the inclusion criteria for this review almost doubled. Particularly well addressed in the included studies is the role of stereotyping in the stigma process, including the primary role of narratives of hierarchies of deservedness, intersections between causes and consequences of abortion stigmatisation, and stigma experiences and practices. Nevertheless, in applying Stangl and colleagues' (2019) comprehensive Health Stigma and Discrimination Framework to the included literature, it has become clear that significant knowledge gaps remain.

The predominance of abortion stigma research based in the US, and the influence of US research on abortion stigma theory and conceptualisations, poses some challenges for the diversity and generalisability of the findings of this review, and to abortion stigma conceptualisations and theory more broadly. Hanschmidt and colleagues' systematic review of abortion stigma (specific) research found that US research dominates the global evidence base (Hanschmidt et al., 2016). The US appears to be somewhat of a social and political anomaly in the context of the wider range of

developed/high-income countries, with increasing abortion restrictions contrasting the increasing legalisation and accessibility improvements seen in much of the world, including Australia, in recent years (Baird & Millar, 2020; Osborne et al., 2022). While decriminalisation of abortion does not necessarily eliminate abortion stigma (Keogh et al., 2017), higher rates of abortion stigma have been documented in more restrictive settings (Cockrill & Nack, 2013, Major & Gramzow, 1999, Quinn & Chaudoir, 2009 and Shellenberg & Tsui, 2012 in Hoggart, 2017). It is therefore likely that the extent and impacts of abortion stigma in the Australian context, for example, may be less significant than in the US, where much of our understanding of abortion stigma is based.

It has been well determined, in alignment with health stigma theory more broadly, that experiences of abortion stigma are determined by an intersection of local, national, and transnational factors and discourses (Cockrill et al., 2013; Littman et al., 2009; Major et al., 2009). Social and local environments, norms and systems interact with personal characteristics to either normalise abortion and promote wellbeing among abortion seekers and providers, or to reinforce narratives of deviance, irresponsibility, and rarity. This goes beyond laws and policies, as demonstrated in research that has found perceived abortion can lead to attempted self-induction of abortion even where abortion is legal (Harris, 2012). Even so, the drivers, facilitators and practices of abortion normalisation remain under-explored (Baird & Millar, 2019). Without a greater focus on contexts where and individuals for whom abortion is normalised, our understanding of the necessary conditions for stigma prevention and management will be limited. Australia, given its lower levels of abortion politicisation and high levels of abortion acceptability compared to the US, offers a valuable context for research to expand evidence-based understandings of stigma processes (Berer, 2017; Betts, 2004, 2009; Osborne et al., 2022).

The included articles identified a number of personal and social characteristics associated with an individual or population's risk of experiencing and being impacted by abortion stigma. A minority of studies, however, have used an explicitly intersectional or justice-focused framework to elucidate the interactions of structural inequalities with abortion stigma (Brown et al., 2022). Health stigmas are well understood to reflect, be enabled by, and exacerbate pre-existing forms of marginalisation and oppression, yet the ways this occurs in varying high-income country contexts in regard to abortion stigma remains ill described (Bommaraju et al., 2016; Deacon, 2006). Research suggests that women experiencing socio-economic disadvantage, (intimate partner) violence and illicit drug use are significantly more likely to have abortions than other women (Jones, 2010; Rowe et al., 2017; Taft et al., 2019). It would follow, therefore, that abortion stigma is likely to be particularly salient for these groups, who are currently underrepresented in abortion stigma research. A consideration of stigma alongside historically stratified reproduction, that is the ways experiences of 'normal' and 'desirable' reproduction vary "according to race, class, gender, age and sexual identity", would be beneficial (Bommaraju et al., 2016, p. 28). Overall, the stigmatisation of abortion has been described as distracting attention away from the social and cultural factors that drive

inequitable access to reproductive health care and commodities, thus fulfilling the neoliberal goals of individualising blame and responsibility for health (Harris, 2012).

While the Australian literature demonstrates links between abortion stigma, provision, and accessibility, particularly in rural communities, significant gaps in knowledge pertaining to abortion stigma in Australia remain. This has implications for Australia's capacity to address abortion stigma and ensure equitable sexual and reproductive health care access for all, especially in the context of the Government's commitments to achieving universal access to abortion care within the Australia's Women's Health Strategy 2020-2030 (Commonwealth of Australia, 2018). This review did not identify any studies that have primarily focused on abortion seekers' experiences and perceptions of abortion stigma. Furthermore, beyond rural abortion seekers, the intersections of marginalisation with abortion stigma in Australia have rarely been explored. The review also failed to identify any national, quantitative research elucidating predictors of abortion stigma in Australia.

Studies suggest young people are more likely to experience individual-level abortion stigma relative to older people, and experience abortion stigma as a barrier to abortion access (Makleff et al., 2019; Mohamed et al., 2018; Ushie et al., 2019). However, research focused on understanding young people's experiences of abortion stigmatisation and their unique vulnerability to stigma due to age and power differentials, both in and beyond Australia, remains limited.

3.5.1 Abortion stigma measurement

While this review did not focus on identifying abortion stigma measurement tools, other reviews have identified a lack of validated, comprehensive, and representative quantitative abortion stigma measurement tools (Hanschmidt et al., 2016; Ratcliffe et al., 2023). Hanschmidt et al. (2016) found that of seven abortion stigma measures they identified during a systematic review, three used non-validated single-item measures of abortion stigma. A systematic review of abortion stigma survey tools identified 21 original measures of abortion stigma, most of which were published between 2016 and 2020 and developed in the US (Ratcliffe et al., 2023). None of the identified tools were developed or implemented in Australia or Australasia, and only a four had been developed for use with mixed gender community samples (Ratcliffe et al., 2023). In a 2017 article, Rice noted that abortion stigma survey tools that had been developed to date (which corresponded with the commencement of this research) were primarily designed to identify the locations, domains (according to Cockrill and Nack, 2013) and management of stigma (Rice et al., 2017). Conversely, there has/had been a dearth of published abortion stigma survey tools that reflect the social and complex nature of stigma, including contextual and structural elements. Measures of structural stigma have primarily included policy analysis and assessments of individuals' attitudes which are then aggregated to provide community-level assessments of stigma (Hatzenbuehler, 2016).

3.5.2 Strengths and limitations

This review offers a comprehensive synthesis of abortion stigma research in high-income countries. Even so, it is possible, if not likely, that relevant citations were missed because of several characteristics of the review process. Firstly, while it is commonly considered best practice for double screening of at least some citations included in a review (that is the screening and selection of citations by two reviewers independently) to avoid missed studies and enable transparency and reliability (Stoll et al., 2019; Waffenschmidt et al., 2019), I undertook these processes independently. Nevertheless, my experience conducting systematic and scoping literature reviews is likely to have minimised the number of missed studies because of the single-reviewer process (Waffenschmidt et al., 2019). Secondly, working with a specialist research librarian to develop, test and implement the search strategy across the seven databases was intended to reduce the risk of relevant studies being missed due to an insufficient search strategy. Thirdly, date and language limits, implemented for feasibility reasons, may have resulted in the exclusion of relevant literature. While the limits were necessary given the scope, time and resourcing constraints of this doctoral study, a wider review would be beneficial to stigma researchers, policy makers and interventionists working to understand, prevent and address abortion stigma.

Given time constraints and the large number of included studies, a risk of quality or bias assessment was not undertaken. While not mandated within the scoping review methodology it would have enabled a critique of the quality of the abortion stigma evidence base presented in this chapter. Small changes were made, as described above, to the search strategy during the third search/update, and thus there was some inconsistency in the searches run across the three timepoints. Finally, it was not possible to present a flow diagram of the study selection process, as is common in scoping reviews. Data pertaining to the number of duplicates removed prior to data screening and reasons for study exclusion during full text analysis were lost in a computer breakdown during the 2022 review update. Nevertheless, numbers of citations retained and removed at each stage of screening are provided.

3.6 Conclusion

Despite burgeoning global abortion stigma research, significant gaps in the Australian (and global) evidence base pertaining to the drivers, experiences, and impacts of abortion stigma remain. This is particularly problematic due to the local and contextual nature of stigma, meaning the relevance of the global research and conceptualisations regarding abortion stigma to the Australian context is unclear. A focus within the wider literature on interpersonal experiences of abortion stigma will continue to undermine the success and potential impact of abortion stigma prevention and

reduction interventions that rely on this evidence base. In response, this research is intended to begin to fill some of these research gaps. It addresses the lack of research into the prevalence and predictors of abortion stigma in Australia through the development and implementation of a valid, reliable, and locally relevant survey tool. In response to the limited local abortion stigma research among young people, including young abortion seekers, this research includes a focus on young Australians' experiences. The review also found that felt/perceived/anticipated abortion stigma is particularly impactful and intersects with a range of other stigma and health experiences and outcomes, informing the focus of this research on felt abortion stigma. Finally, the identified lack of abortion research focused on macro-level structures, systems and narratives informs the data analysis techniques and framing of the thematic and integrated analyses presented in Chapters 7 and 8.

In the following Chapter, the aims, methods, and analysis techniques used throughout this thesis are described and justified. Chapter 4 thus provides a comprehensive description of the way this research meets the research aims and objectives, and in doing so addresses the knowledge gaps highlighted by this literature review.

CHAPTER FOUR: RESEARCH DESIGN & QUANTITATIVE METHODOLOGY

To meet the aims of this research I adopted a sequential mixed methods research design involving a quantitative survey (Phase 1) and qualitative interviews (Phase 2). Chapters four and five describe the methodology adopted, methods used, and justifications for each methodological choice made throughout the research and reporting processes. In this chapter, the mixed methods design and methods used in the quantitative phase of this research are explained in detail. Section 4.1 introduces the mixed methods research design and the ways it addresses the research aims and priorities. Section 4.2 describes Phase 1A of this research, the development and testing of a survey tool to measure felt abortion stigma and its predictors. Section 4.3 describes Phase 1B, the implementation of the survey tool, including sampling and recruitment of participants, data cleaning, analysis, and reporting.

4.1 Mixed methods research design

Mixed methods research design has been defined as,

> an approach to research in which the investigator collects, analyses, and interprets both quantitative and qualitative data, integrates or combines the two approaches in various ways, and frames the study within a specific type of design or procedure (Creswell, 2015, p.59).

In a practical sense, mixed methods research designs can facilitate more comprehensive understandings of complex phenomena than a single method allows (Doyle et al., 2016; Shannon-Baker, 2016; Tariq & Woodman, 2013). They are valued for their flexibility and ability to generate robust, valid, and usable research outcomes (Doyle et al., 2016; Locke, 2021). Mixed methods research designs are commonly employed in health, stigma, feminist, and social justice-focused research (Creswell, 2015; Rice et al., 2019; Sweetman et al., 2010; Taebi et al., 2020). They are compatible with feminist and justice-focused research paradigms as they can be particularly useful for "'giving voice' to research participants who have often been marginalised" by using their perspectives to interrogate and complement quantitative research findings (Locke, 2021, p.3; see also, Creswell, 2015; Doyle et al., 2016; Hesse-Biber, 2012). In practice, it can be challenging to move beyond the use of multiple research methods purely as a way to confirm (triangulate) research findings, and the integration of multiple methods has been under theorised (Tonon, 2019). The processes I used to attempt to foreground young peoples' experiences and understandings of abortion stigma through a mixed methods research approach are described in relevant sections in both this chapter and Chapter 5.

Philosophically, mixed methods research has both had to answer to, and has been described as offering a solution to, the 'paradigm wars': that is, debate around the ontological, epistemological, and methodological incompatibility of qualitative and quantitative research philosophies and methods (Creswell, 2015; Doyle et al., 2016; Panhwar et al., 2017; Shannon-Baker, 2016; Tariq & Woodman, 2013; Wiggins, 2011). Historically, positivism and objectivity, most often understood as underpinning quantitative research methods, have been held up as scientific gold standard, and as in direct opposition to qualitative enquiry, subjectivism, and constructivism (Pernecky, 2016). While many researchers have argued positivist and relativist research philosophies are incompatible, others believe the distinctions between the two are not as stark as are often portrayed (Dawadi, 2021; Panhwar et al., 2017; Wiggins, 2011). Mixed methods researchers have offered solutions to the perceived incompatibilities of the 'two' approaches. Practically, these can include combining qualitative and quantitative methods but prioritising one along with its philosophical approach or using methods sequentially and adopting the epistemological foundations of each in turn (Wiggins, 2011). The specific approach is often determined pragmatically, or via as consideration of the approach that best fits the research aims or questions. Beyond considering the means of 'doing' research, a range of research approaches, philosophies, and paradigms, such as post-positivism, critical realism, pragmatism, transformative-emancipation, and dialectics, have been used to situate mixed methods studies outside of the positivist-interpretivist dichotomy and philosophical singularity (Shannon-Baker, 2016). Pernecky (2016, p.194) outlined the potential of "post-paradigmatic" approaches to research to critically engage with, reflect and address philosophically and methodologically complex and diverse realities. To adhere staunchly to a single paradigm or method, they argue, can be at the expense of not fully addressing or acknowledging the complex suite of influences on, and requirements of, a piece of research work.

I elected to use an explanatory sequential mixed methods design for this study, which begins with the collection of quantitative data and close analysis of these data (Creswell, 2015). Qualitative research is then undertaken to address key questions emerging from the statistical analysis (Creswell, 2015). This process is commonly used within deductive and positivist research paradigms to confirm and strengthen the validity of statistical findings, and thus as a technique of data triangulation (Hesse-Biber, 2012). The explanatory sequential design can also be used to meet the feminist research goals of foregrounding subjugated knowledges (Hesse-Biber, 2012). This can be achieved through assigning equal value to quantitative and qualitative data, and the use of qualitative research to interrogate rather than solely to confirm quantitative research findings. The explanatory sequential approach thus aligns closely with the aims of and values underpinning this study.

As described in Chapter 1 Section 1.3, the primary aims of this research are:

1. to identify the extent and predictors of perceived and anticipated abortion stigma among the general population in Australia, and
2. to describe the experiences and drivers of abortion stigma among young people.

The specific research objectives are mapped to the research design in Table 4 (the table based on a visual model by Ivankova et al., 2006, p. 16). Broadly, the survey study (Phases 1A and 1B) facilitated the establishment of a quantitative baseline understanding of abortion stigma in Australia, while the qualitative phase (Phase 2) was used to build on, explain, challenge, and refine the statistical results.

I chose to integrate quantitative and qualitative research approaches throughout the research design, recruitment, data analysis and interpretation processes wherever possible. Integration firstly occurred at the design level. The diversity and complexity of the research aims and objectives drove the choice to use an explanatory sequential design, which would enable the research process to be responsive to emerging findings (Fetters et al., 2013). At the methods level, the two research phases were linked through the sampling frame, as participants for the qualitative study (Phase 2) were identified by the statistical findings from Phase 1 (Fetters et al., 2013). The quantitative analyses and qualitative coding processes were informed by the findings of each phase of the study, involving an iterative and flexible approach to data analysis. The results of both phases were merged at the interpretation and reporting level through a narrative form of joint data analysis, as defined by Fetters et al. (2013). In the following sections I explain and justify each phase and component of this research and their related methodological choices in detail.

This process was approved by the Flinders University Social and Behavioural Research Ethics Committee (Project numbers 7962 and 2743: approval letters provided in Appendix C).

Table 4: Explanatory sequential design procedure

Phase	Research Objectives	Procedure	Product
Quantitative Data Collection (Phases 1A & 1B)	• Construct a validated measure of felt abortion stigma. • Identify the extent of felt abortion stigma among people >16 years in Australia. • Identify predictors of felt abortion stigma and priority population groups.	• Cross-sectional online survey (n= 70,051)	• Numeric data • Paper: “Going viral: researching safely on Social media” (Vallury et al. 2021)
Quantitative Data Analysis		• Data cleaning • Principal Components Analysis, Raked Weights • Frequencies, Crosstabs, Chi^2 • Bivariate linear regression • Multivariable linear regression	• n= 59726 valid responses • 3 independent & 3 dependent variable factors/sub-scales • Descriptive statistics • Regression coefficients • Reported in Chapter 6
Connecting Quantitative & Qualitative Phases	• Identify predictors of felt abortion stigma and priority population groups.	• Purposive sampling to enable exploration of identified predictors/ risk factors • Identify inconsistencies with extant literature for further exploration • Develop interview questions	• n=20 young people • Diverse case sampling • Interview guide
Qualitative data collection (Phase 2)	• Identify and explain the experiences and drivers of abortion stigma among young people	• Individual semi-structured in-depth interviews –20 young people • Email transcripts to participants for confirmation (if desired)	• Verbal consent • Audio recordings • Interview transcripts (verbatim) • Field journals
Qualitative data analysis		• Inductive & deductive coding • Thematic analysis	• Codes and themes • Illustrative quotes • Reported in Chapter 7
Integration of statistical findings & qualitative results	• Interpret findings and conceptualise abortion stigma in a way that aligns with the full scope of abortion stigma experiences and drivers identified	• Joint interpretation and reporting of results • Challenging statistical findings with qualitative findings	• Joint interpretation • Discussion of implications for future research, theory, & intervention design • Reported in Chapter 8

4.2 Research Phase 1A: Development and testing of The Australian Abortion Stigma Survey

The first phase of this research aimed to develop and test a survey tool to measure felt abortion stigma and its predictors among a sample of the Australian public. As described in Chapter 2 Section 2.1.2, I chose to apply a conflated definition of 'felt' abortion stigma in this phase of the research. This resulted in the development of items that explored participants' "assessments of others' abortion attitudes, as well as expectations about how attitudes might result in actions" (Cockrill & Nack, 2013, p. 974). A draft survey tool was developed, based on pre-existing tools and the literature review presented in Chapter 3, and refined through three stages of reliability and validity testing. Firstly, I undertook two rounds of consultation with an expert panel to assess the draft survey items for face and content validity (Connell et al., 2018). Cognitive think-aloud interviews were then conducted with 10 individuals to ascertain the readability and consistency of interpretation of the draft survey items. The survey was then assessed quantitatively for reliability over time using a test re-test procedure. These processes are described in detail below.

4.2.1 Item development

At the time of developing The Australian Abortion Stigma Survey (hereafter referred to as TAASS) there were no existing survey tools that were appropriate in their entirety for use in the Australian context and that would meet the aims of this research project. There was a need to develop a survey tool that was locally relevant and measured felt abortion stigma among a general community sample.

To develop the initial list of draft items I drew on and adapted individual items from pre-existing validated measures of abortion stigma, including The Individual Level Abortion Stigma scale (ILAS), which was developed and implemented in the US to measure individual level abortion stigma among women who have had abortion experiences (Cockrill et al., 2013). I also adapted items from the Stigmatising Attitudes, Beliefs an Actions Scale (SABAS), an 18-item instrument that was developed to measure individual and community-level abortion stigma in Ghana and Zambia (Shellenberg et al., 2014). While not included in the literature review as it was not developed in a high-income country, this tool was the most comprehensive measure of community-level abortion stigma available, and a number of items were appropriate for use in the Australian context. I also generated a pool of survey items based on the literature review, specifically drawing on studies by Bommaraju et al. (2016), Rice et al. (2017), Sorhaindo et al. (2016), and Martin et al. (2014).

The draft survey contained 151 questions and statements across seven domains (as defined by Boateng et al. 2018). Items pertaining to felt abortion stigma were intended for use as

dependent/outcome variables, while all others were to be used primarily as independent/predictor variables. The seven domains include:

- *Demographics and pregnancy experiences (Demographics):* Nineteen demographic and pregnancy-related items were included due to their hypothesised or previously demonstrated association with abortion attitudes or stigma. Basic demographic questions were borrowed or adapted from the ABS Census (Australian Bureau of Statistics, 2020a) and large-scale social studies (McAllister & Pietsch, 2017).
- *Gender role beliefs and sexism (Sexism):* Research has demonstrated relationships between beliefs about gender roles, benevolent and hostile sexism with abortion attitudes and stigma (Duerksen & Lawson, 2017; Hessini, 2014; Orihuela-Cortés et al., 2023; Patev et al., 2019; Wu et al., 2023). The 22 draft items initially included in this domain were from a measure of hostile and benevolent sexism, the Ambivalent Sexism Inventory (ASI) by Glicke and Fiske (1996) (Huang et al., 2014). Four items from the Egalitarian Sex Role Attitudes scale were later added (Suzuki, 1991).
- *Beliefs about contraceptive responsibility:* As described in Chapter 3, a range of studies have identified and explored the concept of the ‘irresponsible woman’ in relation to abortion and related stigmas. This stereotype, which has been found to be central to stigmatising abortion narratives and beliefs, indicates intersections between ideas about contraceptive responsibility, female sexuality, femininity, unintended pregnancy, and abortion. Thirteen items were developed with the intention of measuring the crossover, and distinguishing between, reproductive beliefs and stigmas.
- *Abortion knowledge, myths, and misinformation (Knowledge):* Knowledge has been found to be associated with a range of health stigmas (Obeid et al., 2015; Smith et al., 2011; Toye et al., 2019). Given the perpetuation of myths by anti-abortion discourses, and the function of misinformation in the production and maintenance of abortion criminalisation and stigmatisation, it was anticipated that knowledge was likely to be correlated with abortion stigma (Levandowski et al. 2012; Belfrage et al., 2022). Eight items designed to assess participants’ knowledge about the prevalence and safety of abortion and associated reproductive experiences, and their agreement with common abortion-related myths, were included in the draft survey.
- *Morals and beliefs about abortion (Beliefs):* This domain included nine items exploring participants’ support for the legality and availability of abortion in Australia, and general statements about the morality of abortion. They reflected both anti-abortion and pro-choice beliefs.
- *Judgment and stigmatising statements (Attitudes):* Thirty statements reflecting common attitudes held by proponents and opponents of abortion were included to assess participants’ abortion-related attitudes. Based on a suite of literature describing relationships between

attitudes towards stigmatised conditions/experiences and stigma, it was anticipated that abortion attitudes would be associated with felt abortion stigma (see for example, Simmons et al. 2017; Hanschmidt et al. 2016). Items in this domain were adapted from previous quantitative abortion stigma research (Bommaraju et al., 2016; Cockrill et al., 2013; Rice et al., 2017; Shellenberg et al., 2014; Sorhaindo et al., 2016).

- *Felt (perceived and anticipated) stigma:* To measure felt stigma, 50 questions to assess perceived social devaluation and anticipated discrimination were devised. Wherever possible, relevant items were adapted from existing stigma measurement surveys (named above). Measuring perceived stigma at a community level is challenging as it requires some level of hypothetical thought by participants. Aggregating individual measures of stigma to the community level can help to overcome same source bias but is prone to underreporting of stigma due to social desirability bias (Hatzenbuehler, 2016). In comparison, asking questions about what participants believe others/the community think about people with stigmatised identities can minimise social desirability bias (Hatzenbuehler, 2016; Quinn & Chaudoir, 2009). In asking participants about their own attitudes towards abortion, abortion seekers and providers, as well as about their perceptions of their community's attitudes, I sought to overcome biases and limitations of each of these approaches to measuring community level stigma.

4.2.1A Measurement Scale

I opted to use a four-point Likert scale to measure the strength of participants' attitudes, beliefs, and felt abortion stigma. Pre-existing abortion stigma measurement tools have used three- to seven- point rating scales, with four- and five-point scales most common (Ratcliffe et al., 2023). Five-point Likert scales include a neutral centre option, while four-point Likert scales lack a neutral option and thus force a choice from respondents (Chyung et al., 2017). Some research has shown that research participants will use a neutral option when responding to a Likert-style questionnaire, even when they do not have a neutral opinion, particularly when they perceive their opinions to be socially undesirable or are uncomfortable with a research topic (Chyung et al., 2017). For this reason, I did not include a neutral option.

4.2.2 Stage 1 testing: Expert panel

After the survey items had been established, I engaged a panel of experts to assess the items and survey tool for face and content validity, that is to ensure the items sufficiently assessed the domains of interest and appeared to measure what they were intended to measure (Boateng et al., 2018, p.6). The use of qualified experts to review and pre-test draft survey items for accuracy,

construction issues, grammar, and biased or offensive content is common (Tsang et al 2017; Boateng et al., 2018). However, the methods used to manage this process vary greatly (Ikart, 2019). Individual reviewers may be invited to provide subjective, open-ended commentary, or may participate in a more formal appraisal process (Ikart, 2019). The number of experts included in expert panels also varies significantly, ranging from two to more than 20 (Ikart, 2019).

I convened a panel of eight experts online. The panel was engaged in a simplified Delphi-style process designed to facilitate the refinement of the draft questionnaire, ensure the survey items were relevant to the Australian context and that each domain had been adequately addressed, and to identify offensive or non-inclusive content (Miller et al., 2020). The Delphi method is commonly used by expert panels during survey development to establish a consensus or convergence of opinion about the items that best reflect the domains in question, relying on the collective intelligence of a group and improving content validity (Boateng et al., 2018; Hsu, 2007). Studies using the Delphi method often use quantitative scoring and statistical procedures to determine consensus (Boateng et al., 2018). However, the small panel used in this research meant the use of statistical methods was not feasible, indicating a modification to the traditional Delphi process.

Expert panellists were recruited using purposive and snowball sampling. My supervisory team identified seven individuals known to them as experts in abortion-related care or research. These individuals were contacted with a formal letter of introduction (see Appendix D) and a participant information sheet (see Appendix E). They were invited to participate in the expert panel process, and to suggest other individuals they considered suitable to be on the panel. These seven experts recommended a further 10 potential panellists who were similarly contacted with formal letters of introduction and invited to participate. A total of 17 individuals were invited to participate in the expert panel process.

The final panel comprised eight health professionals and academics with experience in abortion stigma measurement, abortion research, abortion provision, and women's health care (including Indigenous women's' health care). Seven of the advisors were currently working in relevant clinical and academic positions based in Australia. One panellist was based in the US and was included due to their expertise and experience in conducting abortion stigma research and survey tool development. The discussions were confidential, with experts unaware of each other's identities. Experts participated in two rounds of feedback over a five-month period.

4.2.2A Feedback round 1

During the first round of feedback, experts were asked to rate 108 of the 151 draft survey items based on their relevance, usefulness, or importance using a three-point Likert scale (see Appendix F). Response options were 'very useful/important', 'somewhat useful/important', and 'not at all useful/important'. Experts were also invited to leave general comments, suggest topic areas that

had been missed or inadequately addressed, and propose new items. General feedback was invited regarding 19 demographic items and 22 items comprising a previously validated measure of sexism (Glick & Fiske, 1996).

A consensus method was used to establish which items would be retained, removed, or amended and sent back to the panel for more feedback. Although there is considerable lack of agreement on how to measure 'consensus' in Delphi-style and expert panel processes, similar studies have used consensus score cut-offs of around 70% to 80% agreement (Boulkedid et al., 2011; Hsu, 2007; Khurana et al., 2022; von der Gracht, 2012). Therefore, items that were rated 'very important/useful' by six out of eight experts were retained for inclusion in the survey. Further feedback (in Round 2) was sought on items that achieved five responses in the very important/useful column, while items with four or fewer very important/useful column were removed.

In the first round, 57% of the draft survey items achieved 6 or more 'very useful/important' ratings and were retained for inclusion in the final questionnaire (as shown in Table 5). One quarter of the items received five 'very useful/important' ratings and were amended and included again in Round 2. The 19 items that received 4 or less 'very useful/important' rankings were from removed from the questionnaire, including all but one of the items in the *Contraceptive Responsibility* domain. A further 17 items that received 6 or more very useful/important rankings were also removed based on narrative feedback. These items were generally deemed by experts to be non-inclusive regarding gender and/or sexuality (for example, they assumed heterosexuality of respondents), repetitive, or could have acted as potential triggers for people living with (or living with family members who have) genetic or other conditions (for which pregnant people may choose to abort a pregnancy). Table 5, for example, shows that while six of the Attitudes items received consensus to retain, three of these were removed based on narrative feedback.

Panellists provided a large amount of narrative feedback regarding item wording, order, inclusivity, and response options, along with suggestions for new items or topics. This resulted in 31 new items being generated and included in the Round 2 questionnaire. Response categories for items regarding sex and gender, sexuality, parenting history, and race were amended in consultation with an external advisor with expertise on gender and sexuality research. Panellists requested a more even distribution of positively versus negatively framed statements which was addressed in the second-round questionnaire and final questionnaire design. Re-framing some items to ensure a balance of positive and negatively worded statements was considered important to the panellists

as it can both minimise any potentially performative, stigmatising effects of the survey completion process, and potential acquiescent response bias (Baird & Millar, 2019; Rattray & Jones, 2007).[7]

Table 5: Results of the 1st round of expert panel feedback

Section	No. Items	Scored 6 or more (very useful/ important ratings)	*Total retained*	Scored 5 (very useful/ important ratings)	Scored 4 or less (very useful/ important ratings)
1. General attitudes to abortion	9	6	*3*	1	2
2. Views on contraception & responsibility	13	1	*1*	4	8
3. Abortion knowledge and myths	6	4	*3*	1	1
4. Stigmatising attitudes	30	17	*17*	8	5
5. Perceived stigma	50	34	*21*	13	3
Total	***108***	***62***	***45***	***27***	***19***

4.2.2B Feedback round 2

In the second feedback round, experts were asked to rank a combination of 47 new (n=31) and reworked items (n=16) that failed to achieve 'consensus' in Round 1 (see Appendix G). Six members of the expert panel submitted their feedback for the second round of testing. One panellist expressed feeling like they didn't have further comments to add, and one was lost to follow up. The cutoff for 'consensus' and thus for retention in the survey tool was set at four out of six very useful/ important ratings. As in Round 1, the expert panellists were also invited to provide narrative feedback on any issues or concerns. The panellists were shown the outcomes of the rating and feedback processes from Round 1, and specific comments from other (anonymous) panellists when additional feedback or decisions were needed.

Table 6 shows the results of the rating process in Round 2. The second round of feedback resulted in the retention of an additional 27 items.

[7] Ratcliffe et al. (2023) found that the implementation of abortion stigma surveys among a range of respondent groups did not have stigmatising effects for participants.

Table 6: Results of the 2nd round of expert panel feedback

Section	Number of Items	Retained: Scored 4 or more (very useful/ important ratings) - retained	Scored 3 or less (very useful/ important ratings) - removed
1. General attitudes to abortion	2	1	1
2. Views on contraception & responsibility	9	5	4
3. Abortion knowledge and myths	13	8	5
4. Stigmatising attitudes	10	4	6
5. Perceived stigma	12	9	3
TOTAL	**46**	**27 (58.7%)**	**19 (41.3%)**

Narrative feedback provided by the expert panellists focused on the perceived importance of items, the content of descriptions/preamble to accompany each section of the questionnaire, language, phrasing and terminology, and the relevance of some demographic items to the study aims. One expert expressed a concern over the use of the word ‘women’, and subsequently phrases like ‘women who have an abortion’, throughout the survey, given non-binary people and transgender men also experience pregnancies and seek abortions. Nevertheless, this panellist felt alternative use of the term ‘people’ could be potentially confusing to respondents. Other panellists expressed comfortability with use of the term ‘women’. As a result, the word ‘women’ was chosen for use throughout the survey. It was believed that this would maximise the comparability of the research findings with prior research. The implications of this decision from a rights, justice, and inclusivity perspective are not insignificant however: reflections on this and recommendations for future research are provided in Chapter 9 Section 9.4.

After two rounds of consultation with the expert panel the draft questionnaire included 121 items. This includes demographic and sexism items that hadn’t been quantitatively scored and therefore aren’t reflected in the numbers in Tables 5 and 6.

4.2.3 Stage 2 testing: Cognitive interviews

The second stage of testing involved 10 think-aloud cognitive interviews with staff and students at Flinders University. The interviews were undertaken to assess the draft survey instrument for face validity, meaning and interpretation.

Cognitive interviewing is a qualitative data collection method that involves asking a purposive, usually small sample of participants to work through a draft questionnaire while talking out loud about their thoughts and interpretations of item meaning and scope (Drennan, 2003; Padilla & Leighton, 2017). During this process interviewers commonly ask probing questions, which may be spontaneous, general, and open, or scripted and specific, to garner a better understanding of interviewees' thought processes or interpretations (Drennan, 2003; Padilla & Leighton, 2017). Previous studies involving the development of health-related questionnaires have used cognitive and think-aloud interviewing to identify and resolve item ambiguity and validity issues (Boness & Sher, 2020; Castillo-Díaz & Padilla, 2013; Drennan, 2003). Cognitive interviews have been found to improve survey response and completion rates (Drennan, 2003). The aim of this phase of testing was to identify problems with wording and differences in interpretation between individuals who varied in gender, religion, educational and cultural backgrounds. Ordering issues and any performative effects of completing the survey were observed.

4.2.3A Recruitment and participants

Participants were recruited over a six-week period using flyers placed in common areas and bathrooms around Flinders University's Bedford Park campus. Three of the 10 participants recruited were referred to the study through a friend or colleague. I aimed to recruit a diversity (as much as is practicable with a small sample) of participants in regard to participant gender, age, religion, and ethnicity. Participant information sheets were emailed to each person who contacted the study email address to express interest in participating.

Four males and six females aged from 20 to 68 years participated in the interviews. Two interviewees spoke languages other than English at home and three identified as members of a religion, self-described as Christianity, Orthodox (Ethiopian), and Hindu. All interviewees had at least a high school education and 50% had postgraduate degrees. None of the interviewees identified as Aboriginal or Torres Strait Islander.

4.2.3B Interview process

Interviews were conducted in a private meeting room on the university campus. They began with a discussion of the process and consent forms, and interviewees completed a form providing brief demographic information. Following this, interviewees were invited to read the pre-amble at the beginning of each survey section and comment on readability. They were then asked to read each

survey question aloud. They were not required to state or write their answer to each question. Instead, they told me when they were sure of their intended answer and described their thought pattern, ease of comprehension and interpretation of each item. This is known as concurrent cognitive interviewing (Drennan, 2003). When interviewees took time selecting an answer or appeared unsure, they were invited to talk through their thought and decision-making processes in more detail, whereas when respondents were rapidly and confidently sure of their answers there was often less explanation provided. I asked scripted probing questions regarding the interpretation of key terms that I had anticipated may be variably understood and interpreted, such as ‘human rights’ and ‘public health system’.

Interviews were audio-recorded, though it did not prove necessary to transcribe them verbatim: the extensive notes I took during the interviews regarding feedback specific to each item, as well as regarding interview atmosphere and interactions, provided sufficient detail to facilitate the identification of issues and survey amendment. Survey items were amended throughout the interview process, and new items tested with subsequent interviewees.

I aimed to achieve thematic saturation regarding differences in how and why different respondents variably interpreted survey items (Padilla & Leighton, 2017). However, slow recruitment and the resulting small number of interviews, along with the cultural diversity of participants, meant saturation was not fully realised. Most items had achieved saturation by the tenth interview and were not resulting in misinterpretation. The exception was that varying interpretations of several items were identified in the final two interviews with interviewees who were relatively (to the other interviewees) newly arrived in Australia. For example, for an interviewee who had experience in abortion provision in their country of birth, the term ‘abortion provider’ was interpreted to mean any person engaged in abortion provision, whether that be safe or unsafe, legal, or illegal. This was in contrast to Australian-born participants who assumed the term ‘abortion provider’ referred solely to qualified doctors/abortion providers. Similarly, the intended meaning of a question that referenced ‘protestors outside of a clinic’ was unclear to one overseas-born participant, who didn’t appear to be familiar with the occurrence of anti-abortion protestors outside of abortion services. The relevant question was subsequently reworded to reference ‘abortion clinics’ for specificity.

Along with item amendment, the interview process resulted in the removal of 11 items that proved too ambiguous to achieve consistent, meaningful responses.

4.2.4 Survey amendment

After the cognitive interviews were completed, I chaired a half-day workshop with my supervisory team, during which the team worked through repetition and wording issues and assessed the form and function of the remaining items, sections, and the overall survey tool. The team considered feedback from the expert panellists and cognitive interview participants to decide on, order and format the final draft survey tool.

Item ordering was considered and amended to improve (logical) flow and reduce participant burden and fatigue. The team opted for a survey flow that moved from general to more specific and personal questions, with the intention of minimising participant dropout and improving comfortability (Burton & Mazerolle, 2011). The questionnaire was thus structured to move from demographic and broad attitudinal questions into stigmatising statements and personal beliefs. While short questions are often considered preferable, facilitating clarity and ease of responses, longer items are considered appropriate for sensitive lines of questioning (Boynton & Greenhalgh, 2004). As such, question clarity was prioritised over question length.

This process resulted in a survey with 68 (total) individual items addressing: Demographic information (n=11), reproductive and parenting history (n=5), knowledge (n=8), abortion-related beliefs (n=5), attitudes and judgment (n=13), perceived stigma (n=19), and gender norms/sexism (n=7). The amended survey was uploaded into the Qualtrics online survey platform to enable the final round of testing.

4.2.5 Stage 3 testing: Reliability

To explore the repeatability and internal validity of the draft survey, a test-retest process was undertaken with a convenience sample of Flinders university staff and students. Testing the consistency of survey responses at two time points is considered an optimal measure of reliability for scale development (Polit, 2014).

4.2.5A Recruitment

To recruit participants to this reliability study I briefly presented the research project to five separate lecture groups across a two-week period in August 2019, and placed flyers on university noticeboards and in bathrooms. Recruitment did not occur within any classes or courses with which any member of my supervisory team was associated to avoid actual or perceived coercion. Participants were given the option to enter a draw to receive one of five $25 vouchers as an appropriate incentive, although this was not mentioned in the recruitment materials.

I aimed to recruit between 30 and 50 participants, as is common in test-retest reliability assessments in social sciences and health research (Cetinkaya et al., 2019; Humphreys & Brousseau, 2010). Interested persons were invited to contact the study email address expressing interest in participation and were subsequently sent the participant information sheet (see Appendix E), a link and password to access the online survey.

Some deception was considered appropriate and was approved by the Flinders University Social and Behavioural Research Ethics Committee (SBREC). Participants were not informed prior to completing the study for the first time that they would be asked to complete it a second time, in order to prevent active recording or remembering of answers, a common challenge in test re-test studies (Polit, 2014). Participants were asked to provide their email addresses at the end of the first timepoint/survey and again at the second. These were used to link their responses before being removed for anonymity purposes. I contacted all participants via email a week after their first survey completion thanking them for participating and informing them about the second round of testing. Links for the second timepoint survey and passwords were sent around 14 days after their initial response was received, varying slightly to avoid weekends, and reminder emails sent after 72 hours. Gaps between timepoints of longer than two weeks have been found to increase the chance of attitudinal change due to social interactions or significant events and decrease the accuracy of reliability testing (Humphreys & Brousseau, 2010).

4.2.5B Participant characteristics

A total of 29 complete responses were received at both timepoints, with a retention rate of 85.3% between timepoints. Participants were primarily students and staff from Flinders University, although four had been referred to the study by people they knew. Participants ranged in age from 18 to 68 years (mean age 37 years) and most identified as female (n=25, 86%). The vast majority (93%) lived in metropolitan or outer-metropolitan areas. Nearly a third (30%) identified as a member of a religion. One participant identified as Aboriginal, and two thirds (65%) were born in Australia. A large portion of the sample had completed graduate (n=10) and post-graduate (n=10) qualifications. Around a third (35%) had experienced (personally or via a partner) one or more abortions, and 38% had experienced one or more unplanned pregnancies. These figures suggest the abortion and pregnancy histories of participants in this sample are broadly reflective of Australian population estimates (HTAnalysts, 2022; Keogh et al., 2021; Taft, 2018).

4.2.5C Analysis and results

Data were imported into IBM SPSS Statistics (Version 25) and cleaned. Cases that were missing email addresses as identifiers (n=2) and participants who failed to complete the survey at the second timepoint (n=3) were removed from the dataset.

Basic sample characteristics were explored using descriptive statistics. Test-re-test reliability was calculated using a combination of Cohen's kappa (K) and weighted kappa (Kw) coefficients, which assess the level of agreement between two sets of nominal data (de Raadt et al., 2021; Rodrigues et al., 2019; Yu, 2005). For items with four response categories, binary categories were created, with data from 'strongly agree' and 'agree' categories merged, as with responses 'disagree' and 'strongly disagree'. For questions where other response scales were used (such as 'always' to 'never'), weighted kappa coefficients were calculated, which allowed the retention of all four response categories.

While commonly used cut-offs for Cohen's kappa are understood to be arbitrary, I interpreted scores as representing fair or poor agreement below 0.40, moderate agreement between 0.41 and 0.6, good/substantial agreement between 0.61 and 0.80 and very good or near perfect agreement above 0.81 (Landis & Koch, 1977; Polit, 2014; Svensson et al., 2011). Given the small sample recruited for this round of testing, and as a result the significant impact of even one case deviating from congruency across the two timepoints, any item that achieved a coefficient over 0.41 was retained for inclusion in the final questionnaire. I recognise, however, that in larger studies, or studies primarily focused on the development of a validated scale, a higher inclusion cut-off would be ideal (Polit, 2014).

Test-retest scores were calculated for 44 survey items (excluding demographic, pregnancy and parenting experience, and knowledge items). Kappa and Weighted Kappa scores ranged from 1 (indicating perfect congruency of responses across time points) to 0.28 (poor agreement) (Landis & Koch, 1977) (see Appendix H). Eight of the 44 items achieved scores below the 0.41 cut-off and were removed from the survey tool. Ten items achieved scores of over 0.81 (near perfect congruency) and a further 11 scored over 0.61, demonstrating good/substantial agreement.

After three stages of validity and reliability testing the final survey tool included 64 items. Named *The Australian Abortion Stigma Survey* (TAASS), the survey was manually imported into the online Qualtrics platform in preparation for recruitment and data collection.

4.3 Research Phase 1B: Implementation of TAASS

The Australian Abortion Stigma Survey was implemented in April 2020 as a cross-sectional survey of people living in Australia aged 16 years or over. It was intended that the survey would facilitate the identification of:

- the extent of felt abortion stigma in Australia;
- the demographic, experiential, socio-cultural, knowledge, and attitudinal predictors of felt abortion stigma, and thus
- priority[8] population groups, to inform the qualitative phase of this research.

4.3.1 Survey type, sampling, and recruitment characteristics

4.3.1A Survey design and sampling

Cross-sectional surveys are widely used to gather information about the prevalence or extent of a health outcome, and to describe the characteristics of a population or determinants of health outcomes, at a single point in time (Levin, 2006; Wang & Cheng, 2020). They can be implemented with relative speed and affordability in comparison to other data collection techniques (Wang & Cheng, 2020). Cross-sectional surveys are not necessarily well designed to identify causation, however, given predictor and outcome variables are measured simultaneously, and can result in low response rates (Wang & Cheng, 2020). Nevertheless, multiple studies have used cross-sectional surveys to measure stigma and stigmatising attitudes, including abortion stigma, and the method was thus considered appropriate for this study (Hanschmidt et al., 2016; Reilly et al., 2022).

A self-selecting, convenience, non-probability sampling method was the most feasible option and was used to recruit participants for this study. While probability and random sampling strategies result in more representative (of the population of interest) samples, they can be expensive and difficult to achieve (Berndt, 2020; Wang & Cheng, 2020). Previous abortion stigma researchers have embedded their studies into nationally representative health surveys in order to achieve representative samples (for example, see studies in Brown et al., 2022 and Shellenberg & Tsui, 2012). Even though self-selection non-probability samples may be less representative, they are commonly used in social and clinical research (Althubaiti, 2023). Non-probability samples are often more feasible, timesaving, cheaply implemented, can result in larger sample sizes, and have been

[8] The term 'priority' population is herein used to refer to communities or population groups, which can be geographically determined or defined by a behavioural, demographic, or other characteristic, that are particularly vulnerable to or at risk of experiencing abortion stigma. The term is commonly used in public health to refer to populations at particular risk of experiencing health or socio-economic inequities (for example, see: Rak et al., 2019; Department of Health, 2019)

found to be particularly useful in recruiting minority populations (Berndt, 2020; Lehdonvirta et al., 2021). It is likely for these reasons that non-probability sampling strategies have been employed in previous stigma research (Brown et al., 2022; Pantelic et al., 2022).

A sample size of 640 participants was identified as the minimum number needed to facilitate factor analysis, using the commonly cited ratio of 10 participants per survey item (Cockrill et al., 2013; Costello, 2005). For multiple regression, it has been suggested that 15 participants per predictor are needed, suggesting a minimum sample size of 360 participants was needed (calculated based on 24 potential predictors included in TAASS) (Pallant, 2020). Given the non-probability sampling strategy, however, achieving as large a sample as possible, including participants from as many demographic groups as possible, was likely to mediate potential negative effects of non-representativeness (Althubaiti, 2023). Prior to this research the largest study of abortion stigma was undertaken by Sorhaindo and colleagues (2016), measuring community level abortion stigma among 5600 adults in Mexico.

4.3.1B Participant recruitment on social media

Social media is rapidly becoming a mainstream tool for the conduct and dissemination of research, health interventions and evaluations (Hammer, 2017). The reach, speed, affordability, flexibility, potential for multi-directional communication, and 'sharing features' afforded by social media make it a favourable alternative to traditional research processes (Bender et al., 2017; Capurro et al., 2014; Lunnay et al., 2015). Social media has been utilised to successfully recruit hard-to-reach populations (Capurro et al., 2014). It has been found to be "well-suited to research and practice on 'taboo' public health topics", such as sexual health, in part due to the potential for anonymity on social media (Capurro et al., 2014, p9; Fenner et al., 2012; Gelinas et al., 2017; Germain et al., 2018; Kosinski et al., 2015; Topolovec-Vranic & Natarajan, 2016). Engaging research participants via social media can help to minimise research fatigue, facilitate participant engagement and retention, and contribute a richer data set than traditional methods can achieve on their own (Lunnay et al., 2015).

Participants were recruited to this study using Facebook advertisements targeted broadly at anyone living in Australia who was aged 16 years and over. Facebook advertisements have been found to be a low-cost and effective method of recruitment for general community samples in health research (Lee et al., 2020). I was able to alter and re-target advertisements using population parameters (a function of the Facebook advertising platform) over time to ensure the sample was as representative of the population as possible despite the self-selecting sampling strategy. Furthermore, given my familiarity with using paid Facebook advertising, and the relative speed at which recruitment could occur, recruitment via Facebook was an appealing and logical choice. Of note, the survey was released during the height of the first round of COVID-19 restrictions in

Australia in April 2020, when other methods of recruitment were likely to be more challenging than usual.

The Facebook advertising campaign

The study aimed to recruit a sample that was broadly representative of the Australian population regarding age, setting (rural or urban), using paid, targeted Facebook advertisements. The University media team managed the advertisements through the University's Facebook account. Initially, the media team and I developed three advertisements with slightly differing text and similar but unique images. The three advertisements were released to a broad audience of Facebook users aged 16 and over who were living in Australia and tested for their performance after two weeks. The best performing advertisement, shown in Figure 5, was assessed to be the one seen by the highest number of Facebook users and that resulted in the most 'clicks' on the study link. The advertisement briefly described the aim of the study and linked potential participants directly to the Qualtrics web address where they could read about, consent to, and complete the survey. The two poorest performing versions of the advertisement were 'switched off' after the first two weeks of recruitment. The word stigma was not used in any recruitment materials or in the participant information sheets to avoid skewing results: terms 'attitudes' and 'perceptions' were used instead. Researcher names were not provided in the recruitment materials or information documents, and a generic 'research' email address was provided for correspondence.

Figure 5: Image of the most successful recruitment advertisement

Male-specific advertisements have been shown to result in a higher proportion of male research participants when using social media recruitment (Lee et al., 2020). Therefore, male imagery was used in two of the three initial advertisements, including images of a visibly masculine hand and man looking at a computer. It was intended that this would encourage the engagement of male participants, whom I anticipated would be underrepresented given abortion is typically considered a women's issue. Engaging men and boys in sexual and reproductive health practice, programs and research is necessary for the achievement of equitable SRH outcomes and gender equality (Davis et al., 2016; Shand & Marcell, 2021). Nevertheless, the best performing advertisement was the one containing an image of a woman holding a pregnancy test (Figure 5).

The advertising campaign for study recruitment commenced on Monday the 27th of April 2020. After two weeks of recruitment, the best performing advertisement was retargeted to users who were male, and users who were over 45 years of age. Both groups were under-represented among the 2800 respondents who had begun the survey up to that point. These targeted advertisements did not achieve significant reach, however, because the survey 'went viral' shortly after they were published. The original Facebook advertisement was shared thousands of times across Twitter and Facebook and achieved 'organic' reach, minimising the relative impact of the paid advertisements.

Figure 6 shows the demographic reach of the best performing advertisement over 15 days. It indicates that most Facebook users who saw the study advertisement were female and aged 17 years or younger. This is similar to the respondent characteristics of other Australian health research that has utilised Facebook Ads for recruitment (Lee et al., 2020). The response rate (proportion of Facebook users reached by the advertisement that clicked on the link) was 7.62%.

Figure 6: Demographic characteristics of Facebook users reached by the best performing advertisement

A total of $179 AUD was spent on advertising over a 15-day period. Based on the 2705 complete responses garnered in the first 15 days of recruitment (prior to 'going viral), this is a total cost of six cents per complete response received. This is significantly less than other health-related studies that have used Facebook to recruit community samples (Lee et al., 2020; Burke et al., 2021).

Going 'viral'

The Facebook advertisements resulted in relatively steady recruitment for 14 days, 2800 respondents beginning (2705 of these completing) the survey during this time. This represents 87.75% of the 3,155 people who clicked on the advertisement. Shortly into the third recruitment week the survey was shared by the Australian Christian Lobby (ACL) via their social media channels and email list which resulted in approximately 5000 responses (complete and incomplete) in the following 48 hours.

In the four days following this, women's health, feminist, and reproductive rights advocates became aware that a survey regarding abortion was being shared by the ACL. A member of parliament tweeted about the survey and suggested the ACL may be attempting to sway the results. Her tweet was re-shared 1123 times in approximately 72 hours (see Figure 7). The survey was subsequently shared thousands of times by a range of Facebook and Twitter users and via organisational (women's health organisations, for example) mailing lists, culminating in around 62,000 further (complete and incomplete) responses in 4 days.

Figure 7: Tweet by Member of Parliament Fiona Patten sharing the survey

Many Twitter and Facebook users who commented on related posts misconstrued that the survey was being run by the ACL with anti-abortion intentions. I did not comment on or respond to any

social media shares or comments, on advice from my supervisory team. I did respond to a number of emails (n=<20) sent to the study's email address requesting clarification about the intentions of the research.

Data collection was concluded after three weeks of recruitment. A total of 70,051 (complete and incomplete) responses were received. Table 7 shows the results of the three waves of recruitment, with numbers representing (sufficiently) complete and unique responses that were retained for data analysis after extensive data cleaning.

Table 7: Recruitment 'waves'

Distribution	Responses*	Average responses per day	Time period (days)
Facebook advertisements (minimal organic reach)	2705	180.33	15
ACL – Twitter, Facebook, email	3741	1870.5	2
Widespread sharing – advocacy, women's health, feminist groups, individuals	52280	13070	4
Total	**59726**	**2796.48**	**21**

**Valid (sufficiently complete) and unique responses after data cleaning*

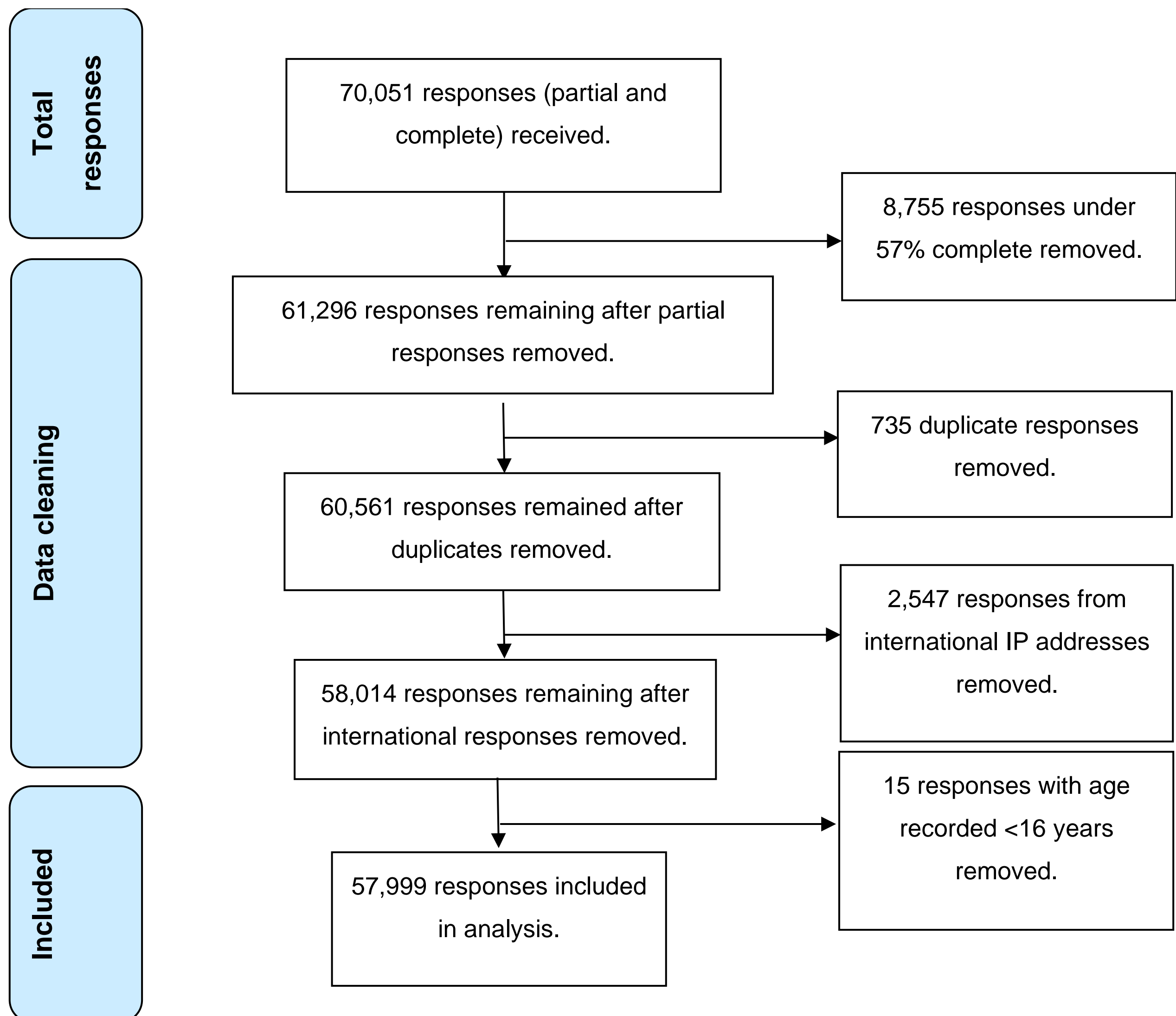
Within two months of survey recruitment, a Freedom of Information (FOI) request was submitted to Flinders University by a member of the Australian Christian Lobby. They requested study information, data, and information about why recruitment had ended. The information they received was subsequently published in an online blog on the ACL's website, in which they claimed the survey was biased (Brohier, 2020). More information about the experience of going viral, and the ACL's ongoing use of online activism to attempt to undermine and silence progressive and evidence-based perspectives and programs, is provided in Chapter 8 Section 8.3.1.

4.3.2 Data cleaning

Survey responses were exported from Qualtrics and imported into IBM SPSS Statistics (Version 27) wherein data were meticulously sorted and cleaned. Figure 8 outlines the data cleaning process. Initially, all responses with under a 57% completion rate were removed as they contained insufficient information to allow for even descriptive attitudinal or knowledge-focused analyses. Duplicate responses were then identified. Responses were treated as duplicates if they had identical answers to three variables; IP address (automatically recorded via Qualtrics), age and sex. Based on this criterion 839 matching cases were identified, that is 839 unique IP addresses with duplicate entries. In instances in which one of the two or more duplicate entries had a lower

completion rate the cases with the lowest completion rates were removed. For the 163 IP addresses that were linked to multiple complete or near complete responses, the second and subsequent (time recorded) responses from each IP address was identified and deleted.

Figure 8: Data cleaning process and outcomes



I then sought support from a software engineer who developed code that identified the country of origin of each IP address. This was necessary given manual identification was not feasible with the unexpectedly large sample size. The code created a score for each response which identified it as ‘Australian’ or ‘not Australian’. This process identified 2547 responses that had been completed by non-Australian IP addresses, and these were removed from the dataset. Finally, responses with a reported age under 16 years were deleted (n=15). The age variable was marked as ‘missing’ where reported age was over 100 years or incomplete.

4.3.3 Data analysis and reporting

Data analysis was conducted using the IBM SPSS Statistics (Version 27) statistical software. The statistical methods are reported in line with the SAMPL guidelines, a set of guiding principles developed to ensure quality and consistency in statistical reporting (primarily in medical and biomedical journals) (Lang & Altman, 2014). The guidelines indicate that data modification and analysis processes, the purpose of each form of data analysis, and types of statistical tests used should be reported clearly enough that a "knowledgeable reader with access to the original data" should be able to verify the results (Lang & Altman, 2014, p. 6).

4.3.3A Describing the data

I conducted a range of exploratory analyses and descriptive statistics to summarise and describe the data, including the characteristics of the sample and the extent of and variation in abortion-related knowledge, beliefs, attitudes, and perceived stigma. As a result, the proportion of respondents who selected each response option to each survey item is described, along with the proportion of missing responses, and measures of central tendency and variability for the limited continuous variables. The results of descriptive and exploratory analyses are provided in Chapter 6 Sections 6.1 and 6.2.

4.3.3B Variable reduction using Principal Components Analysis

Prior to inferential (regression) analyses, Principal Components Analysis (PCA) was undertaken to identify sets of correlated variables pertaining to knowledge, beliefs, attitudes, and felt abortion stigma (see Appendix I) (Santos et al., 2019, p.3; see also Phakiti, 2018). PCA is common exploratory descriptive technique used in the social sciences to enable a reduction in the number of variables and thus to simplify statistical analyses. It is used to identify groups of items, named 'factors', likely to represent a single construct, enabling researchers to create a single variable in place of multiple variables (Phakiti, 2018). With running PCA, Oblimin rotation with Kaiser Normalisation was used to achieve more meaningful factor solutions than unrotated analyses allow (UCLA, 2021).

The minimum factor loading criteria was set to 0.35, a commonly used cut-off to identify meaningful and significant factor loadings (Phakiti, 2018; Schmitt & Sass, 2011). The factor loadings for each survey item and Cronbach's Alpha for each factor are provided in Appendix H.

A total of seven factors were identified through this process: Knowledge – Safety, Knowledge – Commonality, Beliefs, Attitudes, Anticipated Stigma, Perceived Community Stigma, and Choice and Judgment.

Knowledge

To enable PCA on knowledge-related items, variables with originally varying response categories were transformed for comparability. Response options for 7 of the 8 knowledge items were assigned a numerical value based on the degree of accuracy they represented. The (most) accurate response was assigned a value of 1, the least two (or more) accurate response categories, along with ‘I don’t know’, were assigned 0, and categories that were closest to/either side of the correct response category were assigned .75. While a binary variable (correct or incorrect) could have been created, the method utilised allowed more variation in scoring to be captured. For example: the survey item, “How many women in Australia do you think will have an abortion in their lifetime?”, originally had response options of “1 in 3”, “1 in 6”, “1 in 10”, “1 in 15” and “1 in 20”. They were respectively assigned scores of 1, 0.75, 0, 0, and 0. The eighth knowledge-related item, regarding abortion among teenagers (survey item 21), was excluded from PCA as there is no clear ‘accurate’ or ‘inaccurate’ response category. The item instead addresses a common abortion-related assumption.

PCA identified two factors representing five of the seven included knowledge items. These factors together account for 62% of the overall variance in knowledge scores. Three items pertaining to the perceived safety of abortion formed a factor named “Knowledge – Safety”. The Cronbach’s Alpha for this factor is .693, suggesting the internal consistency, particularly given the low number of variables, is acceptable (Tavakol & Dennick, 2011)[9]. The other factor comprises two items related to the estimated proportion of women in Australia who experience abortion and unintended pregnancies, named “Knowledge – Commonality”. The Cronbach’s Alpha for this factor is very low (.237) and there is a low level of correlation between the variables. The factor, which does not meet the requirements of regression analysis, was not included in further statistical analyses.

Abortion rights and morality (beliefs)

All five items intended to measure beliefs about abortion legality, provision, and morality loaded onto a single factor during PCA, labelled “Beliefs”, which explained 84.26% of the variance. The scale demonstrates a high level of internal consistency (Cronbach’s Alpha = .950) and was retained for regression analysis.

Abortion attitudes

Eleven of 13 items pertaining to abortion attitudes (towards abortion seekers and providers) loaded onto a single factor, labelled “Attitudes”, which explained 69.05% of the variance. The scale

[9] Removal of the ‘breast cancer’ item increases the Cronbach’s Alpha to .760 and could be considered in future abortion stigma research incorporating knowledge as an independent variable. Researchers who include the ‘breast cancer’ item in countries/contexts where abortion-related myths are more prevalent may find it to be more highly correlated with other abortion safety knowledge variables.

demonstrates a high level of internal consistency (Cronbach's Alpha =.952) and was retained for regression analysis.

Abortion Stigma

Fifteen items measuring felt abortion stigma were included in PCA. Twelve of the items loaded onto one of three factors. The final three factor model accounts for 60.51% of the variance. The first factor includes five items related to the anticipation of social consequences of abortion seeking and provision and was named "Anticipated Stigma (Social Consequences)". The Cronbach's Alpha of .781 indicates good internal consistency. The second factor includes five items primarily measuring perceived community attitudes towards abortion and was named "Perceived Community Stigma". The Cronbach's Alpha of .778 indicates good internal consistency. The final factor includes two items related to variable judgment of abortion seekers depending on the circumstances (reason and gestation) in which they seek abortion, named "Choice and Judgment". The Cronbach's Alpha does not meet the standard .7 cut-off indicating acceptable internal consistency. Furthermore, there is limited variation in participants' responses to items in this factor. Thus, it was not included in further statistical analyses.

4.3.3C Composite-score calculations and variable creation

Mean scores of participants' responses to the items in each factor – which will subsequently be referred to as 'sub-scales' - were calculated following PCA. Mean scores were generated for all research participants who had answered more than half of the items in the Knowledge, Beliefs and Attitudes subscales (>98% of participants). This resulted in each participant having a single composite score for each of the *Knowledge – Safety, Beliefs, Attitudes, Anticipated Stigma,* and *Perceived Community Stigma* subscales. These scores were used in all subsequent analyses. For the dependent (outcome) variables – *Anticipated Stigma* and *Perceived Community Stigma -* mean scores were similarly calculated for each respondent who had answered three or more of the five items comprising each factor.

4.3.3D Preparation of other independent variables

Dummy variables were generated for independent variables that could not logically be transformed into binary variables, including for *Political preference* and *Religious attendance*. The creation of dummy variables transforms categorical variables into binary variables and thus enables their use in linear regression analyses (Allen, 1997). *Aboriginal and Torres Strait Islander* identification and *Religion* were included as binary variables, as were all variables relating to pregnancy, parenting, and abortion experiences.

A total of four knowledge variables were included in regression analysis. These included the *Knowledge-Safety* subscale variable, described above, along with three individual knowledge

items: two items that didn't load onto the factors during PCA (20 and 22) and one item that was not included in factor analysis (as explained above, item 21, as a binary variable) (see TAASS item numbers in Appendix J).

4.3.3E Assumptions of linear regression

Data were assessed for normality, linearity, outliers, independence (of variables and errors), and homoscedasticity to ensure they met the assumptions of linear regression (Jeong and Jung 2016). SPSS outputs and statistics related to these tests are provided in Appendix L.

Normality

Tests of normality are known to be over-sensitive when conducted on large datasets, likely to pick up even small deviations from normality (Ghasemi & Zahediasl, 2012). Statisticians have gone so far as to recommend ignoring tests of normality with datasets containing hundreds of observations (Ghasemi & Zahediasl, 2012). Linear regression is thus considered to be appropriate for use in large datasets irrespective of the distribution of scores (Lumley et al., 2002). Nevertheless, the assumption of normality was assessed using graphical/visual methods (histograms and P-P plots and Q-Q Plots), and kurtosis and skewness values. While small deviations from normality were indicated for *Perceived Community Stigma* scores this was unlikely to result in inaccurate linear regression results (Ghasemi & Zahediasl, 2012; Li et al., 2012; Pek et al., 2018). The *Anticipated Stigma* variable was normally distributed, as indicated graphically, and with skewness and kurtosis scores that fell well within the -1 to 1 range (Mishra et al., 2019). Standardised residuals for both dependent variables were assessed graphically and found to be relatively normally distributed.

Linearity

Scatterplots and bivariate correlation statistics (using a significance level $P<.001$) were run to assess the linearity of the relationships between the independent and dependent variables. Correlation coefficients equal to or over .1 were considered to indicate (at least a low level of) correlation (Brydges, 2019; Cohen, 1992). Therefore, variables with a correlation coefficient of .1 or over were included in regressions.

Multicollinearity, outliers, and homoscedasticity

The presence of multicollinearity, outliers, and homoscedasticity were assessed while undertaking multivariable linear regression. Variance Inflation Factor (VIF) scores <5 were taken to indicate that the variables were sufficiently independent and high levels of multicollinearity were not present (Frost, 2017; Pallant, 2020). Residual plots graphically/visually indicate the absence of outliers, defined as cases with a standardised residual of more than 3.3 or less than -3.3 (Pallant, 2020). Residual plots also suggested that relatively constant variance of the residuals (around the fit line) indicate the presence of homoscedasticity. While the Breusch-Pagan test identified

heteroskedasticity (p values <.001), again given the (over)sensitivity of statistical testing in this very large dataset, the graphical assessment was prioritised (in consultation with two statisticians).

Durbin-Watson statistics for both models[10] (1.990 for *Anticipated stigma* model and 1.977 for *Perceived stigma* model) indicate no autocorrelation and almost perfect independence of the regression errors.

4.3.3F Weighting

I chose to use raking to adjust the sample to match known population parameters prior to linear regression analysis, to minimise any potential biases present due to the non-probability sampling method used (Yansaneh, 2003). The sample was weighted using Rake Weights based on three characteristics –*Political preference*, *Rural/urban residence*, and *Country born.* Weighting was implemented after descriptive tests had been run and prior to regression analysis. The sample was weighted to match political preferences as reported in a 2019 Election Study (Cameron, 2019), the rural-urban distribution of the Australian population (Australian Bureau of Statistics, 2019), and the proportion of Australians born in and outside of Australia (Australian Bureau of Statistics, 2022a).

The sample was not weighted by age as the age distribution closely reflected the Australian population. The sample was not weighted by sex, despite the significantly larger proportion of female participants. There were several reasons for this. Firstly, weighting according to the other three variables increased the proportion of male participants to >23%. Furthermore, male study participants were found to have higher levels of religiosity than the rest of the sample and the Australian population. For this reason, achieving a representative distribution of male, female and non-binary/other sex participants was likely to skew the sample on other characteristics.

Table 8 provides an indication of the impact of the weighting process on some of the sample characteristics. As a result of weighting the mean age increased, indicating a slight underrepresentation of young people in the final weighted sample. Furthermore, the proportion of participants who reported a religious affiliation increased significantly from 27.7% to 44.9%, and the sample became more politically conservative.

[10] Of note, SPSS was unable to calculate Durbin-Watson statistics for the weighted dataset, and thus these statistics were ascertained through running the models on the full unweighted dataset.

Table 8: Sample characteristics pre- and post-weighting

Characteristic	Whole Sample – raw		Whole sample – weighted	
	Number	**%**	**Number**	**%**
Age – <24 years	8615	14.7%	6617	11.4%
Sex - Female	46997	80.1%	44732	76.8%
Urban residing	47126	80.4%	41962	72%
Aboriginal &/or Torres Strait Islander	967	1.7%	722	1.3%
Born in Australia - Yes	49772	85%	40797	70%
Religion - Yes	16193	27.7%	26162	44.9%
Education - Degree	39198	67%	38230	65.9%
Political left (The Greens)	21426	36.6%	5187	8.9%
Abortion experience - Yes	15970	27.9%	15074	26.5%
Biological parent - Yes	28825	49.1%	35148	60.3%
Unplanned pregnancy experience - Yes	22462	39.1%	23750	41.8%
Teens have more abortions - Agree	9346	18.6%	12453	25.5%
Support Marriage Equality	49764	91%	39897	75.6%

4.3.4 Linear regression analysis and modelling

Simple and multivariable linear regression was undertaken to estimate the strength of relationships between the independent (demographics, pregnancy experiences, knowledge, beliefs and attitudes) and dependent (stigma) variables. All regressions were run on weighted data.

Simple (bivariate) linear regressions were run with 11 independent variables that met the assumptions of linear regression to assess whether they significantly predicted *Anticipated Abortion Stigma.* Similarly, simple linear regression was used to elucidate the relationships between 10 independent variables and *Perceived Community Abortion Stigma.*

While statistical significance is often used in variable selection for linear regression (Bursac et al., 2008; Chowdhury & Turin, 2020), the large size of this dataset and resulting sensitivity of significance tests made this impractical: almost all independent variables were found to be significantly correlated with both stigma variables in bivariate analyses (at the $P<0.001$ level). Thus, the coefficient/effect size was used to determine variables carried forward from bivariate to

multivariable modelling. Variables with correlation (standardised Beta) coefficients over (-).1 were included in multivariable regression analyses (based on threshold established by Cohen (1992)).

Multivariable linear regression was used to test if the independent variables significantly predicted *Anticipated Abortion Stigma* and *Perceived Community Stigma* (independently) when covariates were held constant, along with their explanatory strength. Multivariable linear regression allows researchers to model the impact of multiple independent variables on a continuous outcome variable (Easter & Hemming, 2021). In developing the multivariable models, I explored multiple methods of multivariable regression analysis. I began by building hierarchical models manually. Hierarchical multiple regression allows variables to be added based on a theoretical or logical understanding of the factors that are likely to influence the dependent variable and facilitates an examination of the impact of each additional variable on the dependent variable and predictive strength of the model (Jeong & Jung, 2016). I also explored the potential to use Stepwise selection and purposeful selection, however they were unlikely to be optimal methods of analysis due to the large sample size (Bursac et al., 2008; Chowdhury & Turin, 2020).

The final two multivariable regressions were run (separately) with independent variables placed in a single block and entered simultaneously, using the default "Enter" function in IBM SPSS Statistics (version 27). This is a more reproducible method than other model development processes. Variables that were not significant predictors (at the $P<0.001$ level), or where multicollinearity was identified, were removed from the model (Bursac et al., 2008). In cases of multicollinearity, the variable that made the highest contribution to the model's predictive strength (R^2)[11] was retained as a proxy (Bursac et al., 2008). Again (as above), multicollinearity was defined as VIF scores over five (Choueiry, 2023; Fox, 2015; Frost, 2017).

4.3.5 Sensitivity Analysis

A sensitivity analysis was conducted to explore the impact of the self-selecting recruitment method, lobby groups, and 'going viral' on the regression results, and to demonstrate the outcomes of the statistical weighting process.

As outlined in Section 4.3.1B, informed by social media comments, email feedback, and the daily number of responses received during the recruitment period, three distinct waves of participant recruitment were identified. Participants in the first wave, recruited almost solely via paid Facebook advertising, were predominantly young and female, with relatively high levels of abortion related knowledge and abortion-supportive attitudes. Wave 2 participants were recruited primarily via sharing of TAASS by the Australian Christian Lobby (ACL) and reported higher levels of religious

[11] These decisions were informed by the outputs of the manual hierarchical model building process, which identified the relative R^2 contributions of variables when covariates were present.

affiliation, had less abortion-related knowledge, and were more likely to be male, relative to participants recruited in Waves 1 and 3. Wave 3 participants were recruited when the study 'went viral', and were predominantly politically left-leaning, female, had the lowest level of religious affiliation among the 3 Waves, high educational attainment and relatively high levels of abortion-related knowledge.

Descriptive statistics were tabulated to demonstrate differences in the sample characteristics between the three waves and the whole unweighted and weighted samples. Following this, the final multivariable regression models were run, treating each 'wave' as a unique dataset. The results facilitate a comparison of the models' relative predictive power, and of the predictive strength of the included independent variables, across each of the three recruitment waves and the full weighted dataset. The sensitivity analysis was the final stage in Phase 1 data analysis.

4.4 Conclusion

In order to identify the extent and predictors of felt abortion stigma in Australia I developed The Australian Abortion Stigma Survey. Through three rounds of qualitative and quantitative testing, TAASS was found to be both a valid and reliable measure of felt abortion stigma in the Australian context. An unprecedentedly large sample of members of the Australia public was recruited via social media to complete TAASS. A range of descriptive and inferential statistical tests were run to identify sub-scales within the full scale, and to identify predictors of felt abortion stigma. The results of these tests (presented in Chapter 6) informed the design and focus of Phase 2 of this research, the qualitative interview study, which is described in detail in Chapter 5.

CHAPTER FIVE: QUALITATIVE METHODOLOGY

Phase 1 of this mixed methods study was designed to indicate *who* is most likely to experience felt abortion stigma, while Phase 2 - the interview study - was designed to identify *why* they were most likely to perceive or anticipate abortion stigma. At the conclusion of Phase 1 it was established that young people (aged 16 to 24 years) were more likely than older survey participants to score highly on measures of felt abortion stigma. Previous research indicates young people are often excluded from, and are therefore under-represented in, abortion-related research, despite being particularly at risk of facing barriers to accessing abortion care (Ralph et al., 2022). Therefore, this interview study, informed by research gaps and the results of Phase 1, aimed to explore the drivers, experiences, and meanings attributed to abortion and abortion stigma among young people in Australia.

Stutterheim (2021) has described a range of reasons why qualitative research is crucial to improving our understanding of and responses to stigma. Qualitative research is methodologically best placed to research complex social phenomena, such as stigma (Stutterheim, 2021). Numerous researchers have described the limited potential of quantitative methods in contributing to understandings of stigma, primarily as they do not facilitate an in-depth understanding of experiences involved in stigma, including stigma formation, processes (David et al., 2018; Parker & Aggleton, 2003; Thornicroft et al., 2007). The flexibility of qualitative research, especially when undertaken using an iterative data collection and analysis process, is particularly valuable in generating an in-depth exploration of themes as they are developed (Ngulube, 2015). Qualitative research methods can therefore enable the identification of ideas that fall outside of prior research and theory.

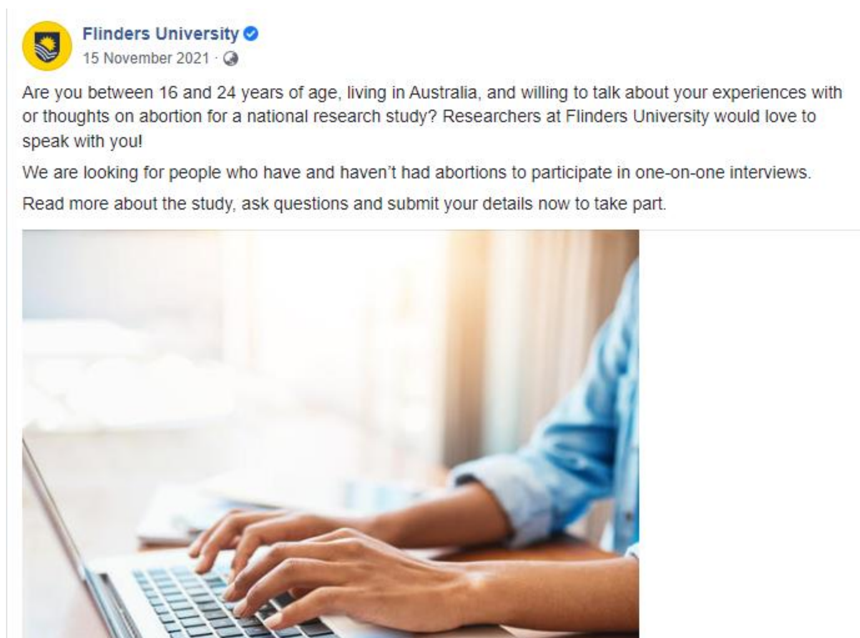
In this chapter, the processes of recruitment, data collection, and analysis related to the qualitative phase of this research are presented. Section 5.1 describes the recruitment process. Sections 5.2 and 5.3 outline the interview guide and process, respectively. In Section 5.4 the data preparation process is briefly described, followed by a detailed overview of the inductive and deductive coding and thematic analysis procedures used to explore and interpret the interview data in Section 5.5. In section 5.6 the process of integrating and jointly interpreting the qualitative and quantitative findings is summarised.

5.1 Recruitment

Purposive, diverse case sampling for maximum variation was used to identify participants representing a range of perspectives and experiences, and who were from as many locations in Australia as possible (Palinkas et al., 2015). A sub-sample of approximately 1000 participants who had completed TAASS, left their email addresses, *and* consented to be involved in further research were contacted regarding the qualitative study. Given I did not have demographic information data linked with survey participants' email addresses, those contacted were aged between 16 and 100 years of age. They were sent an information sheet about the research approximately 16 months after participating in TAASS and invited to complete a screening questionnaire for the interview study if they were aged between 16 and 25 years old. The screening questionnaire collected information about participants demographic characteristics and attitudes towards abortion, facilitating targeted recruitment of a diverse sample of interviewees.

Given the success of Facebook advertising in Study One, a Facebook advertisement was also run for a period of five days to increase the number of potential participants (Figure 9).

Figure 9: Facebook recruitment advertisement



In total, 121 people began the screening questionnaire over a period of 4 months, with 90 providing completed responses including their contact information. Of these 90 respondents, 23% did not meet the age criteria. Most people who provided complete responses to the screening survey were female (82.69%), lived in urban centers (86.14%), and were not religious (81.82%). Those who reported identifying with a religion predominantly self-identified as Christian (n=8) or Catholic (n=4).

There was one respondent who followed each of the following religions: Buddhism, Pentecostalism, Paganism, and Church of the Latter-Day Saints (names/denominations as described by survey respondents). Respondents were widely distributed geographically. All states and territories except for the Northern Territory were represented. One participant had accessibility requirements due to a disability. The screening questionnaire also identified that 80% of potential participants believed abortion should always be legal, 6% believed that it should be legal in most circumstances, 8% in limited circumstances and 6% never, broadly reflecting the TAASS participants. Most (78.89%) reported they (or partners) had not had abortion experiences.

During the four-month recruitment period I contacted a range of participants via email and invited them to participate in a Zoom interview. I purposively sampled participants with diverse gender identities, geographical locations, religions, abortion experiences and beliefs. At this stage, only one participant who reported they 'never' supported abortion access agreed to continue with the study and scheduled an interview time. The participant information sheet (PIS) indicated the study was pro-choice: it stated that the purpose of the research was to build an understanding of young peoples' abortion beliefs and experiences to, "help inform health service delivery and improve equity of access to reproductive health services". Furthermore, in describing the potential benefits of the study it described how the study findings may, "be helpful to policy makers, health services and health promotion projects that aim to combat stigma and ensure everyone has access to the abortion information and services they need". Thus, it is possible that people strongly opposed to abortion did not feel comfortable participating. Of note however, as TAASS identified that approximately 5% of participants were opposed to abortion in all circumstances, recruiting one interviewee out of 20 would reflect the broader sample statistically. Nevertheless, it does not necessarily reflect a diverse case sample in relation to abortion beliefs.

I chose to include participants of a range of genders who had and had not had abortion experiences, to facilitate the comparison of perceived and actual stigma experiences and abortion stigma drivers across participant groups. Given the joint aim of this study to explore the drivers, perceptions, and (but not solely) experiences of abortion stigma, I considered the inclusion of people who didn't have lived experience of abortion to be important. Even among women and people who can become pregnant, "perceptions of reproductive norms and stigmas" form prior to having a stigmatised SRH experience (Rice et al., 2017, p.4). It was intended that a diverse sample would provide a broad understanding of the ways young people learn about abortion and engage with abortion-related discourse and norms.

5.2 The interview guide

An interview guide was developed prior to the commencement of the interviews. The content of the guide was informed by the research aims, literature review, and findings of TAASS, including areas in which the survey findings were different to what was expected/had been identified in previous research. The guide was designed to facilitate the collection of data that explores some of the expected and unexpected findings of TAASS and to create space for interviewees to describe experiences and understandings of abortion stigma beyond what is reflected in literature to date.

The interview guide begins with step-by-step reminders for how to open and seek consent during the interview followed by 'get to know you' and rapport-building prompts. Of note, prompts to check in around consent were included throughout the interview guide. After rapport building questions, the guide includes questions designed to elicit conversation about abortion-related memories from childhood and youth, and abortion-related learning experiences, which often resulted in participants offering a timeline of when they had heard and learnt about abortion during adolescence. These early questions created opportunities for participants to situate their narratives in and direct the interviews towards topics of most meaning to them (Galletta & Cross, 2013).

The middle section of the interview guide includes more specific questions (Galletta & Cross, 2013) designed to explore specific potential drivers of abortion stigma understandings and experiences. Questions in this section focus on participants' anticipated reactions to hypothetical abortion experiences, their own and other's abortion beliefs, and perceived influences on their abortion beliefs. Furthermore, it includes questions pertaining to young peoples' awareness of and beliefs about abortion-related social consequences, abortion norms in Australia and among peers, and knowledge about abortion-related laws and policies. Of note, these questions were often used as prompts or were not asked at all as they had already been addressed in interviewees' responses to earlier questions.

The final substantive questions were designed to offer interviewees the chance to elaborate on, clarify or add any information they may have wanted to (more fully) describe, and to ask any questions they had in regard to the research or abortion more generally. This marks an end to what were potentially quite demanding lines of questioning (Galletta & Cross, 2013). The guide finishes with prompts regarding end-of-interview processes, including re-checking for consent, checking in regarding participants wellbeing and experience of being interviewed, and preferences around checking transcripts and follow-up communication protocols. These final topics were addressed consistently.

Despite including specific questions and prompts, the guide was used very flexibly, and I did not necessarily cover all topics in the guide in each interview. Thus, the interviews were open, flexible, enabled rapport building, and enabled exploration of concepts that *had not* been predicted via the

interview guide (Turner, 2010). After the first interview with someone who had had an abortion experience, however, I did feel a separate guide was necessary to ensure elements of abortion experiences were thoroughly explored. I developed a second guide for use with interviewees who reported having had abortion experiences. For abortion seekers, the introductory rapport-building and timeline questions remained the same and were often similarly covered at the beginning of the interview process. After this, however, most of the interviews with abortion seekers centered around their lived experiences of abortion seeking and stigma. Questions and prompts included in the guide pertaining to their abortion experiences covered decision rightness, social support, disclosure, experiences with health providers and help-seeking, the impacts of stigma and abortion experiences, and the media.

For interviewees who identified as religious or anti-abortion, and for male interviewees, questions were altered, and prompts were added to ensure the interactions between their experience of religion and gender with abortion experiences, beliefs, and perceptions of stigma were explored. The strong relationship between religion and abortion stigma identified in TAASS, and Sex not being identified as a primary predictor of abortion stigma in the survey, drove a focus on these relationships. For example, for participants who indicated they had ever attended religious services regularly, a question about anticipated social consequences associated with abortion was followed, where appropriate, with a question about whether responses from people involved in their religious community would be different to those of others in their lives. The interview guide and variations are provided in Appendix M.

5.3 The interview process

Interviews were conducted over three months from October to December 2021. As a result of the geographic spread of interviewees, funding constraints, and travel and distancing restrictions due to the Covid-19 pandemic, all interviews were conducted online or over the phone. Online interviewing has become increasingly common since the beginning of the Covid-19 pandemic, enabled by technological advances and familiarity with video-conferencing software (de Villiers, Muhammad & Molinari, 2022). Most (18) interviews were conducted online using Zoom video-conferencing software. One interview was conducted over the phone due to the participant's limited rural internet access, and another via email to support the accessibility needs of an interviewee with a disability.

Audio and Zoom interviews lasted between 49 minutes and 2 hours and 21 minutes, with an average duration of 78 minutes. This time included rapport-building conversations before and after the formal (transcribed) components of the interviews. Allowing as much time as was needed to scaffold interviews with rapport building conversations felt particularly important given they were

online. Building rapport has been found to be vital to establishing respect and trust, and in turn for facilitating honest and open disclosure during interviews (Weller, 2017). Online video interviews can lack elements often considered important in rapport building, particularly physical and spatial communication and responding to visual cues ((de Villiers, Muhammad & Molinari, 2022). Even so, the relative lack of formality has been described by some young people as meaning online interviews can be less daunting than in person interviews (Weller, 2017). Furthermore, online interviews allow interviewees to be in a familiar space, often their own home, which can enable comfort among interviewees (Liamputtong, 2007). My interviewees generally, although not universally, appeared comfortable on screen, many moving around their living spaces during interviews, and I felt I had a clear indication of many interviewees' body language despite the online format.

I checked in with interviewees about their comfortability with continuing interviews multiple times throughout the interviews, and more often when there was an indication of discomfort or distress. At the end of all interviews, interviewees were given a chance to ask any questions they might have. Most were happy to end the call without extended discussions, though many wished me well with the study, and some expressed that the interview had been cathartic. I encouraged one interviewee to see a medical professional regarding pain she was experiencing in relation to a contraceptive implant she had felt pressured into having inserted post-abortion. I gave another information about a post-abortion counselling phone-line, as she expressed interests in seeking post-abortion counselling when I mentioned it was freely available. My reflections on the blurring of lines between researcher, friend, and counsellor in sensitive and feminist interviews are provided in Chapter 8 Section 8.3.2.

Interviewees were also asked if they would like to review the transcripts of their interviews, to which half agreed they would, a common process in feminist interview processes (Liamputtong, 2007). Between a day and a week after interviews I contacted all interviewees via email to thank them for their time, check on their wellbeing, and offer to answer any follow up questions or queries they may have.

Journalling during and immediately after each interview enabled me to identify and describe my experiences of conducting the interviews, such reflexivity central to the conduct of quality qualitative research (McBride, 2022). During each interview I took notes describing the level of rapport, trust and comfortability established during the interview process and how this changed over time. After each interview I reflected on the process, any difficulties or visible emotion experienced by the interviewee or myself, and made notes describing interview content that was similar, new, or different in comparison to previous interviews. Writing notes during the interviews assisted me to identify and explore emerging ideas and incorporate new language (as used by interviewees) in later interviews. McBride (2022, p.33) describes this as "linguistic fusing", with

shared language incorporated into the research over time. Similarly, new probes were incorporated into the interview guides over time, resulting in an iterative data collection and analysis process. Journalling also offered me an opportunity to reflect on my own “emotional dilemmas” that arose after some interviews, my “shortcomings” as a novice interviewer, my reflections on sensitive and ethical interviewing, and thus to refine my emotional as well as practical approach to interviewing over time (McBride, 2022, p.29). Further reflections on and details about the interview process are provided in Section 8.3.2.

5.4 Data preparation

Audio files from the zoom interviews were imported into online transcription software Otter.ai which transcribed each recording verbatim. I then listened to all audio recordings and edited the transcripts manually, line by line, to improve their accuracy. The editing process also provided me with an opportunity to identify initial themes and build familiarity with the data.

Once the interview transcripts were accurate and complete they were de-identified, which included removing interviewee and others’ names mentioned during interviews, as well as the any suburb/small town or organisation names. Location and organisation names were primarily removed when they referred to rural communities and had the potential to be used to identify participants. Transcripts were then shared via email with interviewees who had requested to receive them (n=10). All approved of the transcripts as they were, except for one interviewee requesting a story she had shared about a family member not be included in the analysis or publications. The 20 transcripts were then uploaded into the Lumivero NVivo (Version 12) software for coding and analysis.

5.5 Qualitative data analysis

The interview transcripts were thematically analysed though multiple overlapping cycles of inductive and deductive coding (McMillan & Schumacher, 2014, p. 364 in Ngulube, 2015; see also Braun & Clarke, 2006; Braun & Clarke, 2019a; Clarke, 2013). Thematic analysis has been described as a method for analysing, and interpreting "patterns of shared meaning" in qualitative data (Braun et al., 2019b, p.845; see also Braun & Clarke, 2006 and Clarke, 2013). Thematic analysis also facilitates the identification of lived, multiple, and subjugated realities and experiences (Braun & Clarke, 2019b), as is central to both feminist and qualitative research approaches. Within this data analysis method, coding is the process of breaking down, categorising, and interpreting data that, with each stage, supports researchers to move towards increasingly higher levels of abstraction and interpretation (Corbin & Strauss, 1990). The term 'codes' is used herein to describe the labels applied to unique pieces of information telling shared stories that were identified during the 'coding' process (Braun & Clarke, 2019a; van Rijnsoever, 2017). Thematic analysis, and coding more specifically, can be done inductively or deductively, or using a combination of approaches (Ngulube, 2015). Inductive coding techniques are primarily used to generate themes and subsequently theory 'from' data, whereas deductive coding is most often used to test pre-existing theory (Braun & Clarke, 2019b).

I used a method of coding and thematic analysis that incorporated inductive and deductive coding methods. Both methods I used fall broadly into what Braun and Clarke describe as "reflexive thematic analysis" and within a primarily qualitative paradigm, recognising many deductive coding methods often sit within a more positivist/quantitative approach (Braun & Clarke, 2019a, p.589). The process broadly aligned with the foundational method of thematic analysis first outlined by Braun and Clarke (2006, p. 87), which includes six distinct stages of thematic analysis: 1. data familiarisation; 2. generating initial codes/ initial coding; 3. constructing themes; 4. reviewing and defining themes and their relationships, including via generation of a thematic 'map'; 5. defining and naming key themes; and 6. Reporting of results/ telling the story of the data. This process is commonly used for open or inductive coding; however, I incorporated a pluralistic approach to coding and thematic analysis that facilitated both the generation *and* testing of theory, as described by Meyer and Ward (2014). The use of a synthesis of inductive and deductive coding techniques has the potential to strengthen the rigour and quality of evidence produced by tying data analysis to theory (Meyer & Ward, 2014). Specifically, I used inductive coding techniques in Stages 1 to 3, and a deductive approach in Stages 4 to 6. After an initial stage of inductive coding (Stage 2 in Braun and Clarke's 2006 method), which is essential to the identification of data and themes that fall outside of the scope of existing theory, Meyer and Ward (2014) suggest categorising codes and identifying themes with explicit reference to and the incorporation of pre-determined conceptual and theoretical frameworks. I was drawn to this approach, which is informed by the critical realist paradigm, as it supported me to identify latent structures and ideas sitting behind the observations

and beliefs of interviewees identified through open coding. Applying inductively identified codes to categories rooted in existing theory also enabled me to identify the broader structural conditions that drive, maintain, and support the resistance or dismantling of abortion stigma which underpinned interviewees' narratives. Furthermore, I found that explicitly incorporating theory during the coding process allowed me to be more cognisant of and transparent about the influence that my in-depth knowledge of the abortion stigma evidence base was having on the analysis process. The use of structured/pre-determined codes and a focus on reflexivity can support novice researchers to develop a rich and nuanced thematic analysis (Braun & Clarke, 2019b).

Each of the stages of qualitative data analysis are described below in detail, along with examples of the outcomes of each stage.

5.5.1 Data familiarisation

The first stage of data analysis included familiarising myself with the interview data. I did this via recording and re-reading field notes and through the transcription editing processes, during which I noted emerging ideas, contradictions, patterns, and other observations. The notes I took at this stage were consulted and informed the identification and organisation of codes during the third stage of analysis.

5.5.2 Initial inductive coding: identifying and labelling words and concepts

The first substantive round of coding involved open coding all transcripts line by line, whereby ideas, phrases and words were categorised and labelled (Ngulube, 2015). Codes developed at this stage were largely descriptive and often acted as "domain summaries", that is collections of data that included everything participants said about a particular idea or experience (Braun and Clarke, 2019, p.846). Fragments of text were coded to as many codes as were conceptually relevant. Once created, codes were applied to subsequent transcripts. Code names weren't fixed but instead codes were renamed, redefined, merged or split as the first round of coding progressed, to ensure related concepts were fully captured.

Given that I undertook qualitative data analysis towards the end of my doctoral candidature and was thus deeply aware of the extant literature on abortion stigma and stigma theory, there are elements of theory-driven conceptualisations present in the initial 'inductive' codes. This is inherent to a reflexive coding process (Braun and Clarke, 2018). Figure 10, for example, shows an excerpt of the coding tree generated from Stage 2 analysis, and includes the phrase 'contraceptive pressure' (see number 16 in the left column), which relates to reproductive coercion and abuse, an

issue and area of research I am actively engaged in outside of my PhD work. The open coding process resulted in the development of 380 distinct codes.

Figure 10: Sample of initial descriptive codes nested under parent code "abortion experiences"

15. Contraception preconception	Contraceptive use or non-use prior to finding out pregnant	1	1
16. contraceptive pressure	Pressured to use or not to use contraception (RCA)	1	5
17. cost	Associated with an abortion procedure	5	9
18. "couldn't go through it again"		1	4
19. covid	Reflections on Covid re. interaction with abortion experiences	3	4
20. current feelings	At time of interview, pertaining to past abortion	3	4
21. decision rightness	Decision-making ease/difficulty, post-abortion feelings re. decisions	3	5
22. fear of reactions	From others re. an abortion experience	5	11

5.5.3 Intermediate coding: interpretation and thematic organisation of ideas

The second round of substantive coding, and third stage of analysis in Braun and Clarke's process, was intended to "re-focus the analysis at the broader level of themes" (Braun & Clarke 2006, p. 89). It involved sorting, grouping, and splitting the initial codes to generate initial themes. Duplicate codes were removed as appropriate, and parent and child codes (themes and sub-themes) were re-structured to bring together related ideas and to reflect conceptual hierarchies. Codes developed and refined at this stage remained data-driven yet became increasingly conceptual. Figure 11 provides some examples of the way excerpts of text were coded and grouped at stages 2, 3, 4 and 5 progressively.

After the restructuring, sorting, and tidying of codes was complete I wrote comprehensive descriptions of the initial themes and drew mind maps to visualise relationships between them as recommended by Braun and Clarke (2006). The prevalence of a code (number of pieces of text coded to it) indicated important areas for further exploration, yet themes were selected for further analysis based mainly on their salience to the research question and richness of the stories they told.

5.5.4 Reviewing and defining themes

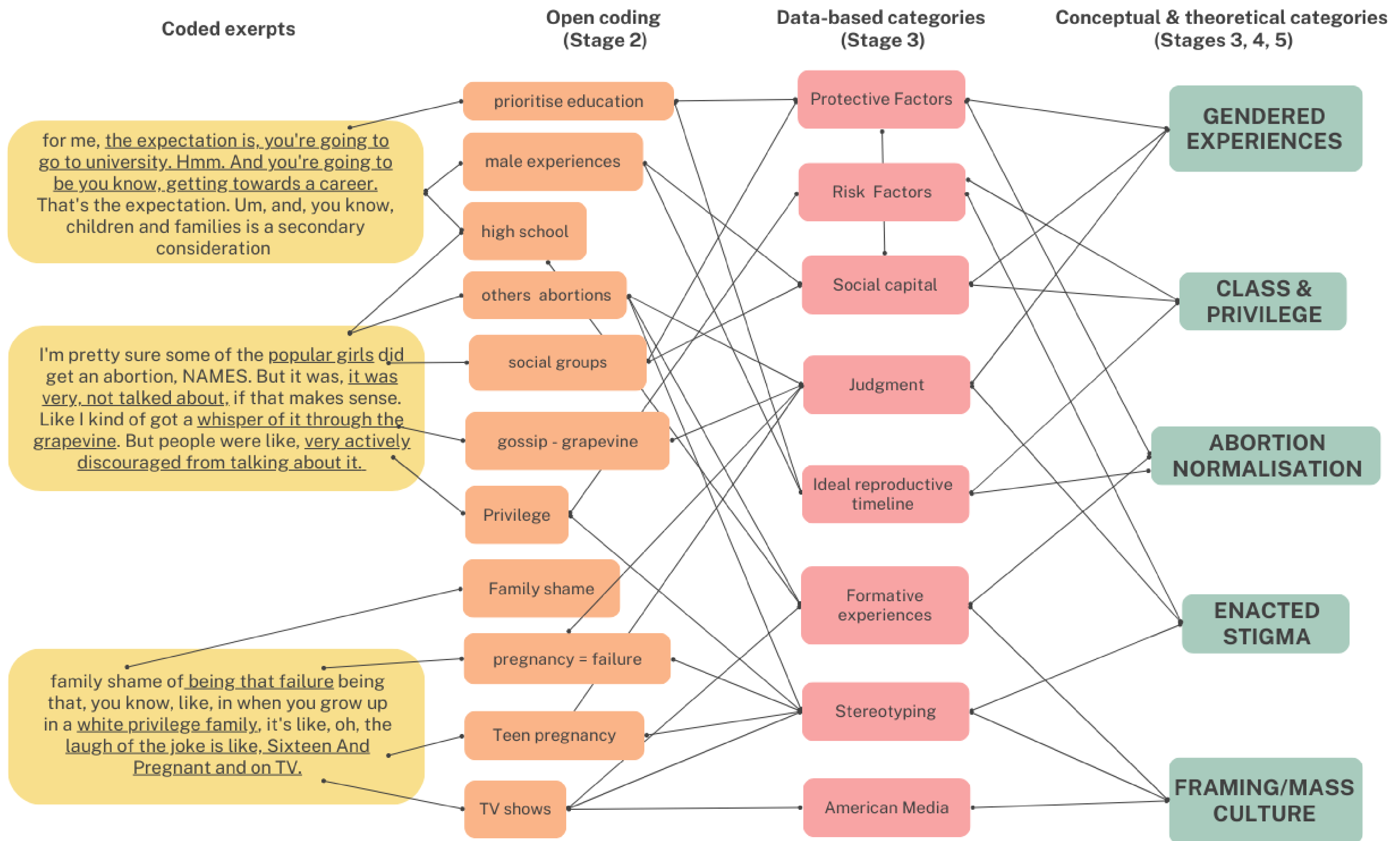
Stage 4 of this thematic analysis involved a synthesis of processes described by Braun and Clarke (2006) and Meyer and Ward (2014). Firstly, as Braun and Clarke (2006) suggest, I re-read coded

extracts under each thematic heading to explore and confirm the consistency and validity of the initial themes, and condensed, removed, and recoded text and themes as needed to maximise the fit of the coded extracts with thematic headings.

I then completed another round of re-organising and re-defining codes and themes in line with Meyer and Ward's (2014) process. Firstly, I mapped the thematic headings onto a series of pre-defined categories related to abortion stigma theory and conceptualisations. These categories included the levels of abortion stigma according to socio-ecological models, and the five components of the Health Stigma and Discrimination Framework (Stangl et al., 2019). Other categories reflected factors impacting abortion beliefs/acceptability (historical references, personhood of fetus, knowledge, religious framing, blaming providers) and the concept of class. While some inductively generated codes fit neatly into these theoretical categories, others needed to be split or merged, or coded text required re-coding.

As an example of recoding and grouping done at this stage, the interviewees' narratives suggested that they believe social and economic capital mediate the likelihood that a young person will be exposed to and impacted by abortion stigma. This story was told within content assigned to codes named 'capital', 'privilege', and 'education'. These codes were brought together at this stage of the analysis to create a theme named 'Class', in line with recent conceptualisations by Love (2018, 2021). Similarly, codes labelled 'America', 'topic avoidance' (previously coded under 'evidence of abortion stigmatisation'), 'media', 'social media', and 'politics', along with a suite of sub-themes, were grouped together under a new theoretically driven heading, 'framing - mass culture', in line with a socio-ecological understanding of stigma.

Figure 11: Examples of coding and theme generation



5.5.5 Selecting and naming key themes

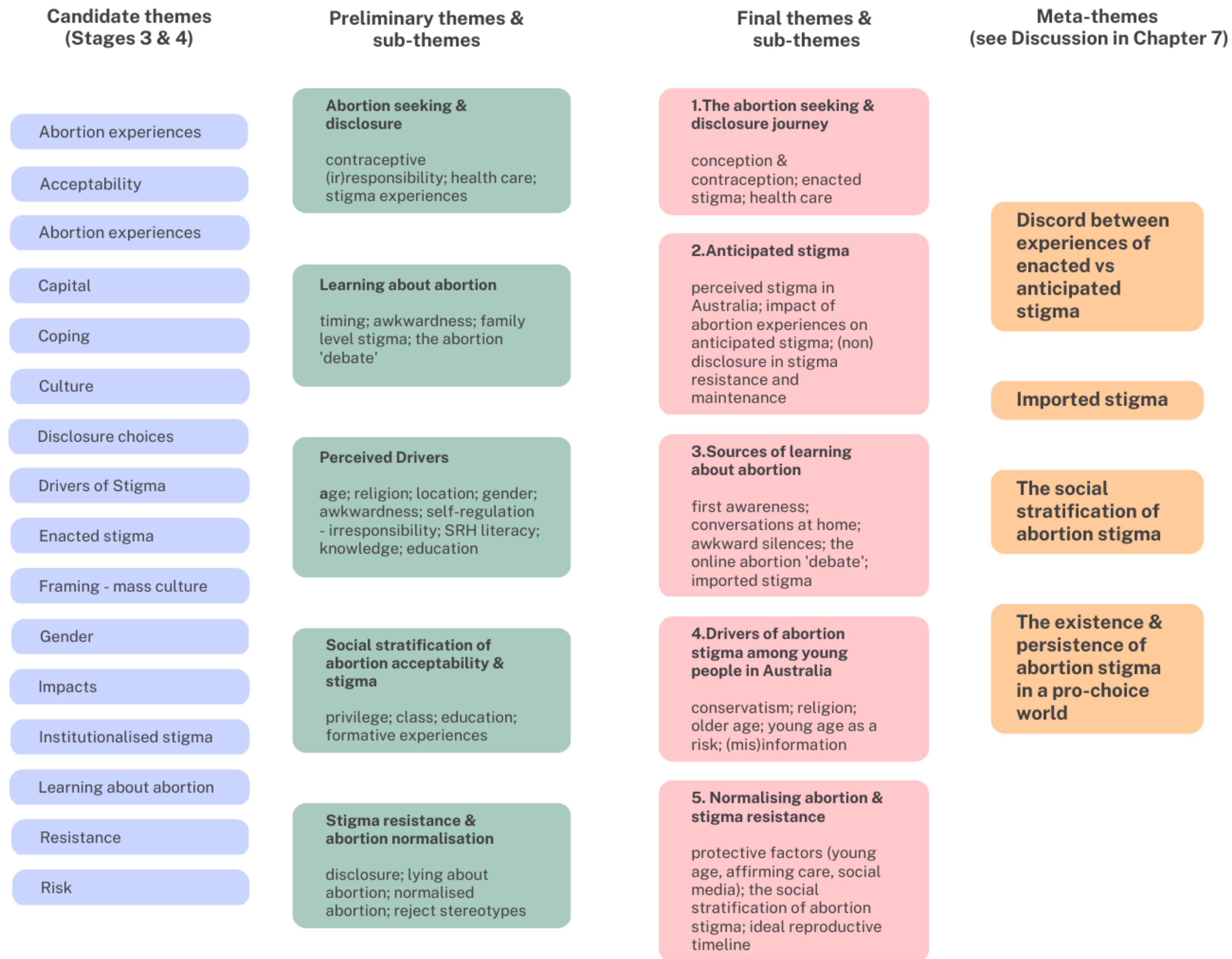
Stage 5 involved selecting, naming, and defining key themes (Braun & Clarke, 2006). I selected key themes from the large number of potential themes generated during analysis stages 3 and 4 based on a combination of factors. These factors included how prevalent a theme was in the data, themes' salience in young peoples' narratives, and their alignment with the research aims and objectives. As a result, some of the selected themes are conceptual and were generated inductively from the data (such as Final themes 1 and 3 described in Figure 12) and some are theoretical, in that they were developed to reflect aspects of abortion stigma theory described in prior research (Final themes 2, 4, and 5 in Figure 12).

During this stage I re-read all transcripts and coded excerpts, wrote case studies for each interviewee to re-center themes and concepts in their narratives holistically, and analysed each theme by writing about it in detail. These processes supported me to identify areas of conceptual murkiness and repetition and to clarify the scope of each theme. At the end of this stage of analysis, the themes described under "Final themes and sub-themes" in Figure 12 were chosen as the focus of final stage (Stage 6) of the analysis.

5.5.6 Telling the story of the data

The sixth and final stage of thematic analysis involved telling the stories that emerged throughout the analysis process (Braun & Clarke, 2006). Chapter 7, which reports the results of this analysis, is structured in line with best practices for the reporting of thematic analyses (Braun & Clarke, 2006). It includes a combination of description, interpretation, critique, and evidence to support all assertions I make in the form of interviewees' quotes and case studies.

Figure 12: Draft, preliminary and final themes



5.6 Quantitative & qualitative data integration

The final stage of data analysis and reporting involved an integrated interpretation of the quantitative and qualitative data and results. I used a narrative 'weaving approach' to data integration, whereby the quantitative and qualitative findings were grouped and interpreted thematically (Fetters et al., 2013). I used the research aims as theme headings, grouping data according to the 'extent' of perceived and anticipated abortion stigma and 'predictors and drivers' of abortion stigma. 'Predictors and drivers' of abortion stigma was defined in line with the Drivers & Facilitators component of The Health Stigma and Discrimination Framework (Stangl et al., 2019). Qualitative and quantitative findings were assessed for coherence or 'fit'. This involved an assessment of convergence (ways the two sets of findings support each other), complementarity (the way the two datasets expand upon each other's findings), and discrepancies or discordance between the datasets (Fetters et al., 2013; Hesse-Biber, 2012; O'Cathain et al., 2010). These are components of data triangulation, which is commonly used in mixed methods research to strengthen the validity of research findings (Farmer et al., 2006). While commonly used to confirm research findings, such methods can also facilitate the identification of meta-themes running between the unique components of mixed methods studies (O'Cathain et al., 2010).

I found the use of processes of data triangulation, which are commonly used to primarily strengthen or confirm research findings, facilitated the interrogation and expansion of my initial interpretations of each dataset. In giving equal weight to both the quantitative and qualitative findings, and in attempting to foreground participant voices and lived experience, I ran some additional statistical tests on the survey data to explore themes generated from the interview data. For example, 'Sex' was not identified as a significant predictor of abortion stigma during bivariate regressions analysis of the survey data and was therefore not included in the final multivariable regression models. In contrast, I identified gender (explored more so than sex in the qualitative component) as central to many interviewees' abortion stigma experiences and understandings. As a result, while conducting the integrated analysis, I re-ran the statistical models with Sex included as a predictor variable to identify potentially missed relationships, the results of which are reported in Chapter 6. I found that moving back and forward between the qualitative and quantitative analyses helped me to centre participants narratives and not simply report the qualitative data as confirming or contrasting the quantitative findings. In this way, the research design was constantly evolving (Tonon, 2019). In building the findings of these iterative analyses into the chapters related to the qualitative and quantitative research components separately/respectively, as well as bringing them together in the joint analysis in Chapter 8, I was able to more fully realise methodological and analytical integration.

5.7 Conclusion

In this chapter I have explained in detail the processes undertaken to design, implement, and analyse data from a qualitative interview study with young people living in Australia. I have also described the process of quantitative and qualitative data integration and triangulation employed to maximise the strengths of the mixed methods research design. Across Chapters 4 and 5 I have described and argued for the relevance and value of the methodological choices made, and methods used, throughout this research project. I have described the way the two phases of the research project build upon each other to address the research aims and facilitate a multi-dimensional exploration of abortion stigma in Australia. These chapters offer the foundation, in the spirit of transparency and to maximise the potential for repeatability, on which the remaining four chapters of this thesis are built.

CHAPTER SIX: FINDINGS OF THE AUSTRALIAN ABORTION STIGMA SURVEY

This chapter presents the results of Australian Abortion Stigma Survey (TAASS), which was implemented in April and May 2020 and resulted in the largest abortion stigma dataset globally to date. This chapter begins by describing the characteristics of the study participants in Section 6.1, followed by descriptive statistics pertaining to key independent and dependent variables in Section 6.2. The results of the simple (Section 6.3) and multiple linear regression (Section 6.4) analyses are then presented, culminating in two multivariable models which describe the predictors of perceived and anticipated abortion stigma. In Section 6.5 a sensitivity analysis is presented which illustrates the impact of the cross-sectional, self-selecting recruitment method and 'going viral' on the final statistical models. Section 6.6, the discussion, situates the findings in the broader research context and reflects on their implications for abortion stigma research, including the qualitative component of this study.

6.1 Results: Descriptive – Sample characteristics

Despite the influence of lobby group interests and the non-traditional recruitment trajectory, participants who completed TAASS were geographically and socio-culturally diverse. The very large sample size means that all population groups are well represented in terms of the quantity of data, even those that are underrepresented relative to others and to the Australian population at large. Table 9 provides an overview of participant characteristics and further details are provided in Appendix N.

Participants ranged from 16 to 99 years of age with a mean age of 39 years. Most participants identified their sex as female (80%), were born in Australia (84.7%), and lived in urban areas (80.4%). Participants were more highly educated than the wider Australian population with 67% holding a degree, compared with the 32% of Australians (Australian Bureau of Statistics, 2022b). Participants were also more politically 'progressive' than the Australian population: 36.6% of participants reported a political preference for Australian Greens (representing the political 'left'), a quarter for the Australian Labor Party, and just 9.8% the Liberal and National (conservative) parties. In comparison, 40% of the wider Australian population reported a preference for the Liberal/Nationals around the time of the survey (Cameron, 2019).

Table 9: TAASS participant characteristics

Characteristics	Categories	Frequency	% of sample^
Sex	Male	11126	19%
	Female	46997	80.0%
	Intersex/Other	544	0.9%
Age	16-24 – "Young"	8615	14.7%
	25-34	16840	28.7%
	35-44	14680	25.0%
	45-54	9464	16.1%
	55-64	5784	9.9%
	65+	3263	5.6%
Rural/Urban	Metro/outer metro	47126	80.4%
	Rural/ remote	11469	19.6%
Aboriginal and Torres Strait Islander identification	Not Aboriginal or Torres Strait Islander	55398	98.3%
	Aboriginal and/or Torres Strait Islander	967	1.7%
Country born	Australia	49772	85%
	Other	8789	15%
Education	Primary education or less	100	.2 %
	Completed high school year 10 or 12	9899	16.9 %
	Trade/cert/apprenticeship	9295	15.9%
	Degree or higher	39198	67.0%
Religion	None	42212	72.3%
	Religion identified	16193	27.7%
Political affiliation	None/ don't know	14880	25.4%
	ALP (Labor)	14104	24.1%
	LPA (Liberal) & Nationals	5762	9.8%
	Australian Greens	21426	36.6%
	Other	2360	4%

^ *Valid % reported*

Most participants did not report an affiliation with any religion (72.3%), almost double the 38.9% of Australians who report having no religious affiliation (Australian Bureau of Statistics, 2022c). The most common religious affiliations were Christian denominations, reflective of the Australian population (Australian Bureau of Statistics, 2022c). Regular (weekly or more) attendance at religious services was more common among survey participants than it is among Australian (Christian) norms (Powell, 2020), indicating survey participants who identified with a religion had unrepresentatively high levels of religiosity (see Appendix N Table N1).

6.1.1 Parenting, pregnancy, and abortion experiences

All participants, regardless of sex, were asked about all parenting experiences. Responses to key items are provided in Table 10, and others in Appendix N Table N2. Half of the (49.1%) participants were biological parents. Just over a quarter (27.2%) reported having ever experienced (including having had a partner who experienced) one or more abortions. The likelihood of reporting an abortion experience did not differ (significantly) by sex, although it did differ significantly by age: only 9.2% of young people (aged 16-24) reported an abortion experience, in comparison with 21.7% of participants aged 25 to 34, 32.1% aged 35 to 44, 40.1% of participants aged 45 to 54, 41% of 55 to 64-year-olds. A Chi Square test of independence revealed the association between age and abortion experience was statistically significant with a moderate effect size (χ^2 (6, n=57212) =3062.407, P<.001, Cramer's V = .231) (Pallant, 2020).

Table 10: Parenting, pregnancy, birth, and abortion experiences

Characteristics	Categories	Frequency	% sample
Biological parent	Yes	28825	49.1%
	No	29901	50.9%
Ever had (or partner had) an abortion	No	41319	70.4%
	Yes	15970	27.2%
	NA/ Prefer not to say	1437	2.4%
Ever experienced (or partner experienced) unplanned pregnancy	No	34964	59.4%
	Yes	22462	38.2%
	Prefer not to say/ Missing	1300	2.2%

Participants who reported living in rural or remote areas (χ^2 (1, n=57182)=102.379, *P*<.001, Phi = .042), identified as Aboriginal and/or Torres Strait Islander (χ^2 (1, n=55036)=41.964, *P*<.001, Phi = .028), and who reported no religion (χ^2 (1, n=57032)=327.726, *P*<.001, Phi = -.076) were significantly more likely than their counterparts (urban, not Aboriginal or Torres Strait Islander, religion yes) to report an abortion experience (See Appendix N).

6.2 Results: Descriptive – knowledge, beliefs, attitudes & stigma

The following section provides an overview of the descriptive statistics pertaining to knowledge, beliefs, attitudes, and perceived stigma items and sub-scales. Statistics in this section were calculated using unweighted data. While knowledge, beliefs and attitudes were treated as independent variables for regression analysis purposes, a brief explanation of key participant characteristics associated with each is provided as they are helpful in interpreting the results of the regression analyses in later sections.

6.2.1 Knowledge

Overall, there was a low level of endorsement of abortion-related myths. Only 3.3% of participants agreed that having an abortion increases the risk of breast cancer, and a further 16.6% were unsure. Most participants (correctly) agreed that early medication (86.1%) and surgical (88.5%) abortion are physically safe.

Despite low levels of myth endorsement and high levels of understanding about abortion safety, most participants underestimated how common abortion and unplanned pregnancy experiences are in Australia. For example, 65.4% believed that 30% or less pregnancies are unplanned. Participants commonly overestimated the availability of abortion services. Responses to the eight survey items that assessed abortion-related knowledge can be found in Appendix O.

Participants aged under 55 years, who reported their sex as intersex/other or female, were not biological parents, reported having had an abortion experience, and who were non-religious or rarely/never attended religious services had significantly (*P*<.001) greater abortion-related knowledge than their counterparts.

Table 11 provides descriptive statistics for the two knowledge sub-scales identified via PCA. The distributions of both the *Knowledge- Safety* and *Knowledge-Commonality* factor scores were skewed with median scores of .917 and .750 respectively[12]. With a range of 0 to 1, 1 representing perfect knowledge, these numbers indicate relatively high levels of knowledge across both factors. Histograms are provided in Appendix K.

Table 11: Describe statistics for subscales (unweighted)

	Knowledge – Safety	***Knowledge – Commonality***	***Beliefs***	***Attitudes***
Nvalid	58249	58466	58065	57568
Nmissing	477	260	211	1158
Mean	.825	.691	1.339	1.374
Median	.917	.750	1.000	1.091
Standard Deviation	.276	.241	.729	.603
Range	1 (0-1)	1 (0-1)	3 (1-4)	3 (1-4)

6.2.2 Beliefs – Abortion rights and morality

TAASS participants were predominantly pro-choice: 82.5% believed abortion should be legal and available in Australia in all circumstances (always), and only 5.6% agreed abortion should never be legal and available. The distribution of responses was similar across all 5 items in the *Beliefs* sub-scale (see Appendix N, Table N3 for a breakdown of responses to all *Beliefs* items). The mean *Beliefs* subscale score of 1.399 and median of 1 (within a 1-4 range with 1 representing abortion-supportive beliefs and 4 indicating opposition to abortion) indicate very low levels of stigmatising *Beliefs* (see Table 11).

Table 12 shows variations in *Beliefs* mean scores according to a range of participant characteristics, scores ranging from 1 (pro-choice) to 4 (anti-abortion). Participants who were female and who reported their sex as intersex/other, were urban residing, non-religious, not a biological parent, and reporting having had an abortion experience were more likely than their counterparts to have abortion supportive beliefs (all associations significant at the $P<.001$ level). Along with the sub-group comparisons presented Table 12, younger participants were also found to hold more abortion-supportive Beliefs: as age increases abortion related beliefs become

[12] Medians are provided when variables are not normally distributed (Lang & Altman, 2015).

increasingly anti-abortion. People aged 25-34 years had a *Beliefs* mean score of 1.254 in comparison with 2.243 for people aged 75 years and over (*P*<.001).

Table 12: Beliefs & Attitudes subscale mean scores (and standard deviation) by participant group

	Sex		**Rurality**		**Religion**		**Abortion Experience**		**Biological Parent**	
	Male	**Female & Other***	**Rural**	**Urban**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Beliefs mean score	1.509 (.889)	1.3 (.681)	1.435 (.826)	1.315 (.701)	1.92 (1.085)	1.115 (.318)	1.169 (.469)	1.397 (.79)	1.473 (.855)	1.21 (.553)
Attitudes mean score	1.541 (.764)	1.336 (.553)	1.458 (.664)	1.353 (.585)	1.847 (.861)	1.194 (.32)	1.228 (.401)	1.425 (.651)	1.500 (.69)	1.253 (.476)

6.2.3 Attitudes towards abortion seekers and providers

There was, overall, a low level of endorsement of stigmatising statements about, and generally supportive attitudes towards people who seek and provide abortions. Only 9.7% of participants felt women who have abortions are doing “something wrong” and 11.8**%** agreed with the statement**, “**a woman who has more than one abortion is irresponsible”. Most (89.1%) participants agreed that they, “respect a health professional who helps women have a safe abortion”. Responses to the 13 items assessing abortion-related attitudes and judgment can be found in Appendix N, Table N6.

As described in Chapter 4, 11 of the 13 items loaded onto a single factor during PCA, thus comprising a sub-scale named *Attitudes*. As demonstrated in Table 12 above, the low mean score for *Attitudes* indicates low levels of stigmatising attitudes among participants. As with *Beliefs*, participants who were female or intersex/other, urban residing, non-religious, not a biological parent, and reporting having had an abortion experience were more likely to hold abortion supportive attitudes than their counterparts (all correlations were significant at the *P*<.001 level). Similarly, as age increased, negative judgments towards abortion seekers and providers increased significantly (*P*<.001), though remained a minority.

6.2.4 Abortion stigma

As noted previously, the survey was intended to measure 'felt' abortion stigma. This term was used – as it has been in prior abortion stigma research – to refer to both the anticipation of stigma related to abortion seeking and provision and to perceptions about others' abortion related beliefs and attitudes (see sections 2.3.1 and 3.4.3). In this section and for the remainder of this thesis, however, as a result of the findings of TAASS, anticipated and perceived abortion stigma are referred to separately. The anticipation of social consequences (i.e.. stigma and discrimination) associated with abortion is herein referred to as 'anticipated abortion stigma'. Beliefs about others' abortion attitudes are herein referred to as 'perceived abortion stigma'. The importance of, and literature supporting, the differentiation between the two component parts of 'felt abortion stigma' is described in detail in Section 6.6.1.

TAASS participants were more likely to anticipate abortion-related social consequences than they were to perceive the Australian community as anti-abortion. Table 13 provides a breakdown of responses to the 15 stigma items.

Most participants believed the Australian public are generally supportive of legal abortions: 87% of participants agreed that most people in Australia believe abortion should be legal and available. Thus, there was a low level of perceived abortion stigma identified.

While only 23.7% of participants agreed that most people in Australia think negatively about women who have had an abortion, more than twice as many participants (53.5%) agreed that most people think negatively about women who have had more than one abortion. Almost all participants agreed that 'women are more likely to be judged' for having abortions after the first trimester and for 'personal' compared with 'health-related' reasons.

Regarding anticipated social consequences associated with abortion, 49.7% of the sample agreed that "most women who have abortions are likely to be gossiped about" and 65.2% agreed women are at risk of harassment because of an abortion. Fewer participants believed that women who have abortions are rejected from social or family groups (36.9%).

Table 13: Responses (conflated/ binary) to stigma items

Question	Low felt stigma (Agree)		High felt stigma (Disagree)	
	N	%	N	%
37A. Most people in Australia believe abortion should be legal and available	49705	87%	7416	13%
37B. Most people in Australia would think negatively about a woman who has had an abortion*	43520	76.3%	13542	23.7%
37C. Most people in Australia would think negatively about a woman who has had more than one abortion*	26519	46.5%	30542	53.5%
38. Most people in my local community are supportive of access to safe and legal abortions/ are pro-choice	47083	83.3%	9462	16.7%
39. Women are more likely to be judged if they have an abortion (for non-medical reasons) later in pregnancy, rather than earlier/ in the first trimester*	7108	12.5%	49596	87.5%
40. Women are less likely to experience judgment for abortions that are for health reasons (rather than for personal/relationship/financial reasons) *	4918	8.7%	51781	91.3%
41A. Most women in Australia who have abortions are likely to be gossiped about*	28394	50.3%	28004	49.7%
41C. Most women in Australia who have abortions are at risk of harassment because of their abortion*	19622	34.8%	36721	65.2%
41B. Most women in Australia who have abortions should keep their abortion secret from colleagues*	37905	67.6%	18205	32.4%
41D. Most women in Australia who have abortions are rejected from social or family groups*	35460	63%	20808	37%
42.I would expect health professionals who provide abortion services to be friendly and supportive	54990	97.9%	1169	2.1%
43. Women may receive negative or judgmental treatment from their regular healthcare provider or GP if find out about their abortion*	34547	61.6%	21552	38.4%
44. Women may be discouraged from having an abortion if they see protestors outside of the abortion service*	10412	18.5%	45781	81.5%
45 I would expect most abortion providers in Australia have experienced some form of harassment or violence due to their work*	10704	19.1%	45211	80.9%
46. Most people think more negatively about abortion providers than other types of health professionals*	17281	30.9%	38662	69.1%

**Item reverse coded, so "low felt stigma" reflects a 'disagree' response and "high felt stigma" represents an 'agree' response.*

Descriptive statistics for the *Anticipated Stigma* and *Perceived Community Stigma* sub-scales are provided in Table 14. They indicate that *Anticipated Stigma* scores were, on average, higher than *Perceived Community Stigma* scores.

Table 14: Descriptive statistics - Stigma sub-scales

	Anticipated stigma	Perceived community stigma
Number	58726	58726
Mean (SD)	2.700 (.544)	1.926 (.486)
Median	2.700	2.000
Range	3 (1-4)	3 (1-4)

6.3 Results: Simple Linear regression

Simple linear regression analysis was undertaken to test if the independent variables hypothesised to predict abortion stigma significantly predicted *Anticipated Stigma* and/or *Perceived Community Stigma*. Only independent variables that sufficiently met the assumptions of linear regression were included in regression analysis.

6.3.1 Anticipated Stigma

Simple linear regressions were run to assess whether 11 independent variables significantly predicted *Anticipated Stigma.* All 11 variables were found to be significantly associated with *Anticipated Stigma* $P<.001$).

The strongest predictors of *Anticipated Stigma*, based on an assessment of standardised (Beta) coefficients, are *Age*, *Beliefs, Knowledge-Violence*, and *Biological Parent*. On average, *Anticipated Stigma* scores are lower among participants who were older, have a religious affiliation, attend religious services more frequently, hold a university degree, are politically conservative, and/or have less abortion-supportive beliefs and attitudes. Conversely, non- and less-religious, younger, and pro-choice participants have greater *Anticipated Stigma* than their counterparts.

All 11 variables resulted in standardised (Beta) coefficients of greater than (-).1 and were retained for multivariable regression analysis (see Table 15).

6.3.2 Perceived Stigma

Simple linear regressions were conducted with 10 independent variables, all of which were found to significantly predict *Perceived Community Stigma* (see Table 15).

The strongest predictors of *Perceived Community Stigma* are abortion-related *Attitudes* and *Beliefs,* followed by *Knowledge – Safety* and *Sexism.* In contrast to the findings pertaining to anticipated stigma, participants who express the least support for abortion, hold more negative judgments towards abortion seekers and providers, and have higher *Sexism* scores are more likely to perceive abortion stigma. Similarly, participants who have a religious affiliation and attend religious services frequently have higher *Perceived Community Stigma* scores than their counterparts. As predicted, higher *Knowledge-Safety* scores, having had an abortion experience, and being politically progressive are associated with lower *Perceived Community Stigma scores.*

All 10 bivariate regressions had coefficients great than the (-).1 cut-off and were retained for inclusion in multivariable analysis.

Table 15: Simple linear regression statistics

	Anticipated Stigma (social consequences)				Perceived Community Stigma			
Independent variable (For binary variables, 0 = No & 1= Yes)	**Coefficient: Unstandardised/ standardised**	**95% CI (unstandardised coefficients)**	***P*-Value**	**R^2 (Standard error)**	**Coefficient: Unstandardised/ standardised**	**95% CI (unstandardised coefficients)**	***P*-Value**	**R^2 (Standard error)**
Age	-.010/ -.295	-.010, -.010	*P*<.001	.087 (.50242)		NA		
Religion	-.153/-.145	-.162, -.145	*P* <.001	.021 (.52045)	.314, .301	.306, .322	*P* <.001	.090 (.49557)
Religious attendance:				.038 (.51596)				.151 (.47864)
Weekly^								
Monthly/semi-regular	.193/.111	.177, .209	*P* <.001		-.345/-.200	-.359, -.330	*P* <.001	
Rarely/Never	.216/.129	.201, .231	*P* <.001		-.414/ -.250	-.429, -.400	*P* <.001	
Never (non-religious)	.249/.235	.239, .259	*P* <.001		-.490/-.469	-.499, -.480	*P* <.001	
Politics:				.024 (.51967)				.089 (.49593)
Liberal & National^								
Greens	.236/.128	.220, .252	*P* <.001		-.306/-.168	-.321, -.291	*P* <.001	
Labor	.148/.131	.138, .158	*P* <.001		-.347/ -.311	-.357, -.338	*P* <.001	
Other	.073/.030	.052, .093	*P* <.001		-.164/ -.067	-.183, -.145	*P* <.001	
None	.139/.093	.126, .152	*P* <.001		-.252/-.171	-.264, -.240	*P* <.001	
Biological Parent	-.216/ -.201**	-.225, -.208	*P* <.001	.040 (.52578)		NA		

Abortion Experience	NA				-.189/ -.161	-.199, -.180	*P*<.001	.026 (.51100)
Someone told you about their abortion	NA				-.164/ -.142	-.173, -.155	*P*<.001	.020 (.51440)
Knowledge - safety	.183/ .120	.171, .195	*P*<.001	.014 (.52451)	-.671/ -.447	-.682, -.660	*P*<.001	.200 (.46681)
Knowledge – public provision	.209/.162	.199, .220	*P*<.001	.026 (.51913)	NA			
Knowledge – violence, abortion	.261/.202	.251, .271	*P*<.001	.041 (.51534)	NA			
Knowledge – teens more abortions	NA				-.263/ -.221	-.273, -.253	*P*<.001	.049 (.50555)
(0 =Agree, 1= Disagree)								
Sexism	-.166/ -.160	-.174, -.157	*P*<.001	.025 (.53173)	.418/.412	.411, .426	*P*<.001	.170 (.48001)
Beliefs	-.109/ -.212	-.114, -.105	*P*<.001	.045, (.51736)	.263/ .516	.260, .267	*P*<.001	.266 (.44788)
(1 low stigma, 4 high, continuous)								
Attitudes	-.126/ -.194	-.132, -.121	*P*<.001	.037 (.52234)	.361/ .561	.357, .366	*P*<.001	.314 (.43546)
(1 abortion supportive, 4 least/not abortion supportive)								

**P>.001 = non-significant*

^ Reference category (Dummy variables used)

6.4 Results: Multiple Linear Regression

Multiple linear regression was undertaken to identify predictors of *Anticipated Stigma* and *Perceived Community Stigma* when all other variables were held constant. Results show that predictors of the two forms of stigma differ. Furthermore, the direction of the relationships between *Anticipated Stigma* and most of its predictors contrast what was expected.

6.4.1 Multivariable model: Anticipated Stigma

Age, *Beliefs* and *Knowledge* (*Safety, Public Health,* and *Violence*) were found to be the strongest predictors of *Anticipated Abortion Stigma*[13] (see Table 16), as in the bivariate analysis. As expected, having higher levels of knowledge about abortion safety is associated with lower *Anticipated Stigma* scores. Unexpectedly, higher levels of knowledge about the public provision of abortion, and the association of abortion seeking with intimate partner violence, were found to predict higher *Anticipated Stigma* scores. Also unexpectedly, older age, frequent religious attendance, and having less abortion supportive beliefs predict lower *Anticipated Stigma* scores, while being politically progressive predicts greater *Anticipated Stigma*.

Overall, nine variables were found to significantly predict *Anticipated Stigma* and are included in the final model (see Table 16). This model explains 15.5% of the variance in *Anticipated Stigma* scores, and is statistically significant (R^2 = .155, $F(14, 54352) = 713.896$, $p < .001$) (see Appendix P for full model statistics).

[13] Standardised (Beta) coefficients close(r) to 1 (or -1) represent stronger associations with stigma (Siegel & Wagner, 2022).

Table 16: Multivariable regression results - Anticipated Stigma

Independent variable	Standardised Coefficient	*P*-Value
Age	-.225	*P*<.001
Religious Attendance:		
Weekly	-.052	*P*<.001
Monthly	-.005	*P*=.250
Rarely/Never	.004	*P*=.318
Never – no religion^		
Political preference:		
Greens	.027	*P*<.001
Labor	.025	*P*<.001
Other	.006	*P*=.117
None	.008	*P*=.078
Liberal/National^		
Biological Parent	-.050	*P*<.001
Knowledge - Safety	-.112	*P*<.001
Knowledge – Public provision	.099	*P*<.001
Knowledge – Violence	.147	*P*<.001
Sexism	.044	*P*<.001
Beliefs	-.162	*P*<.001

^ *Reference category*

6.4.2 Multivariable model: Perceived Stigma

Abortion-related *Attitudes* were found to be the strongest predictor of *Perceived Community Stigma*, in line with the bivariate regression results. Simple linear regression found that *Attitudes* alone predicted 31.4% of the variance in *Perceived Community Stigma* scores, not accounting for the influence of other variables. The final multivariable model, comprising 8 predictors, also predicts 31.4% of the variance in Perceived *Community Stigma* scores (R^2 =.314, F(13, 44842) = 1578.525, *P*<.001) (see Table 17). As anticipated, holding more anti-abortion attitudes is

associated with greater perceived stigma, as is higher *Sexism* scores. In contrast to expectations, being politically progressive also predicts greater *Perceived Community Stigma*.

As expected, greater knowledge about abortion safety, having had an abortion experience, and having been told about another's abortion experience predict lower levels of perceived stigma, although the predictive strength of these variables is low. Frequent religious attendance was also found to predict lower levels of perceived stigma in the full model, in contrast to the bivariate analysis which found religious attendance predicts higher perceived stigma scores.

Table 17: Multivariable regression results - Perceived Community Stigma

Independent variable	Standardised Coefficient	P-Value
Religious Attendance:		
Weekly	-.096	*P*<.001
Monthly	-.018	*P*<.001
Rarely/Never	-.009	*P*=.028
Never – non-religious^		
Political preference:		
Greens	.045	*P*<.001
Labor	.005	*P*=.342
Other	-.009	*P*=.029
None	.007	*P*=.110
Liberal/National^		
Abortion experience (no = 0, yes = 1)	-.033	*P*<.001
Someone told you about their abortion (no = 0, yes = 1)	-.034	*P*<.001
Knowledge – Safety	-.103	*P*<.001
Knowledge – Teens	-.014	*P*<.001
Sexism	.038	*P*<.001
Attitudes	.510	*P*<.001

6.5 Sensitivity Analysis

As described in Chapter 4 Section 4.3.5, the final multivariable models were run using unweighted data from each of the three recruitment waves to facilitate a comparison of the models' predictive value.

The predictive strength of the *Anticipated Stigma* model increases substantially when applied to the Wave 1 sample, which has more young, socially progressive, and female participants relative to the other waves (R^2=. 247, F(7, 2649) = 120.563, P<.001). The model's strength reduces when applied to the Wave 2 sample, who are relatively older, more religious, and have lower levels of abortion-related knowledge (R^2=.106, F(7, 3604) = 60.866, P<.001). *Age* and *Knowledge* are consistently significant and strong predictors across all waves, suggesting they are likely to predict anticipated abortion stigma across varying population groups.

The *Perceived Community Stigma* model was found to be strongest when run with the entire weighted sample (R^2 =.314, F(13, 44842) = 1578.525, P<.001) and has the least predictive strength when run with Wave 1 data (R^2=.094, F(1, 2645) = 209.916). *Attitudes* is the only significant, and consistently the strongest, predictor of *Perceived Community Stigma* across all waves. This indicates that the full model is relevant primarily when applied to a sample that is broadly representative of the Australian population. In contrast, abortion-related attitudes appear to predict perceived abortion stigma across a range of population groups.

The characteristics of survey participants across the three recruitment waves are provided in Appendix Q, Table Q1, while Table Q2 facilitates a comparison of model statistics when run on each of the three waves of data.

6.6 Discussion

The quantitative phase (Phase 1) of this research aimed to establish a foundational understanding of the extent and predictors of felt abortion stigma in Australia. It resulted in the development, validation, and implementation of The Australian Abortion Stigma Survey (TAASS). TAASS was completed by 58,000 people in Australia aged 16 years and over, resulting in the largest global dataset to date on abortion stigma. The data subsequently provides comprehensive information about the extent and correlates of perceived abortion stigma in Australia. The identification of two distinct dimensions of felt abortion stigma has implications for how we conceptualise, measure, and address abortion stigma.

The identification of relatively high levels of anticipated abortion stigma among participants who generally perceive low levels of community disapproval of abortion raises questions about the

origin, salience, and sources of abortion stigma. While nine out of 10 participants believe the Australian community is generally supportive of abortion/pro-choice, most participants anticipate that abortion seekers and providers are likely to experience social consequences. For example, 65.2% of participants believe that abortion seekers are likely to experience harassment and even more (80.9%) expect most abortion providers in Australia experience harassment or violence due to their work. These figures align with international research which has found that half to two thirds of abortion seekers in US studies (Biggs et al., 2020; Shellenberg & Tsui, 2012) and just over one third of abortion seekers in a German study (Killinger et al., 2022) anticipated and/or perceived abortion stigma.

Unexpectedly, this study found distinctions between the characteristics of participants who were most likely to *anticipate* social consequences related to abortion seeking or provision compared with those most likely to *perceive* abortion stigma. Participants who are young, politically progressive, and pro-choice were found to be most likely to anticipate abortion-related social consequences, despite being least likely to perceive community level abortion stigma. In contrast, participants most opposed to abortion are least likely to anticipate social consequences associated with abortion, despite being more likely to perceive community disapproval of abortion.

The remainder of this discussion section situates these key and surprising results in the context of the wider abortion and health stigma evidence base and reflects on their implications for research, theory, and practice. It begins with an exploration of the (sub)domains of abortion stigma identified, followed by a discussion about the key predictors of anticipated and perceived abortion stigma. The contribution and value of TAASS to the existing suite of validated abortion stigma measurement is then discussed, along with study limitations and preliminary conclusions (which are expanded on in Chapter 8).

6.6.1 Anticipated and Perceived abortion stigma are unique domains

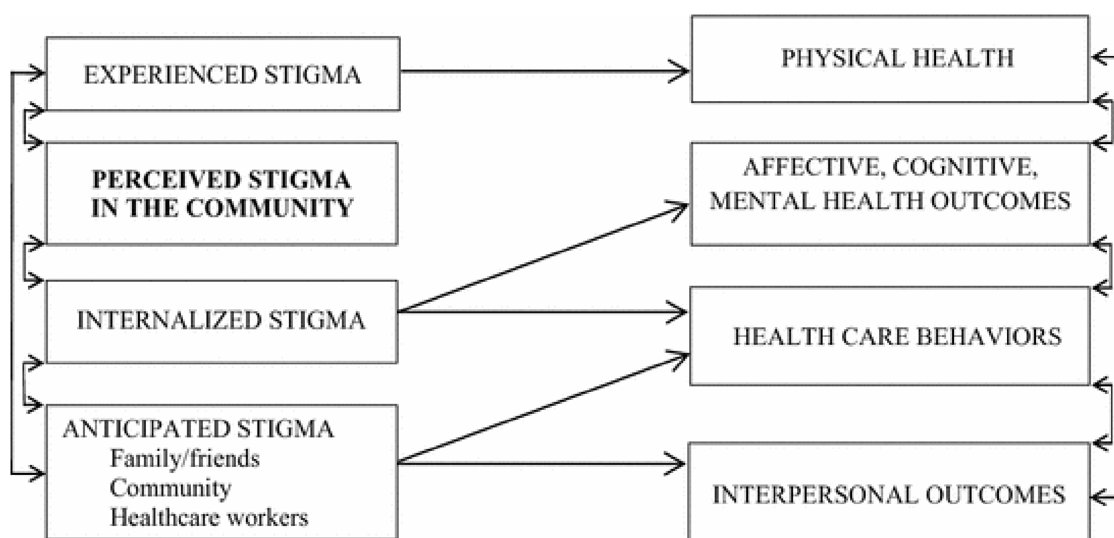
Reflecting the multidimensionality and complexity of the stigma concept, TAASS identified three unique domains within what has previously been referred to as 'felt' abortion stigma: *Anticipated Stigma*, *Perceived Community Stigma*, and *Choice and Judgment*[14]. As noted above, unique predictors and response patterns were identified for anticipated and perceived abortion stigma. Participants with the highest levels of support for abortion legality were found to be least likely to perceive community level stigma (disapproval of abortion) but most likely to anticipate (enacted) abortion stigma. While age was a strong predictor of anticipated stigma, it was not found to be a significant predictor of perceived community stigma.

[14] Noting *Choice and Judgment* did not meet the assumptions of, and was not included in, regression analysis, for which reasons it will not be discussed further here.

Differences between anticipated and perceived stigma have been described by some stigma researchers. Anticipated stigma has been defined as the anticipation or expectation of enacted stigma or discrimination in certain contexts or conditions (Earnshaw & Chaudoir, 2009; Moore et al., 2013; Quinn & Chaudoir, 2009; Salih et al., 2022; Stangl et al., 2019). Perceived stigma, in contrast, has been defined as awareness of stereotypes or stigma associated with stigmatised behaviours, conditions or identities (Chi et al., 2014; Kane et al., 2019; Moore et al., 2013; Turan et al., 2017). Perceived stigma, or perceptions of others' attitudes towards and beliefs about abortion therefore mediate experiences of anticipated stigma (Quinn & Chaudoir, 2009; Turan et al., 2017). Despite such clarifications, felt, anticipated, and perceived stigma are commonly conflated, as described in Chapter 2 Section 2.1.2 (Quinn & Chaudoir, 2009). Interestingly, Cockrill and Nack (2013, p.974) identified (statistically) two factors in their measure of felt abortion stigma which they labelled "worries about judgment" and "community condemnation". These factors are similar to the domains of anticipated and perceived stigma identified in this research. However, Cockrill and Nack did not name their factors as such, likely because much of the clarification work around these domains of abortion stigma had not yet been published when they conducted their research. As a result, the distinction between anticipated and perceived abortion stigma has not been adopted in subsequent abortion stigma research.

Research on the specific impacts of and interactions between individual domains of stigma is limited (Moore et al., 2013), yet the potential value of distinguishing between the anticipated and perceived stigma is "immense" (Turan et al., 2017, p. 284). Public health interventions are likely to be more effective when they are based on a detailed understanding of the stigma mechanisms driving particular health outcomes (Turan et al., 2017). Turan and colleagues (2017) found, for example, that internalised and anticipated HIV stigma mediated the impacts of perceived stigma – including impacts on mental health outcomes - among people living with HIV. They argue for the inclusion of anticipated and perceived stigma as distinct mechanisms in health stigma frameworks (See Figure 13) (Turan et al., 2017). Moore and colleagues also found differences in the extent and experiences of perceived compared with anticipated stigma among jail inmates, concluding the two stigma domains are "distinct phenomena with potentially different implications" (Moore et al., 2013, p. 541). It is clear that future abortion stigma research and interventions would benefit from a consideration of the differences between the predictors, drivers, and impacts, and relationships between, anticipated and perceived abortion stigma.

Figure 13: Turan et al.'s (2017)* adapted Health Stigma Framework



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6.6.2 Key predictors of abortion stigma

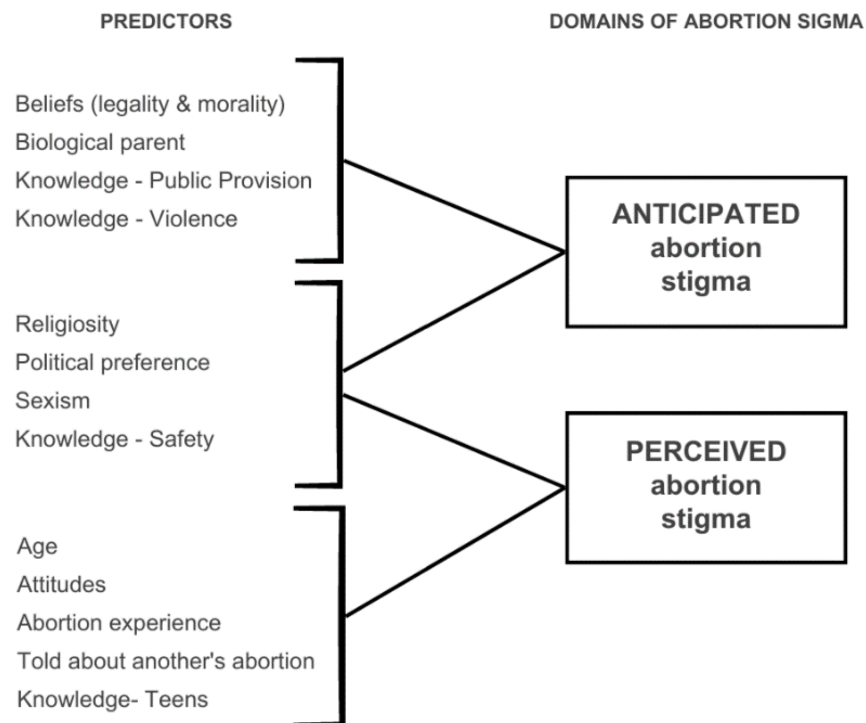
Previous Australian abortion stigma research has focused heavily on rural abortion stigma experiences and implications for abortion accessibility, yet rurality was not found to be a significant predictor of perceived or anticipated abortion stigma in this study. It is nevertheless likely that immense logistical barriers to abortion access in rural communities exacerbate the salience of abortion stigma and vice versa, warranting a research and intervention focus in these areas.

Sex, country of birth, and Aboriginal and/or Torres Strait Islander identity were also found not to be meaningful predictors of anticipated or perceived abortion stigma. Very little research has included people of diverse sexes or genders *and* reported disaggregated stigma scores, making comparisons with the wider evidence base challenging. Sex and gender have, however, been found to be associated with stigmatising attitudes towards abortion (Loll & Hall, 2019; Osborne et al., 2022; Sorhaindo et al., 2016). Barkan (2014) found that religiosity may mask gendered differences in support for legal abortion. In response, I experimented with the final multivariable models. When added to the models with other variables, sex (used in the test as I did not assess gender in the survey) did become a significant predictor of perceived and anticipated abortion stigma. Thus, Barkan's (2014) suggestion that religiosity masks gender- (or sex) based differences in abortion attitudes likely applies to abortion stigma and warrants further research.

Variables found to predict abortion stigma are outlined in Figure 14. Of note, country of birth was included as a binary variable, with responses including Australia and Other. If the data were further disaggregated (open ended data with country names were collected but not analysed due to the

large sample size) it is possible that more nuanced relationships between country of birth and stigma may be identified.

Figure 14: Predictors of Anticipated & Perceived abortion stigma



6.6.2A Beliefs, Attitudes, and religiosity

Anti-abortion beliefs and stigmatising attitudes predict higher levels of perceived community stigma and lower levels of anticipated stigma. This indicates that participants broadly perceive their own abortion beliefs and attitudes to be the norm. People with anti-abortion attitudes, however, don't necessarily believe that these attitudes result in enacted stigma and discrimination.

The relationship between religion and stigma appears to be more complex. This research indicates that abortion attitudes and beliefs mediate the association between religiosity and abortion stigma. In bivariate regressions, having a religious affiliation and religiosity were associated with lower anticipated abortion stigma and higher perceived community stigma scores. This aligns with the response patterns of participants with anti-abortion beliefs and attitudes. In multivariable regression, however, when accounting for the influence of beliefs, attitudes and other covariates, higher levels of religiosity were found to predict lower anticipated *and* perceived abortion stigma[15]. This is in direct contrast to a suite of prior abortion stigma research that has consistently found higher levels of religiosity are associated with higher levels of (multiple domains of) abortion stigma (Cockrill et al., 2013; Cutler et al., 2021; Martin et al., 2017; Zaręba et al., 2017). This unexpected

[15] Religious affiliation more broadly became non-significant.

finding is likely the result of including abortion attitudes and beliefs as independent (predictor) variables, rather than as indicators or abortion stigma itself. There has been limited explanation or exploration of the intricacies of the relationship between religion, attitudes, and abortion stigma to date. As a result, further potential conceptual explanations for this surprising finding are lacking. Further research – including more complex modelling – would be valuable in supporting the identification of the causal pathways between these variables.

6.6.2B Abortion-related knowledge

This study identified relatively high levels of abortion related knowledge among participants. Prior research in Australia has found comparably less knowledge about abortion, noting the specific questions asked in this study are different to those asked in other studies (Phillips et al., 2012; Wiebe, 2015). For example, this research found a very low level of agreement (<4%) with the myth that abortion is associated with an increased risk of breast cancer, while half of the participants in a multi-country study believed the association to be real (Wiebe, 2015). Greater knowledge about the physical safety of abortion was found to predict lower levels of anticipated and perceived abortion stigma. This aligns with studies of abortion and other health stigmas which have similarly identified higher levels of condition-related knowledge are associated with lower levels of stigma (Chekol et al., 2022; Huang et al., 2016; Letshwenyo-Maruatona et al., 2019; Makleff et al., 2019; Smith et al., 2011; Yeni et al., 2018). It was surprising, therefore, that higher levels of knowledge about the public provision of abortion in Australia and about the correlation between intimate partner violence and abortion were found to positively predict (higher) anticipated stigma scores.

As noted in the section above, it is likely that there are mediating relationships between knowledge and other variables included in the multivariable regression analysis which could explain this unexpected finding. For example, abortion related knowledge has been shown to be associated with abortion beliefs, attitudes, and political beliefs (in the US) (Bessett et al., 2015; Kavanaugh et al., 2013; Kim & Steinberg, 2023; Wiebe, 2015). Anti-abortion attitudes have been found to be associated with poorer abortion related knowledge, for example (Wiebe, 2015). Again, more complex modelling may be critical to unpacking the relationship between knowledge and abortion stigma. This may also be important for informing the design of activities intended to reduce abortion stigma. Knowledge and attitudes are often addressed concurrently in health education and stigma reduction programs (Abd El Salam et al., 2023; Chekol et al., 2022; Wiebe, 2015). Improving the effectiveness of stigma interventions relies on nuanced knowledge about stigma predictors and mechanisms of change. This is particularly important given that educational interventions comprise the majority of abortion stigma interventions to date, and that education-focused stigma interventions demonstrate variable levels of effectiveness (National Academies of Sciences, 2016; Sorhaindo & Lavelanet, 2022).

6.6.2C Age

This research identifies age as the strongest predictor of anticipated abortion stigma. Young people were found to be significantly more likely to anticipate social consequences associated with abortion than older people, in line with previous abortion and health stigma research (Cockrill et al., 2013; Collins et al., 2014, p.2-3; Hall et al., 2018; Killinger et al., 2022; Makleff et al., 2019; Swendeman et al., 2006; Ushie et al., 2019). The current study did not provide any clear indications as to why young people are particularly likely to anticipate abortion stigma. Young participants in TAASS have the lowest levels of stigmatising attitudes and beliefs about abortion, the highest level of abortion-related knowledge, and the lowest levels of religiosity, all of which – previous research suggests – should lead to lower levels of abortion stigma (as described in Chapter 3 Section 3.4).

Both health stigmas and associated attitudes are understood to form at a young age and often before a stigmatised identity is acquired (Pang et al., 2017; Quinn & Chaudoir, 2009). Young adolescents develop early understandings of stigma-related stereotypes and perceived personal failings, which contribute to lower self-esteem, health disclosure and help-seeking once a stigmatised identity is acquired (An et al., 2020; Collins et al., 2014; DeLuca, 2020; Quinn & Chaudoir, 2009). Even in the absence of enacted stigma, "perceived stigma [is] sufficient to create negative feelings of self and need for secrecy" around abortion experiences (Shellenberg, 2010, piii). As identified in Chapter 3, secrecy and healthcare avoidance stemming from abortion stigma can result in lack of social support, abortion delays, and avoidable financial burden and medical complications, including (attempted) self-induction of abortion (Harris, 2012; Mohamed et al., 2018; Shellenberg et al., 2014). Anticipated abortion stigma among young people may therefore be an important predictor of health and wellbeing throughout adolescence and into adulthood. For this reason and given the lack of indication as to *why* young people are most at risk of anticipating abortion stigma, further research exploring the interaction between young age and abortion stigma is warranted[16].

6.6.3 Explanatory strength of the models

The final models provide a strong and reliable indication of a number of predictors of perceived and anticipated abortion stigma in the Australian context, especially given the large dataset. However, the models' overall predictive strength was relatively low: 15.5% of the variance in anticipated stigma and 31.4% of the variance in perceived stigma scores were explained by the models identified. This is not uncommon and R^2 values under 50% are the norm in the social sciences, particularly when the independent variables are statistically significant (Hamilton et al., 2015; Ozili,

[16] Of note, age did not have a linear relationship with perceived stigma and thus is not discussed as a primary predictor of perceived abortion stigma in this section.

2022). Even so, these values indicate there is a large proportion of anticipated and perceived stigma that remain unaccounted for by predictors included in TAASS. Previous research has identified a suite of individual, family, community and structural factors that are correlated with abortion stigma and thus may be important predictors of perceived and anticipated abortion stigma specifically. These potential predictors, and the implications for future research, are described in detail in Chapter 8 Section 8.2.3.

6.6.4 The future of TAASS as a novel measure of abortion stigma

The Australian Abortion Stigma Survey has been found to be a valid and reliable measure of perceived and anticipated abortion stigma among a broad community sample of peopled aged 16 years and over living in Australia. It's unique contribution to the pool of existing abortion stigma measurement tools lies in its ability to measure and distinguish between anticipated and perceived stigma, and its inclusion of (stigmatising) attitudes as a predictor rather than outcome variable. It has the potential to enable further research into the prevalence, predictors and mediators of community-level abortion stigma among a wide range of population groups, beyond abortion seekers and providers. The validated sub-scales provide researchers with the option to measure specific and relevant aspects of stigmatising attitudes, beliefs, perceived and anticipated abortion stigma, making measurement more feasible in individual projects and health care settings.

Of note, the unexpectedly large dataset achieved, and the limited scope of this doctoral research, have resulted in a large body of data that has not yet been analysed nor utilised to their full potential. Scoring thresholds, and the value of using the whole scale to generate single abortion stigma scores, have yet to be determined.

6.6.5 Limitations

There are several methodological and conceptual limitations that require consideration when interpreting the findings of TAASS. Firstly, due to the large sample size, data gathered via open ended questions, including regarding country of birth and religious denomination, were not included in the analyses presented in this thesis. Other research identified religious denomination as a key predictor of abortion stigma in both the US and New Zealand, meaning the exclusion of this variable may have weakened the strength of the explanatory models (Cockrill et al., 2013; Osborne et al., 2022). Beyond the size of the dataset, the self-selecting sample has potential implications for the representativeness and generalisability of findings, as noted in Chapter 4 Section 4.3.1. Statistical weighting and sensitivity analysis, along with the sample size, are likely to have mitigated the potential impacts of the recruitment method on the representativeness of the data, however.

The study received a wide array of criticism, on social media and via email, during participant recruitment. Most was pertaining to a perceived 'bias' by community members opposed to abortion, who assumed the study to be inherently 'pro-choice', although I also received multiple pieces of correspondence from people concerned that the study was anti-abortion/ religiously motivated. The study was, undeniably, designed from a public health perspective and with a focus on establishing an evidence base to support the improvement of abortion accessibility and health equity. The participants involved in survey testing were roughly reflective of the Australian population in that they were also predominantly pro-choice. While I consider this to be less of a bias and more of a sign of methodological validity and evidence-based research practice, given its alignment with Australian population characteristics regarding abortion beliefs, the sensitivity analysis did reveal that the predictors of abortion stigma among Australians with anti-abortion beliefs are likely to vary significantly from the pro-choice Australian majority. Further research into the meaning of the stigma concept and implications of abortion stigma among anti-abortion Australians would support validation of the tool among this sub-population.

6.7 Conclusion

The Australian Abortion Stigma Survey reveals high levels of abortion-supportive attitudes and low levels of perceived abortion stigma in the Australian community. Simultaneously, many people anticipate that abortion seeking and provision result in judgment, gossip and/or harassment. Widespread pro-choice beliefs do not appear to shield most people in Australia from the anticipation of abortion related stigma and discrimination. Rather, people who support abortion are most likely to anticipate abortion stigma. This is particularly true for young Australians, who concurrently report the highest levels of abortion-related knowledge and high levels of abortion supportive attitudes, along with the greatest likelihood of anticipating abortion stigma. These findings raise a suite of questions about the drivers of and relationships between anticipated and perceived abortion stigma and their predictors. For example, if anticipated stigma is not the result of a lack of abortion-related knowledge or anti-abortion attitudes, what *is* driving it?

This research is the first of its kind in Australia and presents both a validated measurement tool and a plethora of quantitative data about abortion stigma. Further research is needed to expand on, confirm, and explain the findings presented herein, particularly those which contrast international research. Improving our understanding of the specific impacts of higher levels of anticipated abortion stigma among young people will be critical to informing efforts to prevent its perpetuation, salience, and negative outcomes for the future abortion seekers and providers. I begin to address these research gaps in Chapter 7, which presents the findings of the qualitative component of this research, and Chapter 8, which provides an integrated discussion of the TAASS and qualitative study findings.

CHAPTER SEVEN: FINDINGS FROM THE INTERVIEW STUDY – EXPERIENCES, PERCEPTIONS, AND DRIVERS OF ABORTION STIGMA AMONG YOUNG AUSTRALIANS

The qualitative interview study was designed to explore the reasons why young people were found to be most likely to anticipate abortion stigma and discrimination in The Australian Abortion Stigma Survey. As such, through the interview study I garnered insights into the drivers, experiences, and/or meanings attributed to abortion and abortion stigma among young people. In this chapter I present the findings of the in-depth interviews I conducted with 20 young people in 2021.

This Chapter has three parts. The first, Section 7.1, describes the characteristics of the interviewees. Section 7.2 provides a descriptive thematic analysis of key findings pertaining to the research aims. Here, I centre interviewees' voices with direct quotes and two case studies. Part 3 includes a discussion of the meta-themes that were generated during the thematic analysis and reflects on these in the context of the extant stigma literature and theory.

7.1 Interviewee characteristics

I interviewed 20 young people from around Australia. Fifteen interviewees identified as women, four as men, and one as non-binary (with she/her pronouns). They were aged between 17 and 26 years at the time of the interviews. Six young people reported having had one or more abortion experiences, all of whom identified as women.

At the time of the interviews the young people I spoke with were living throughout seven Australian states and territories (excluding the Northern Territory). Four interviewees were living in rural or remote areas, while nine had grown up or spent long periods of time living in regional communities. Four interviewees had spent time living overseas, primarily in Asia and North America. Two interviewees spoke languages other than English at home.

Most of the young people I spoke with had attended Christian (primarily Anglican and Catholic) private schools (n=10) or a combination of public and private schools (n=7). Only three interviewees had attended solely public schools[17]. Six interviewees identified with one of five different religions, including (as named by the interviewees themselves) Christianity, Buddhism, Paganism, Pentecostalism and Church of Jesus Christ of the Latter-Day Saints.

[17] In Australia in 2022, 64.5% of students were enrolled in Government/ public schools with the remaining 35.5% enrolled in private/independent schools (Australian Bureau of Statistics, 2023). While socio-economic diversity among Australian private/independent school students is greater than in other developed countries (Jerrim et al., 2016), there is nevertheless an apparent bias towards economically and socially advantaged perspectives in this dataset.

7.2 Thematic analysis

In this section, the results of the thematic analysis of the interview data are presented under five key theme headings and 10 sub-themes/sub-headings, described in Table 18.

Table 18: Themes and sub-themes

Overarching themes	Sub-themes	See Section:
1. Learning about abortion norms and narratives	Conversations at home	7.2.1A
	Awkward silences: Perceived causes and consequences of stigma	7.2.1B
	Imported stigma: the proliferation of American social media content	7.2.1C
	Social media and abortion stigma resistance	7.2.1D
2. Anticipated stigma	Perceived drivers of abortion stigma	7.2.2A
	Case study: Belle's Story	
3. Class and privilege as mediators of abortion stigma		7.2.3
4. Age and abortion stigma	Ideal reproductive timeline	7.2.4A
	Age as a feature of abortion stigma risk and resistance	7.2.4B
5. Abortion experiences: The abortion seeking and disclosure journey	Conception and contraception: internalised stories of (ir)responsibility	7.2.5A
	Case study: Chloe's Story	
	Enacted stigma: Disclosure and choice	7.2.5B
	The impact of abortion experiences on perceived stigma: "I got pretty lucky"	7.2.5C

7.2.1 Learning about abortion norms and narratives

After rapport building, I began almost all interviews by asking interviewees about when they first heard, thought, or talked about abortion. This commonly inspired rich discussions about the timelines and evolution of interviewees' understandings and beliefs about abortion. As a result, I garnered a rich array of descriptions of the ways the interviewees learnt about and were socialised into norms and narratives around abortion.

Most interviewees could recall first being aware of abortion during their high school or teenage years, and several had clear memories of exposure to abortion related media or discourse in

earlier childhood. Many interviewees could not recall explicitly the first time they heard about abortion. Others had clearer memories: James[18] remembered seeing an episode of South Park (an animated adult television series) where a “Satan baby” was aborted. Ben recalled memories of playground conversations about abortion while living in the US during his second year of primary school. For many of the young women and non-binary interviewees, becoming sexually active and/or having pregnancy “scares” were catalysts for learning and having conversations with family or friends about abortion.

7.2.1A Conversations at home

Several female interviewees described that abortion was “never ever” (Naomi) discussed in their homes due to their parents religious or ‘traditional’ values, and how they primarily learnt about abortion through books and the media. In contrast, around half of the (primarily female) interviewees described having had formative conversations with their mothers, and on occasion with both parents, about abortion during their teenage years. For some interviewees, these conversations appeared to facilitate understandings of abortion as acceptable, normal healthcare. For example, for several women conversations with their mothers appeared to explicitly introduce abortion as a pregnancy option for them should they ever become pregnant as teenagers. Lexi recalled,

> The first conversation… my mum's always been very big on if you had... fell pregnant, like, I would not look after it. So, she was very much like, if you got pregnant, I want you to think about it. You don't have to keep it.

Several women described the discussions about abortion that occurred in their homes as uncommonly positive. They ascribed their parents’ openness with topics like abortion were due to their scientific, education-focused, or feminist outlooks and careers. These young people described that abortion was framed as a right and necessary healthcare from adolescence. In contrast, Courtney, whose family was Pentecostal, recalled conversations with her mother that she felt were attempts to deter her from experiencing teenage pregnancy and abortion. She recalled her mother saying something,

> like, “if you got pregnant, like, obviously, it’s not what I want for you. But a baby would always be very welcome.” ... That would be the preference like, there was never any sense of like, you get pregnant you'll get kicked out or anything.

Chloe described that she regularly watched television shows about pregnant teenagers with her family when she was a teenager herself. She recalled how her family members frequently made

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[18] All names used to refer to interviewees are pseudonyms.

judgmental comments about the pregnant young people. When Chloe later had her own abortion experiences, she described feeling immense shame, and that,

> I'm that loser. I'm that failure. I'm that like, you know, reckless rebel teenager that gets… that should get disowned by family, because she deserves it.

Chloe appeared to have embodied the negative messaging about young abortion seekers she had been exposed to in her teenage years. This appears to have manifested as internalised, perceived, and anticipated stigma, noting she anticipated stigma primarily from the same family members, when she had her own abortion experiences (described in further detail in Section 7.2.5). Chloe used the words “stigma” and “shame” interchangeably throughout her interview.

In contrast to many of the young women’s early conversations with their parents that normalised abortion, several male interviewees described conversations with family members in which abortion appeared to be framed as an exceptional experience. For Ben, this included his Mum talking about her friends who had sought abortions when they were university students as a result of drunken one-night stands. Leon described first hearing conversations about abortion among family members who referred to it as an experience that primarily occurs in response to fetal diagnoses. Nick recalled,

> one of my brothers telling me, like, ah, you know, it’s when like, something goes wrong with the baby or whatever, and you have to like, you know, kill it, like cut the pregnancy or something. And they just like inject something. And it just, like, kills the baby.

Nick’s recollection, including his use of language, reflects both his own awkwardness talking about the process of abortion and the misinformation that characterised his early abortion-related education.

7.2.1B Awkward silences: Perceived causes and consequences of stigma

Interviews talked about a kind of secrecy that surrounds abortion, and the awkwardness of adults when talking (or not talking) about abortion, as indicators that abortion is stigmatised in Australia. Leon’s description of Australian news coverage of abortion-related stories as “sanitised” and “clinical” was particularly notable:

> We're [Australians] just very awkward about it, in the sense that, like, you see it on the news, and then it’s everyone's like… the same rehearsed lines… You don't see. I feel like I haven't seen too many genuine personal stories…Very clinical. Very rehearsed. Sanitised almost… like they just do it in a way that's not natural. Yeah, yeah. Like watching that person who doesn't normally dance to try to dance at the party (laughs).

Interviewees also described the omission of abortion from sex education and other classes during their schooling as indicative of the awkwardness of abortion as a topic and one that schools prefer to avoid. The only two interviewees who described having experienced abortion related 'education' in school had attended religious schools, their 'education' directed at intentionally preventing and stigmatising abortion. Ali, for example, described how a man "from the church" and his wife came to school to speak to her year 10 class (students of 15 to 16 years of age) and told them:

> stories about this girl who had abortions all the time as a way to like as a form of contraception and how that's really bad.

For the several interviewees who were studying or had studied health related and medical degrees at university, all explained that they were primarily taught about abortion in 'ethics' classes. As a result, for most students, abortion had been framed as a professional and moral quandary in higher education, rather than taught as other health care procedures were. Asheni, who was studying medicine, had received a single medically oriented abortion-related lecture, describing,

> it was only the one session, though. And we do have, we do have ethics tutorials throughout our degree. But, you know, abortion, only crops up occasionally is one of the few things and like, they just mentioned that, you know, this is a contentious issue, and then they don't really talk about it more.

Multiple interviewees spoke about the avoidance of abortion as a topic of conversation in social as well as educational environments. Their narratives alluded to a perceived social silence about abortion which they interpreted to be both a cause and consequence of stigma. For example, when I responded to relevant comments by interviewees by asking why or how they came to believe abortion was stigmatised, many responded with examples about a perceived social silence. Asheni assumed the Sri Lankan community, of which she was a part, was anti-abortion. This assumption appeared to be based on both her understanding of Buddhist principles and a lack of abortion-related discourse among the Sri Lankan community, beyond her own family:

> In Sri Lankan culture, I think it's [abortion] not very talked about. So, it's kind of difficult to decide where people lie on it. I'm assuming, though, that they're going to be majority pro-life.

When I later asked Asheni if she thought abortion is stigmatised in Australia, this perceived 'silence' and peoples' discomfort with talking about abortion appeared to inform her response, as it did for many interviewees. She responded,

> I'm gonna say yes, I'll just say, abortion is stigmatised. Overall, I know it's changing. But it's still very much like, people are still uncomfortable talking about it. Even like, even though they might be pro-choice. They're still uncomfortable talking about it…

Camila believed shame drives a lack of abortion disclosure and the perceived social silence around abortion, describing how 'hiding' an abortion was the norm:

> There are plenty of people who go out and get them [abortions]. You know, but I think that a lot of people don't talk about it because of that kind of shameful aspect of it…even in my liberal circles, you know, I honestly think that, you know, maybe some of my friends have gotten abortions and haven't told me because they wouldn't even though they know that I would never care.

Interviewees commonly interpreted abortion seekers' secrecy about their abortion experiences as evidence of the stigmatisation of abortion. For example, Liz shared,

> I don't think any, mostly women, disclose their abortion… I have seen some in the last couple of years talking about it, mostly in response to Texas[19], and I don't think that's something that happens without a lot of consideration going into those posts or comments about it. So, I think that's why, that's where you can tell it's stigmatised in that it's not done [disclosed] without thought.

Interviewees who had experienced abortions indicated that secrecy is both a cause and consequence of anticipated and enacted abortion stigma. For example, Mel described supporting a friend to access an abortion by covering her in blankets to protect her anonymity while walking past anti-abortion protestors. She talked about how her friend was shaking and crying, and how this and other 'awful' elements of the experience meant her friend no longer discussed their abortion. In contrast, Mel described her own abortion experience as relatively positive, and related this to why she is subsequently open to talking about her abortion. The stories and quotes shared in this section suggest that abortion disclosure and non-disclosure are perceived to be driven by and drivers of 'social silence', and thus to be causes and consequences of abortion stigmatisation. Interviewees indicated that they believe secrecy around abortion is normal and unavoidable, which suggests they understand the stigmatisation of abortion seekers is also normal.

7.2.1C Imported stigma: The proliferation of American social media content

The news, primarily consumed via social media, was portrayed as a key source of abortion-related information and learning. Ellie described,

> a lot of the things that I've heard about with an abortion is mostly in the news, because I just think that there's still so much stigma around it.

[19] At the time of the interviews (social) media content regarding the recriminalisation of abortion in Texas was prolific.

Most interviewees described that the abortion related news content they saw was primarily American. Natalie shared,

> I think a lot of what we know [in Australia] is based in America, and America is just like a whole different world in itself… But whenever something [abortion-related] happens in America, it's all over Facebook and Instagram.

In fact, Gaby was one of only two interviewees who recalled seeing an Australia-specific abortion story in the media/news:

> The only Australian media that I really get is like… the local newspaper would run things about the anti-abortion protesters, and also the religious pharmacy owner, who no longer wanted to sell contraceptive items.

Interviewees drew distinctions between American, which they perceived to be commonly anti-abortion and/or extreme, and Australian abortion narratives, within which they perceived abortion to be less politicised and contested. Many interviewees shared Courtney's view that,

> American politics is so stuffed up like, they're just so extreme… [whereas in Australia] some people might have quite strong opinions, but like, as a whole Australia's pretty, like centre [politically] compared to everyone else.

Despite drawing these distinctions, exposure to American content undeniably informed interviewees' understandings of the social risks and consequences associated with abortion seeking. Mel described how seeing American content about anti-abortion protestors online,

> …sort of sets in you that this [abortion] isn't a good thing. This is nasty. This is something to be ashamed of.

Gaby described how pervasive social discourse and media content were in framing her understanding of abortion as a stigmatised experience, despite not experiencing stigmatisation during her own abortion experience:

> …just reading about a lot of Roe versus Wade, and how, you know, conservative states in the US feel about it… and I understood the shame and stigma around it growing up as well. I just didn't experience it from the people close to me.

As a result, fear of harassment, whether online or at abortion clinics, appeared to have been imported from American news content and conversations into interviewees' imaginations and experiences. When Naomi went to an abortion clinic, it was the messages and imagery from this kind of content that drove her anticipation of stigmatisation. She said,

> I was nervous going there physically, because obviously you see stuff on social media about people standing up in front of these places, more in the US really, I haven't seen too

> much here. And so that's what I was scared about the most is someone being out there and talking to me.

Interviewees' understandings about and experiences of abortion stigma – internalised, anticipated, perceived, and enacted – appeared to be greatly influenced by American abortion stories, narratives, and stereotypes (both about young people and American abortion norms). Social media, for example, was described as the primary location of interviewees' exposure to moral debate about abortion. Young women (primarily) described the abortion "debates" they saw online as occurring in the comments sections on American news articles and characterised by misinformation and aggression. They described how the combative nature of the online abortion debate deterred them from engaging in abortion-related discourse online. Courtney, who had mixed views about abortion, described feeling she could not comment on abortion-related posts on feminist pages she followed on social media as,

> It seems to be quite a militant view of it…sometimes you feel a bit demonised by the stuff that you read that they're like, so like, you know, if you don't support abortion in every circumstance, you're like, a woman hater.

Natalia had similarly witnessed people online "raining down hate" on religious abortion commenters, and Camila described seeing violent and emotive content posted by anti-abortion activists that she believed was intentionally used to shock and scare viewers. Along with abortion 'debate' in public social media spaces (such as comments sections on news articles), young women talked about experiencing 'debate' and harassment in private online communities, such as social media groups you had to apply to be accepted into. Belle, for example, had joined several miscarriage support forums after her miscarriage experiences, and had assumed they would be supportive spaces. Instead, she described being harassed,

> told that it was my choice that I had a miscarriage and things like that. Or that I was a bad person for even considering having an abortion [prior to her miscarriage].

7.2.1D Social media and abortion stigma resistance

Alongside widespread exposure to combative, polarizing, and harassing content on social media, it was also described by some interviewees as source of stigma resistance. Interviewees told stories about social media as a tool of community building. For example, social media was described as a space in which people would intentionally disclose their abortions as acts of activism and stigma resistance, communicate with other abortion seekers, and seek support post-abortion. Britt, for example, described seeing an abortion disclosure on social media that was explicitly intended to counter stigma:

> Like, my best friend's housemate. She had had one. And she wouldn’t speak about it for like three years. And then just basically, like, wrote this big Facebook post about it and was like, “Well, I'm sick of it being a stigma and like, I've had this done. So, if you've also had this happen, you know, you're not the only one”.

Some interviewees also discussed the way social media content expanded their knowledge about global abortion discourses, laws, and positive, stigma-resistant abortion narratives. As a result of her active participation in, and efforts to seek out global and diverse discourses online, Sal described getting a sense that abortion is becoming increasingly normalised. Social media had also directly informed Ali’s beliefs that abortion is a normal healthcare experience. She explained how following public figures on Instagram exposed her to abortion normalising narratives:

> So, I follow Clementine Ford and this other writer called Rosie Waterland who I love. And they were both really open and candid about their [abortion] experiences. And I think, because they, they essentially normalised it and normalised the conversation on their platforms.

Because she had not had any abortion-related conversations with her family or friends, this exposure to pro-abortion content was formative for Ali.

Several interviewees also spoke about the way American abortion related social media content prompted destigmatising conversations online and within their social groups in person. As noted above, at the time of the interviews increasing restrictions on abortion in Texas in the US were receiving significant media attention. I asked most interviewees about their awareness of and responses to this content. Natalia said “people get outraged*”* when criminalisation in Texas is discussed (online and in person), and Ellie described how,

> it feels more like the discussion’s [locally, in person] been behind how barbaric that is, rather than agreeing with it.

Media coverage about abortion criminalisation in Texas was primarily described as enabling abortion-normalising conversations among the Australian young people I interviewed.

It is worth noting that, in contrast to their experiences online, many interviewees described having conversations in-real-life, including with friends and peers at university, which counteracted and contradicted the extreme nature of the online commentary they had seen. Most described their social circles/peer groups as spaces where abortion could be discussed safely. Ali described working in a pharmacy that, despite having a “religious” owner, was one of the first to dispense medication abortion, and did so in a “matter of fact”, non-judgmental way. As a result, many

interviewees had come to believe that people's views about abortion generally aren't extreme as they are portrayed to be online.

7.2.2 Contextualising the anticipation of abortion stigma

In all 20 interviews I either asked interviewees to describe, or they described unprompted, the characteristics of communities or individuals they believed would be most likely to stigmatise or judge an abortion seeker, and whether they thought abortion was stigmatised in Australia. The latter question was asked in a range of ways. Interviewees' responses indicate that they interpreted the concept of 'abortion stigma' to mean that abortion is widely disapproved of, and abortion seekers are judged. All interviewees described thinking abortion was stigmatised in Australia, to varying degrees, even when they had not experienced any stigmatisation during their own abortion experiences and when they believed most Australians are pro-choice.

Most interviewees believe, accurately, that Australians are predominantly supportive of abortion, yet all simultaneously anticipate abortion-related stigmatisation in certain circumstances. When I asked Gina if she thought abortion seekers are likely to experience social issues related to their abortions she replied,

> Yeah, gossip at the very least. Yeah. Like, at the very least, that's guaranteed in my books. Yeah. But definitely some. Definitely, if someone I didn't know was to find out about it [an abortion]. I feel like there would be some form of harassment.

Some interviewees struggled to articulate why they believe abortion is stigmatised. For example, when I asked Lexi if she thought abortion seekers are likely to experience gossip or social consequences she replied,

> Yeah, I think so. I haven't encountered it at all. I don't really know anyone in like, my close circle of friends who's had one, it's like, I know people who know people. But like, even when I found out it wasn't like they were gossiping.

7.2.2A Perceived drivers of abortion stigma

Young people believed the likelihood of experiencing abortion stigma was dependent on the cultural or geographical characteristics of an abortion seeker's community. Most young people assumed greater levels of abortion stigma exist in rural compared with urban communities. Asheni, who had lived in rural and urban areas, said,

> I think that [judgment] changes depending on where you are in Australia, as well. So, in a rural area, that's [abortion is] going to be a big thing. In the city, not so much.

Rural communities were described as being more conservative and less “PC” [politically correct] than urban ones. As a result, young people anticipated both overt and unintentional stigmatisation of abortion and abortion seekers in rural communities. James defined “conservative” as,

> when cultural and religious elements become, like, intertwined. Yeah. Almost inseparable… Christian Anglo Saxon white culture. So, it is like probably a fundamental religious base, but it’s become, like they wouldn’t talk about it specifically as a... like they wouldn’t necessarily be saying, “Oh, she shouldn’t get an abortion because it’s against Gods will”, or something like that, that wouldn’t be directly [said]. More like it’s not a done thing, in the town.

Others, like Leon and Ben, indicating a sense of cultural otherness, thought disapproval and judgment related to abortion was primarily determined by religiosity. Ben said,

> I mean, Australia is such a diverse place. I think, in my area, [abortion is] probably not [stigmatised], because it’s very liberal and progressive. Go into, you know, Lakemba in Western Sydney where you have a very strong Islamic community. I think it'd be very heavily stigmatised.

Most interviewees assumed or had experienced religion to be a primary source of anti-abortion discourse and judgment, in and beyond the Australian context. They described communities with higher levels of religiosity, irrespective of religious denomination, as places where anti-abortion beliefs are most likely to proliferate. Gaby said that “growing up” she understood that “religious people are against” abortion and atheists or less conservative people “are usually pretty happy with” abortion. Natalia shared,

> I know there's a big religious population here [in this regional town] … I think, the anti-anything are always the most vocal in things. Even though potentially they are the minority. So, I think the biggest anti [abortion] argument is from a religious perspective.

At school in Year 9, Sal was shown a video which included,

> about five minutes of a woman graphically detailing her late-term dilation and curettage abortion and how much she regretted it and how upsetting it all was and saaave the baaabieeesssss!

Sal described having “promptly walked out of class” after it was shown, confused as to how this perspective fit within narratives of a “loving God”. She further explained that,

> the topic was rehashed with my 6-8 strong girl group at lunch times for the next few days with dissent between myself and some more devout Christian members, and some ambivalent parties. This conversation and our divergences in faith ultimately led to the splintering of our group by year 10.

In this excerpt, Sal centres the topic of abortion in a wider conversation about the ways reproductive autonomy and abortion were a part of identity and social group formation among her peers. She appears to have framed beliefs about abortion as symbols of Christian devotion and dissent.

Ellie joined the Mormon church, of which her partner was an active member, as a young adult and witnessed members of the congregation being shamed and shunned, including for having sex outside of marriage. When she had a pregnancy scare she chose not to tell her boyfriend to ensure she could consider abortion as an option. She describes worrying about being pregnant and,

> it causing a problem, because you know, I still feel like in today's society, if someone like in my situation, back then I feel like I probably would have been blamed more than him because I'm the woman and I can close my legs. Whereas my parents wouldn't have had that view, I feel that maybe perhaps his parents would, and church people would, or church people probably definitely would.

Ellie's narrative reflects a combination of religious, gendered, and generational narratives related to unplanned pregnancy and abortion that she believed would have impacted her ability to choose, access and cope with an abortion and the related judgment and (anticipated) exclusion from her religious community.

In contrast to other interviewees' beliefs about the relationship between religion and abortion stigma, Nick and Courtney, the interviewees who expressed the highest levels of religiosity, framed anti-abortion beliefs as a response to harm and disempowerment they believed abortion seekers experience. Nick, a member of the Church of the Latter-Day Saints, believed that abortions are often the result of societal, cultural, or partner pressure or coercion. He expressed sorrow for women who have abortions, who he believed do not truly choose abortion and end up feeling "guilty, unsettled and sad", given their natural preference to "nurture" fetuses. Nick also described people who seek abortion for non-medical reasons, who he believed were likely a minority of abortion seekers, as the same kinds of people who are "negligible parents". Thus, his beliefs were informed by a range of, though not exclusively, the kind of pro-woman stereotypes found in anti-abortion discourse[20]. Courtney, who grew up in the Pentecostal religion, had mixed views about abortion, but largely understood it to be an undesirable outcome of a lack of social and structural supports for pregnant women and mothers.

Asheni was one of two participants who were first generation migrants and felt that religious and cultural norms within the (her) Sri Lankan community were rooted in stereotypes about "good

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[20] Here, "pro-woman" refers to a common anti-abortion narrative that problematises abortion by framing abortion seekers as uninformed victims of coercive individuals and systems. This is further explored and referenced in Section 8.1.2A.

women”. Along with stories about unsafe abortions that were shared around her parents’ village in Sri Lanka, and thus beliefs about the dangers of abortion, she anticipated that the Sri Lankan community would see abortion as a symbol of promiscuity and “damaged goods”. Asheni also described her cultural community as “conservative” and spoke about a tension between younger and older generations and their values. She said she and her friends who were “Asian” and “Middle Eastern” were aware of a “conservative culture” among their parents and communities. She described that,

> we [the children of Asian and Middle Eastern migrants] can be the ones to change it. So yeah, I think yeah, we have certainly, like done a bit of disassociating between like, oh, that's old people's culture.

Others similarly anticipate that ‘older’ people are more likely to hold anti-abortion views than younger people, particularly “someone older, like someone like 50 plus, just traditional” (Nick). Interviewees assumed that ‘older’ people were less likely to have had open conversations about abortion and more likely to have heard about or experienced unsafe abortions. Therefore, they believed, it was logical to assume that older generations of people in Australia would perceive abortion as rare and taboo. With this in mind, interviewees generally felt that abortion attitudes are changing, and the likelihood of stigmatisation related to abortion is reducing, with each generation.

Belle’s lived experience, described in the case study below, echoes many of the interviewees’ beliefs about the contextually dependent nature of abortion stigma. Her story elucidates relationships between rural, “conservative” culture and experiences of (anticipated and enacted) abortion and reproductive stigmas.

Belle's Story

Belle is 18 years old and identifies as non-binary, with she/her pronouns. She grew up in a small, "conservative" rural town in New South Wales that was "very political… right wing", where "everyone went to church on Sunday". She explained how young women were,

> expected that you would drop out of school and have kids because... or go to TAFE or for the girls anyway, and the boys would work in a trade.

Belle has had two miscarriages. She described considering her pregnancy options during her first pregnancy, prior to her first miscarriage. Her doctor had suggested abortion to her as a first response to her pregnancy news. She didn't know if she wanted one due to associated costs of travel and anticipated negative emotional consequences. She anticipated that having an abortion would have had substantial material impacts on her life, and people would inevitably find out:

> If I had chosen to like get an abortion or terminate kind of thing it would be spread, and I might also lose my job as well. That was a real possibility, which means I won't be able to support my family but then I'd also have the expense of having a kid as well.

Belle also anticipated being kicked out of home:

> You can't even be in the same household [if you've had an abortion] because it's such a big thing. And up until moving to the city, I thought that was normal.

After her first miscarriage, Belle felt shamed and excluded by her family and community. She had to keep her miscarriage "hush hush" as it symbolised her "failing [her] one function as a woman". Her partner at the time,

> joined the army. That's pretty standard because they had that shame on his family because a few people found out [about the miscarriage], so he joined the army to get back the pride.

After "getting out" of her hometown and moving to an urban centre to study at University, Belle recalled feeling surprised at how people weren't ashamed to buy period products. She also described that young people in the city where she now lives are not forced to have adults with them during medical appointments. In contrast, when seeking medical help for reproductive health issues in her hometown,

> my grandma had to be in the room. I wasn't allowed to be by myself which is, again it's a big breach of confidentiality and all that but yeah, she had to consent. I was like 17.

Now, when Belle goes home to visit, she and a friend make a point of offering sexual health-related information to any young people who want it in an attempt to counter misinformation and shame.

7.2.3 Class and privilege as mediators of abortion stigma

Just as abortion stigma and anti-abortion beliefs were perceived to be contingent on individual and cultural identities and characteristics, middle class (most) interviewees suggested they believe vulnerability to abortion stigma is mediated by (perceived) class differences. Where economic markers of social class weren't explicitly described, references to (a lack of) commitment to education and undesirable social behaviours (such as smoking) were taken to indicate perceived "cultural markers" of social class (Nichols, 2023, p.665).

Only a few interviewees talked about knowing people who had had abortions at school. Those interviewees who did spoke, unprompted, about social 'groupings' as indicative of the likelihood of someone having an abortion experience in their teenage years. Asheni, referring to experiences at her private Christian high school, said,

> We [her and her peers] do know people that have had abortions. Yeah. Like, they're primarily like girls who dropped out in year 10 and that. cos. Not...I don't know whether they dropped out because of pregnancy, or whether they dropped out because of other circumstances, but we do know of people who did pursue abortions.

Leaving school and having an abortion were conflated in Asheni's narrative, reflecting stereotypes she held - as a middle-class young person - about the kinds of people who have abortions. Camila very similarly described hearing about girls who had had abortions at school who,

> would smoke out the back of the toilets and stuff like that and you know, would skip school so, not that I would think that they would be, but that's what people would refer to them as.

Here, Camila was careful to indicate that she did not necessarily believe there was truth in this interpretation of abortion seekers that she understood was common among her peers.

Some interviewees described how the social and economic capital accrued by young people with higher income and education levels protected them against enacted (interpersonal) abortion stigma. Both male and female interviewees described that the 'wealthier' girls in school were protected by unspoken rules about acceptable judgmental behaviour, including who it was and was not acceptable to gossip about. Camila explained how, at the private Catholic high school she attended in a "farmery", "conservative" rural town,

> it kind of like it was fair, fair use and abuse when it was the girls that people kind of looked down upon. But then when it was one of the popular girls, who everybody was friends with, you know, it was suddenly we didn't talk about it.

Several middle-class interviewees reflected that it was likely that girls of similar socio-economic status may have experienced abortions during high school that they were unaware of. Ben was

attending a private boy's school in New South Wales at the time of our interview. He reflected on his experience at a socially diverse public school in the US when he was younger:

> I'm sure, there have been cases where, you know, the, the rich white girl had to get an abortion, but you'd never see that talked about, but it was always that particular poor demographic that you would notice it. And it was more, you know, obvious.

In contrast to his experience in the US, he was unaware of whether any of the boys in his "selective" private Australian school had been involved in abortion experiences. He appeared to suggest that the protection that wealth afforded his male peers when they were involved in "consent scandals" (which he described as sexual assault cases that had received extensive media attention) would similarly shield them from abortion-related social consequences:

> I haven't heard of any specific abortion examples so far, but I'm sure they it'd be quite similar. Lots of gossip, but nothing, nothing too much. And then it would go away because of some [financial] settlements or whatever.

Beyond the school setting Asheni, who was studying medicine, understood wealth afforded abortion seekers discreet access to abortion care:

> They're [people on lower incomes] not going to be able to access abortion in a manner that's going to like, it can't be covered up, if that makes sense. Like I know people who are of higher socioeconomic situations are able to get it in a discreet manner.

Several interviewees also described education, as mediating the likelihood of someone engaging in and experiencing abortion stigma and discrimination. Natalia shared,

> I think in a well-educated group of people, there shouldn't be harassment, there shouldn't be any, like negative connotations to anything that happens… I think a lot of these issues, like a lot of it stems from how much you know, and sort of the level of thinking that you have, and that kind of comes from the level of education that you have, and the surrounds that you grew up in as well.

As well as being associated with the likelihood of experiencing abortion-related gossip and (self) judgment, education was also described as mediating interviewees' confidence in and ability to participate in abortion related conversation and debates. Ben explained,

> you may have thought about views about abortion but might not have the education or background knowledge to have complicated political discussions, or maybe have the space to have discussions or them being encouraged in the home.

A number of interviewees similarly suggested that the education level of an individual and their social groups and families determines the level of politically nuanced and informed conversation people are likely to engage in. It was subsequently implied that pro-choice abortion beliefs are an outcome of (higher levels of) education. From interviewees' primarily middle-class perspectives, people who were more likely to gossip about, not understand the nuances of, experience and be stigmatised because of abortion were primarily poorer and with less education.

In contrast to the perceived interaction between socio-economic privilege and enacted stigma, several interviewees spoke about shame as a feature of middle class and "privileged" (Chloe) young women's abortion experiences. For example, Chloe described economic privilege as facilitating easy, quick access to a private abortion service, but also as contributing to a crisis of identity following her abortion experiences. She shared that,

> when you grow up in a white privilege family, it's like, oh, the laugh of the joke is like, 16 and pregnant on TV… these women as like, so far from anything you would know, like, they're just in a different world to you.

At the same time, Chloe talked about struggling with experiencing abortions in a context of privilege. She described her abortion experiences as "humbling" and taught her that "literally anyone" from any social group can need/seek an abortion. She described how,

> the whole facade of like the perfect private school girl and like the perfect life and the perfect this and the perfect that and the reality just so different … I think just having that such a big contrast in my life is like two different completely worlds, like two different worlds, and of who I should be and who I am trying to put myself out there as .... I think that was just really hard, like the expectation of who I was and proving that I am that person is what really knocked me round and still does.

In Chloe's mind, having an abortion experience contradicted the "perfect" and "academically successful" student she and others had previously seen her as. In an interview with Camila, who hadn't had an abortion experience, I asked whether she thought the social status of the "popular girls" (Camila's words) was the reason people didn't gossip about their abortions, to which she replied,

> Yeah, I think that's exactly it. I think there was an element of shame there. Which, interestingly, I don't think was necessarily present for the other girls [i.e., those who "smoked out the back of the toilets"].

Thus, while middle-class interviewees perceived (their) social status as protective against gossip, wealth and privilege were also described as drivers of abortion related "shame", which girls of lower socio-economic status were not expected to experience. Interestingly, the few interviewees

who had grown up in a context of (relative) socio-economic disadvantage, including Belle, did not refer to socio-economic status or markers of class as mediators of abortion stigma experiences. As indicated in her case study, Belle instead perceived that abortion-related stereotypes and stigma were the result of rural, “conservative”, gendered community and family norms.

7.2.4 Age and abortion stigma

7.2.4A The ideal reproductive timeline

Interviewees’ narratives reflected the notion of an ‘ideal reproductive timeline’ which, influenced by factors like age, gender, disability, education, and relationship status, appears to have informed their anticipation of stigma related to (teenage) pregnancy and abortion. For example, the belief that adolescence is not an ideal time to have a child appeared to be protective against abortion related stigma in some interviewees’ stories. Ben, who was economically privileged and a self-proclaimed “nerd”, described how, if he was involved in an abortion experience,

> I think, obviously, it'd be a shocking experience especially coming from someone like me who's obviously totally outside of any of that world. But I wouldn’t feel any stigma from anyone close to me. [I would] be more worried about sorts of reactions of the pregnancy. Like, I don't think anyone would, you know, fault me as a 17-year-old boy for not wanting to be a father at this point. Um, I think my parents would be concerned about me being a father at this point… you know, children and families is a secondary consideration over that expectation [of continuing education].

Asheni similarly felt that judgment around adolescent pregnancies she’d witnessed was largely around pregnant young people prioritising having children over continuing their education. This is one of the reasons she anticipated that if she had an abortion,

> like my parents, for example, they would be probably happy that I did get an abortion. My friends would be very supportive.

In contrast, in their 20s, many interviewees felt they met the conditions for socially acceptable pregnancies. They therefore anticipated that being in more committed relationships with fewer (what they perceived to be socially acceptable) reasons not to continue a pregnancy could make abortion decisions and experiences more emotionally difficult. Thus, the interviewees’ stories reflect the intersections of and crossover between reproductive, pregnancy, parenting and abortion stigmas with classed reproductive timeline norms and ideals. Several interviewees talked about the relationship between stigmas associated with age, pregnancy, and abortion as inextricable. Camila spoke about anticipating feeling shame if she sought an abortion and described that it would be the result of,

> feeling of like, well, why didn't you prevent it? You know, why did you even have to in the first place?

I asked Camila if she believed the shame would be tied to the pregnancy or abortion itself. She described,

> I think a bit of both, I think, for mostly the fact that you hadn't prevented it in the first place and therefore had to get an abortion to get rid of it. But yeah, it's they're tied in together. I would say I'd say it's not one or the other. It's both of them at once. Yeah. But yeah, a little bit unplanned pregnancy true. Like, I mean, I feel that she shame's a bit stronger when you're a bit younger. I mean, right now, you know, I'm 25. Like, I don't think that it would be entirely unreasonable for someone of my age to have a child. But I think they tie in together. Because the only reason you'd have to have an abortion is because you have an unplanned pregnancy, generally.

Britt, as did other interviewees, anticipated abortion-related stigma from friends should she ever seek an abortion, tied to the notion of contraceptive and sexual irresponsibility:

> I think there'd probably be a bit of, like, what? Like, what have you done to end up like this? But what have you done to put yourself in this position? Maybe for some of them.

For many interviewees, anticipated stigma, shame, and guilt appeared to be tied to norms and responsibilities associated with pregnancy prevention, particularly at a young age when pregnancy and parenting were seen as less socially acceptable. Abortion was understood to be stigmatised as it was as symbol of the interaction between norms around age, pregnancy prevention and parenting, rather than due to features of or judgments related to the abortion experience itself.

Lexi and Gaby, who have had abortion experiences, adopted the concept of the ideal reproductive timeline to frame and justify their abortion decisions. Lexi talked about how her abortion enabled her and her partner to achieve goals related to relationship and material stability and life experience prior to childbearing:

> Like we don't live together, we don't have our own place, I think would have been so impractical. I think I probably would have resented having a kid, because there's stuff I still want to do.

In contrast, Gaby, who was in what she believed many would describe as appropriate circumstance to continue a pregnancy - engaged and with stable employment - talked about having had an abortion at the age of 22 in spite of these ‘ideal’ conditions. While she hadn’t wanted to have a child, and felt she was too young, she believed others may have perceived that she

hadn't adhered to pregnancy and parenting norms by seeking an abortion while engaged and employed.

Subscribing to the concept of the ideal reproductive timeline was, for both abortion seekers and other interviewees, framed as enabling young people to situate their abortions within 'good abortion' narratives. Thus, while young age was described by some as increasing the risk of experiencing stigma associated with abortion, others described ways in which young age was protective against abortion stigmatisation. Some interviewees, for example, described holding pro-choice beliefs as the norm among their peers, with anti-abortion views seen as socially unacceptable. This may have contributed to young people describing their peer groups as safe spaces for discussions and even disclosures of abortion (as described above). Britt explained, "like I think it is a bit like out of fashion to be openly against abortion".

Furthermore, while abortion-related gossip was seen to be inevitable if someone's abortion story was shared among peers, in either school or university settings, interviewees felt it was not likely to be malicious and would be largely inconsequential. Liv described a "messy teenager" stereotype, in the context of living in residential (educational) colleges, as protective against abortion-related stigmatisation:

> I don't think they [students at university] necessarily would have treated anyone badly because of [an abortion], because a lot of people are making, you know doing embarrassing things because you're 18, and often, you know the first time away from home a lot of people are drinking, you know things are happening, it kind of, would news cycle away pretty quickly.

Ben, the only participant still at school at the time of the interviews, described that gossip would be related to the experiences and choices assumed to surround an abortion experience. For this reason, Ben and others felt abortion was likely even among pro-choice peers:

> It was odd because everyone who gossips about it was pro-choice, right? You never hear someone say, "Oh, how dare they get an abortion", or "Oh, that was against God" or something. And they would also be quite supportive openly. But there was still some level of stigma kind of subconsciously, I think. Like people would, you know, say they supported it, but they would kind of feel like, why would they get into that situation? Or how could they end up there? Why would they be so irresponsible? [Irresponsible] was a term that was thrown around a lot. So, I think that no one would ever be openly malicious or hostile. No one would question the decision itself. But there's always been a lot of, you know, assumptions that would come along with the experience of having an abortion

7.2.4B Age as a feature of abortion stigma risk and resistance

Interviewees perceived several characteristics of adolescence to exacerbate the risk and impacts of abortion stigma. Some interviewees described adolescents as lacking a sense of self and having a strong desire to fit in, as well as being vulnerable to misinformation, making them vulnerable and sensitive to the potential social impacts of abortion. Natalia described having recently learnt about the characteristics of women undergoing abortion, which she believed challenged stigmatising abortion-related stereotypes:

> I recently found out that most abortions in South Australia are by older women, and not just like 16-year-olds, but yeah, like more like 30-year-olds. And so, I found that fascinating. I think if more people knew that it would change the way that people view like abortion, or just, you know, the stigma around a young person getting an abortion, we think that abortions are all just messy teenagers that don't know what they're doing.

Wanting to 'fit in' was also believed to result in young people being more likely to engage in or go along with abortion-stigmatising conversations and behaviours, even when these behaviours were in conflict with their own values.

Leon's reflection on the dependence of some young people on their parents for emotional and material support making them vulnerable to parental judgment was unique:

> A good example of that is right at the moment, because I'm doing placement back home. I'm not getting paid. So, I'm staying with my parents for free. Yeah. Like, if that relationship was strained, I wouldn't be able to do this placement and realistically graduate.

Norms around 'appropriate' ages and the 'ideal' conditions for pregnancy and parenting, and the emotional and financial reliance of young people on adults in their lives, emerged as mechanisms through which age mediates the social and material risks, and salience of, abortion stigma.

7.2.5 Abortion experiences: The abortion seeking and disclosure journey

I asked the six young women who reported having had abortion experiences to share with me the stories of their pregnancies and abortions. I invited them to elaborate on key aspects of their stories that related to stigma, though the interviews often followed the parts of their experiences where they found most meaning, with latent references to stigma and judgment emerging through the coding process.

Characteristics of the six abortion seekers, useful in contextualising their abortion stories, are provided in Table 19.

Table 19: Characteristics of interviewees with abortion experience

Name	Age (age at time of abortion(s) in years)	Location: current/ childhood	Abortion information	Personal/ family religious affiliation (if different)	Relationship (time of abortion)	Educational background & current employment
Mel	22 (21)	Vic – Melbourne/ SA - Adelaide	1; Melbourne; Private; Surgical abortion.	None/ None	Partner during conception – single during abortion	Incomplete undergraduate degree; Public primary schools; Combination & private high schools. Works in car sales.
Lexi	24 (23)	NSW – Sydney	1; Sydney; Private women's health clinic; Early medication abortion.	Christian	Partner	No higher education. Private primary school (Catholic): Private high school (Catholic) Works in insurance claims.
Gaby	24 (22)	Qld – Brisbane/ NSW Regional center	1; Brisbane; Private; Early medication abortion.	None	Partner	Studying undergraduate degree; Private primary school (Christian); Public high school. Works in marketing.
Naomi	25 (21)	NSW - Sydney	1; Sydney; Private; Surgical abortion.	None/ "very Anglican"	Casually dating	Completed undergraduate degree; Public primary school; Private high school (Christian). Works as a social worker.
Ali	26 (24)	WA – Perth/ SA – Adelaide	1; Perth; Private GP; Early medication abortion then surgical abortion for incomplete abortion.	None	Married	Studying postgraduate degree; Public primary school; Private high school (Christian). Works in education as a school teacher and deputy.
Chloe	23 (17-18)	NSW - Sydney	2; Sydney; Private; First abortion was an early medication abortion resulting in infection & antibiotic use. 2nd experience was a surgical abortion.	None	Single 1st abortion, boyfriend 2nd abortion	Completed undergraduate degree; Private school - primary & high (Religion not described). Works in sex education.

They had all found out about their pregnancies and accessed abortions in the first trimester of pregnancy. All young women had been living in capital cities at the time of their abortion experiences[21].

7.2.5A Conception and contraception: stories of (ir)responsibility

The six women abortion seekers I spoke with were all pro-choice. They all described feeling confident in their decisions about their abortions, making their abortion decisions easily, and framing their decisions as a "no brainer" (Chloe). Mel described that she didn't want to have children, saying,

> I've always been the sort of person who said like, I'm not designed to be a mum, I don't want to be a parent, if I ever get pregnant, fetus deletus, I'm not having it.

The six young women (as did most interviewees) made it clear they were actively seeking to reject, and disapproved of, stigmatising abortion-related narratives and stereotypes. For example, they did not use language that attributed personhood to fetuses (as demonstrated in Mel's comment above) and rejected the notion of irresponsibility in relation to abortion seekers generally.

Despite their conscious rejection of abortion-related stereotypes, their stories indicated that most of them had, to varying degrees, embodied negative beliefs about abortion seekers. However, they appeared to be more likely to incorporate stigmatising stereotypes about abortion seekers into their interpretations and descriptions of their own (rather than others') pregnancy and abortion experiences and behaviours. For example, even though I didn't ask abortion seekers about their use of contraception, all described and framed the circumstances surrounding becoming pregnant in relation to their use or non-use of birth control. Such framing suggests they had internalised narratives about women's contraceptive responsibility and irresponsibility. For Ali, who had been taking the oral contraceptive pill when she became pregnant, finding out about her pregnancy made her feel,

> Nervous and upset… because I didn't think it was possible because I'd been on the pill. But I must have missed a day and not realised, or the timing. I don't know. So, it was really shocking.

[21] Of note, none of the abortion seekers I spoke with had were living in Adelaide (South Australia) or Darwin (The Northern Territory), the two cities in Australia with arguably the easiest access to free, public, first-trimester abortions, at the time of the research (Baird, 2023; Children by Choice, 2023; NTGov, 2022)

Naomi noted that shame and stigma around her abortion experience was primarily the result of the circumstances of conception and sex rather than the abortion itself, saying, “This is like a Tinder story. This is why it’s, like, shameful.”

Lexi’s narrative indicated that she experienced internalised abortion stigma and shame related to her abortion and unintended pregnancy experiences. Prior to her pregnancy, Lexi had, “tried to get a copper IUD put in, but they couldn't get it in me”. She talked about her and her partner relying on condoms as she didn’t like taking “the pill”. When she became pregnant and sought her abortion, she felt like,

> I've tried to do the right thing. So, it kind of made me feel like I was irresponsible. And I'm like, That's not me. Like I tried not to have this [pregnancy].

Lexi then described that a “doctor at the clinic” where she had sought her abortion asked her, “how are we going to stop this from happening again?”. The feeling of irresponsibility this incited, along with pressure from her mother and health provider, led to Lexi agreeing to have an (unwanted) IUD inserted on the day of her abortion appointment. At the time of our interview, many months later, she was experiencing chronic pain she attributed to her IUD but had not sought medical care. Her narrative suggested she felt it would be problematic or irresponsible to ask to have it removed.

Chloe, the only interviewee who had experienced two abortions, spoke at length about experiencing abortion-related stigma and shame. Her case study, below, highlights intersections between classed norms and ideals and the salience of contraceptive use in abortion narratives.

Case Study: Chloe's story

Chloe described having grown up in an emotionally tumultuous "white privilege" family. She had experienced two abortions during her "chaotic" final year of high school at a prestigious private girl's school, about five years prior to our interview.

Chloe found out she was pregnant on taking a pregnancy test at school. She immediately called and had an appointment with her regular GP. The GP was supportive but encouraged her to tell her parents. Chloe didn't want to tell them, anticipating judgment. She recalled how they had watched a television show together, "Sixteen and Pregnant", and judged the pregnant teens, who were "just in a different world to me". She told her parents about the pregnancy but lied about having not used contraception. Even so, her father shamed her, saying, "If you play with fire, you're going to get burnt". Her sister later said she was, "pathetic and embarrassing".

Family norms and "perfectionistic tendencies" appear to have driven Chloe's internalisation of stereotypes about young abortion seekers and the resulting anticipated stigma, secrecy, and shame. These experiences were particularly salient during and after her second abortion, which she never told her family about. She described having,

> internalised…just society's idea of like, you know, oh, well, you must not have been using protection, because the second time I did and it failed. And like that's, I think why as well, it just, I just didn't even bother telling people because it's like, they're just gonna automatically think that, you know, I was a reckless person.

Chloe described the physical experience of abortion as inconsequential, despite having experienced a serious infection post-abortion, relative to the impacts of abortion-related "shame":

> The biggest problem that comes out of it really… The shame and the embarrassment and the judgment and mentally makes you feel like a failure, and it makes you feel, you know, it really does bring you to a bad place.

Chloe shared that her experiences led to severe anxiety around sex, as well as a strained relationship with her father. She also struggled to situate her abortion into her identity as a privileged and academically successful young woman:

> when I was going through the [post-abortion] infection, I was really sick, and I went up to do a speech [at school] and I'll literally never forget this. I was bleeding. I was so sick. And I was like, making a speech about fucking being a private school girl. I don't know. And I just remember thinking in my head, if only everyone knew like… Everyone thinks I'm this like, you know, like high achiever. And here I am, like, literally having an abortion on stage.

7.2.5B Enacted stigma: Disclosure and choice

The six abortion seekers described having shared the news of their pregnancies and abortion decisions with someone prior to their abortions. Their anticipation of stigma and judgment, and the types of responses they received, appear to differ, and be influenced by the degree of choice they had in each disclosure they made.

When women were in control of their abortion story and journey, they almost always reported receiving support and non-judgmental responses to their disclosures. For example, all of the abortion seekers I spoke with had shared that they were pregnant and/or seeking an abortion with their female friends. They uniformly described their female friends' reactions as positive and talked about these friends providing emotional and practical support, including making appointments for them and driving them to medical appointments. In cases where a friend (or family member) had previously disclosed they had themselves experienced an abortion, an additional sense of safety was evident around women's choices to disclose. As Mel described,

> My girlfriend, she ended up going through the procedure… when I found out that I was pregnant, she was the first person I called, so throughout the whole way she, she was my anchor.

Along with female friends, none of the six abortion seekers reported receiving stigmatising or judgmental reactions or interactions from the men or boys involved in conception. The two women who weren't in relationships when they became pregnant did talk about receiving minimal emotional or material support, however. In contrast, several abortion seekers in committed relationships described having previously discussed with their partners what they would do in the case of an unintended pregnancy. Having discussed this prior to a pregnancy experience appeared to facilitate ease of decision making and a lack of anticipated stigma. Gaby was with her fiancé when she found out she was pregnant, her experience reflective of those of several interviewees who were also in committed relationships:

> it [the pregnancy test] came out and I was half like smiling half like, "holy shit". Like joking. I'm sorry for swearing. I was like, "I'm pregnant." And he's like, "Oh God, gotta make an appointment." So, made an appointment… It was not really even discussed that we were keeping it. Both of us had had previously talked about, obviously, way before we got engaged.

After their abortions, all six women described having shared their abortion stories with friends, family and/or strangers and had received almost entirely positive reactions. While some of the women had anticipated they may receive negative reactions from family or friends who were religious, having difficulty becoming pregnant, pregnant, or who had young children, they described having been pleasantly surprised by the support they received. Ali said,

> Every time I've bought it up to anyone, they've been great… I've got two friends who are religious, and I told them and both of them were like, you know, your choice kind of thing. They were really great, which was surprising.

Naomi did suggest that receiving solely positive responses was the result of being selective about disclosure:

> I had been like very, very selective as well like… I tend to always try and figure out what someone's views are [before telling them].

Experiences talking about their abortion experiences with strangers were also described positively by several young women. Talking about their abortions was a way they could express solidarity with others having or who had had abortion experiences, whether in the bathroom at nightclubs with people they didn't know, colleagues at work, or friends. While Chloe experienced some 'gossip' after disclosing news of her abortion to friends at school, none of the six abortion seekers described post-abortion disclosures resulting in judgment or discrimination.

In contrast to the almost solely positive reactions women received from friends, partners, colleagues, and strangers when their abortion disclosures were entirely voluntary, the responses they received to disclosures that were pressured or forced were less uniformly positive. This included responses from university staff, work managers, and - most commonly - health professionals.

Three women I spoke with willingly shared the news of their pregnancies and abortion decisions with their parents. None of these women anticipated stigma, confident in their parent's views due to prior conversations, and all received supportive responses. As Ali described,

> I just told my family as it was happening. They were really supportive. They would have been supportive with either option… I knew that my mum had had one around my age with like when she was with my dad… So yeah, I'm really glad that she had told me, and she had told me this years prior to my abortion.

In contrast, Chloe, whose GP encouraged/pressured her to tell her parents, anticipated and received shaming responses from them and her sister (as described in her story above). Naomi was required to provide 'evidence' to her university so she could access special leave to attend her abortion appointment. Not knowing what they expected, she sent her abortion appointment confirmation letter to the university. She subsequently received,

> like, three-minute voicemail from the wellbeing unit at my uni asking like, you know, if there's anything you need, please give us a call… that was like, they freaked out. And it

> was a man as well… he wouldn't like [say the word abortion], the way he went around [the topic]. It was just quite funny, it made me laugh actually.

While not inherently judgmental, the voicemail reflected a potential breach of confidence along with discomfort and internalised stigma among the staff member who called her, who she'd hoped would just be able to be "adult" about it.

Gaby explained that the only judgment she experienced during her abortion seeking journey was from her "boss". She had requested time off and told her "boss" she was experiencing a non-viable pregnancy and would be having an abortion. Her boss responded – Gaby felt from her own position as a 32-year-old who wanted to have a child - with,

> "Oh Gaby, you don't want to keep it?... What if you can't have kids when you're older?" She was quite judgmental.

Experiences of enacted abortion stigma during health care encounters were relatively common among the abortion seekers I spoke with. It is relevant to note that five of the six abortion seekers I spoke with had sought abortions in private clinics and were required to seek referrals and tests, prior to their abortions, from separate health services. This exposed them to stigmatising interactions during appointments with sonographers and GPs who were not directly involved in abortion provision and not necessarily supportive of their abortion decisions. Ali and Naomi had their abortions at private clinics in Sydney and Perth respectively. They both described seeking referrals, in the first instance, from GPs who were not their regular health care providers. Ali described how,

> when I told the doctor [about the pregnancy], he was so happy… And we were like, oh we're having an abortion. And then he then he was like, "ah, you know, I can't give you a recommendation. But here's someone else who can write you that" because he must have had religious beliefs or something against it.

While Ali said she "was not offended" and "laughed it off", she also described feeling glad her partner was with her for that experience, indicating it was not as emotionally straightforward as she initially described. Similarly, Naomi sensed the GP she first saw for an abortion referral, who a friend had taken her to and who wasn't her usual doctor, was attempting to delay her access to abortion care. She subsequently returned to her regular GP and received non-judgmental care and a prompt referral to a private abortion clinic.

Gaby was the only abortion seeker who described experiencing a stigmatising interaction in a health service providing abortion care. Her experience of predominantly anticipated abortion stigma illustrates the pervasive nature of anti-abortion narratives even in contexts and for people

who are explicitly pro-choice. Gaby had a medication abortion at a private clinic in Brisbane and made her pregnancy outcome decision easily with support from her partner. The health practitioner she first saw (at a service offering abortions that she found online) asked her to explain the reason she was seeking an abortion. Gaby indicated being aware in that moment of the power the doctor held to dictate her access to abortion. As a result of her discomfort and anticipation of stigma, she lied about why she wanted an abortion:

> I understand they have to ask. And I felt a bit tense just saying, “Well, I don't want to be pregnant”. So, I just said, “we're not financially stable”.

When invited to reflect further on this interaction she explained,

> I was just worried about the judgment because I did feel slightly vulnerable about this doctor. I just didn't want to deal with like having this initial appointment be like a witch hunt or like an interrogation on why we wouldn’t keep a perfectly healthy baby if we're so happy and I'm engaged and that kind of stuff. And I think I would have been fine if I just said I don't want it. But I yeah, I think I just lied because I was a bit worried about like, a bit shameful about keeping it or not keeping it sorry…I was just a bit worried about the judgment and worried about how I would take it as well [the doctor opposing abortion]. Not that I would change my mind at all, but just having to deal with that.

Gaby did not articulate feelings of blame or shame, nor did she describe feelings or experiences that would indicate she had internalised or anticipated abortion stigma prior to seeking an abortion. Nevertheless, when asked about the reason for her abortion, narratives about good and acceptable abortions, and anti-abortion language – reflected in her reference to having “a perfectly healthy baby” - were brought to the fore, resulting in anticipated stigma, (fleeting) feelings of shame, and secrecy. Stigmatising narratives about abortion appeared to be present in the minds of and embodied by the young abortion seekers I spoke with irrespective of their own beliefs and efforts to resist and reject stigmatising stereotypes.

In contrast to young women’s stigmatising experiences in health care settings not directly involved in the provision of abortion, and beyond Gaby’s experience, women consistently described interactions with abortion providers as affirming and non-judgmental. Interviewees described their abortion providers as “wonderful”, “passionate about really giving women opportunity and like freedom” (Chloe), “kind” and “comforting” (Naomi), “lovely” and “softly spoken” (Ali). Lexi, who had her abortion at a private women’s health clinic in Sydney, spoke explicitly about being grateful for affirming conversations with her abortion provider:

> I was like, “well I just started a new job”, and she's like, “oh, yeah, you need to think about you”. I just remember her, pretty much anything I said she was like, “oh yeah, you need to do you”.

For some abortion seekers, receiving affirming health care appeared to reduce distress and the embodiment or reinforcement of judgmental abortion narratives and feelings of shame. For example, Naomi was reassured when her GP normalised abortion seeking during her initial appointment:

> As she was writing up the referral she was like, “I had to refer another person to this place this week. There's a lot of people wanting to get abortions.” And I'm like, okay, makes me feel better.

Along with interpersonal interactions with health professionals, the physical characteristics of abortion clinics played a role in the stigma experiences of two interviewees. Lexi described the women’s health clinic where she accessed her abortion as “run down” and “underfunded”, with blocked out windows and an entry way “down an alley”. These physical characteristics of the health facility appeared to reinforce her understanding of abortion as clandestine and beyond the remit of regular healthcare. Lexi said the clinic she attended,

> kinda seemed like this is the place you'd go where you don't want people to know what's happening… I feel like, it couldn’t just be in a normal doctor's clinic… like I was doing something dodgy.

For Chloe, a vastly different experience in “privileged abortion place” made her feel like she was “too privileged” and had access to services most others would not be able to afford. She talked about her experience at a “very comfortable” and “perfect” looking private facility as feeling “wrong”. Her narrative expressed she believed abortion experiences shouldn’t be so “comfortable”, and a sense of middle-class guilt. For her second abortion experience she attended a different private clinic which she preferred. She described it as “less fancy”, “more realistic” and with more “diverse” patients, which contributed to her feeling it was more “human and genuine”. Of note, this was Chloe’s interpretation in spite of having received apparently unproblematic care at the first private clinic she attended.

Women’s narratives indicated their stigma experiences were significantly impacted by the autonomy they had over their abortion care journeys and disclosure decisions. Health care settings emerged as key sites of all domains of stigma experiences – internalised, perceived, anticipated, and enacted. Furthermore, health care interactions and thus practitioners appear to play a central role in the normalisation of abortion for abortion seekers, or in exacerbating internalised anti-abortion narratives.

7.2.5C "I got pretty lucky": The impact of abortion experiences on perceived stigma

Abortion experiences have variable impacts on the ways abortion seekers feel about and perceive abortion norms and narratives. For some of the young women I spoke with, surprisingly positive reactions they experienced in response to their abortion disclosures changed their perceptions of abortion stigma in Australia. For Mel and Lexi, for example, the solely positive reactions they received before, during, and after their abortion experiences meant they no longer perceived abortion stigma in the way they had prior to their abortions. Speaking with Mel around a year after her abortion I asked if she felt abortion was stigmatised in Australia, and if her feelings about this had changed since her abortion. She responded,

> I think if you had asked me that question a year ago, I would have said that people in Australia aren't supportive of it, and that would have been because going to school in the city, I remember seeing protesters and people with signs, you know, literally forcing down your throat that abortion is this is this awful, horrible thing. Now that I've had one, and I've spoken to people, I haven't had a single person tell me that I've done the wrong thing. So absolutely, my opinion in that one year has totally changed.

Similarly for Lexi, sharing her abortion story and hearing others' stories in response helped to normalise her experience and altered her understanding of the social acceptability of abortion in Australia. To the same questions she responded,

> Not really. I think, like, going to get one you feel like it is. But then when you speak to other people and you realise, "oh, that person's had one". I think the kind of image that you first think about, maybe because of like the school I went to, is it's like irresponsible, like you have got yourself there in the first place. But when you speak to people it's not like just single people who maybe got drunk, didn't think about the consequences. Like, it's people in relationships. People who were unlucky where the pill didn't work, the condom broke.

For other women, however, it became evident that by interpreting their own relatively positive abortion experiences as the exception rather than the norm they retained their understandings of abortion as a broadly taboo, stigmatised experience. For these women, their own relatively normalising abortion experiences did not seem to change their perceptions that abortion is broadly stigmatised in Australia.

Irrespective of their pre- and post-abortion perceptions of abortion stigma, a sense of "privilege" and "luck" at having had relatively straightforward and positive abortion-seeking experiences carried through the stories of most of the abortion seekers I interviewed. They described their experiences as "the best of a bad scenario" (Mel), enabled by supportive partners and having *"*really good friends*"* (Lexi). When describing the first "privileged" abortion clinic she attended, Chloe described how,

> I was thinking like, so many women wouldn't have like, this wouldn't be their experience like, and I just remember thinking that in the moment, and you know, I was lucky.

Despite describing a range of experiences related to physical complications, secrecy, family judgment and conscientious objection, all of the young abortion seekers I spoke with described their experiences of the physical abortion process positively. For example, while Naomi felt unable to tell her family about her pregnancy or abortion experiences, which led to a range of logistical challenges, she described the relative accessibility of abortion care and a lack of medical complications as indicative of a positive abortion experience. She said she'd read about places outside of Australia where abortion seekers face significant barriers to abortion access, and thus felt:

> I got pretty lucky overall, in just the ease of it and having you know, a few people around me that I could tell. It would have been a lot harder had I not been able to tell anyone or felt like I couldn't… it could have been worse, like my body, like, in terms of the actual procedure. Like it wasn't traumatising. It wasn't anything of the sorts of what other women might have gone through elsewhere.

Gaby felt lucky she had found it easy to decide to have an abortion, as friends had told her "they would find it difficult to make the decision". She knew of a friend who had been coerced into a termination in her teenage years and had spoken to women who felt they had to justify their abortions when she worked in a pharmacy. Gaby felt lucky that was not her experience. Other interviewees described feeling lucky that the men involved in their conceptions expressed genuine support for any decision they'd make, indicating they had a prior assumption that that level of supportiveness was not the norm.

Thus, narratives around the women's 'luckiness' seemed to emerge from understandings about, and witnessing the experiences of others who have/had greater psychosocial and stigma-related challenges choosing, and more difficulty accessing abortions than they did. They also appeared to be informed by dominant narratives of abortion as a generally difficult and unpleasant experience. While one interviewee had experienced a post-abortion infection and become very sick, one had an incomplete medication abortion requiring surgical follow-up, and two had encountered GPs who were conscientious objectors, they nevertheless saw their experiences as less difficult than what they anticipate 'other' abortion seekers face. Thus, they perceived their relatively positive experiences to be abnormal and lucky.

7.3 Discussion: Meta-themes

My interpretation of the interviewees' narratives, and of the themes explored above, reveal meaningful insights into the drivers, facilitators, practices, and experiences of abortion stigma among young people in Australia. The findings of this analysis shed light on why young people emerged as more likely than older interviewees to anticipate abortion stigma in The Australian Abortion Stigma Survey and make important contributions to understandings of the intersections between age, class, and abortion norms, narratives, stereotypes, and stigma in the Australian context.

The anticipation of abortion stigma and discrimination was common in the narratives of the young people I interviewed. Nevertheless, anticipated stigma varied in salience and manifestations based on formative experiences (conversations and media exposure), gender (it was more common among women and non-binary interviewees than males), religiosity in young peoples' immediate social circles, and pregnancy and abortion experiences. Consistent with previous research, abortion stigma was contested and resisted as evidenced through the language and framing young people used to explain and understand abortion beliefs, norms, and experiences (Hoggart, 2017). Many interviewees, including those who had and had not had abortion experiences, and primarily who were non-religious and had non-religious families, presented what Beynon-Jones (2017, p. 225) described as "untroubled" (i.e., non-stigmatised) identities related to and understandings of abortion. While many interviewees rejected abortion stigmatisation as both a feature of their own experiences and their own beliefs, many nevertheless appeared to have internalised stigmatising messages, and believed a sense of deviance and differential treatment does exist in relation to abortion seeking in Australia. There was therefore a tension across and within interviewees' narratives between what was true for them and what they imagined was true for others.

Interrogating this tension is vital to ensuring abortion stigma (including this) research doesn't reify an interpretation of power, and of stigma power, as purely top down and not resisted (Millar, 2020). Tyler and Slater (2018) have proposed a Foucauldian interpretation of stigma power as dynamic and productive, flowing between subjects rather than purely from the powerful/ stigmatisers onto the stigmatised (Tyler & Slater, 2018). Tyler encourages stigma researchers to explore the broader meta-social forces that produce, maintain and benefit from stigma, and how these forces legitimise and enable injustice (Tyler, 2013; Tyler & Slater, 2018). This tension is explored in the remainder of this chapter in a framework of four meta-themes that I identified as running through the thematic analysis presented above. The first meta-theme explores an apparent discord between experiences of enacted versus anticipated stigmatisation. The second describes how the US is point of cultural reference and knowledge for young people in Australia, and the way their abortion stigma experiences are based on imported norms and narratives. The

third meta-theme refers to the 'feeling lucky' narrative and the exceptionalisation of (relatively) positive abortion experiences. The fourth and final meta-theme explores the social stratification of abortion stigma.

7.3.1 Is there a discord between anticipation and enactments of abortion stigma?

Young peoples' stories and experiences indicated a discord between their perceptions of the risks associated with and likelihood of experiencing abortion stigma and discrimination in varying contexts, versus their lived realities of interpersonal abortion stigma experiences. Previous research has described a variation in the apparent commonality of anticipated abortion stigma, versus the relative rarity of enacted abortion related stigma and discrimination (Millar, 2020).

All of the young people I spoke with shared a perception that abortion stigma and discrimination were most likely to be present in contexts, or to be enacted by individuals, that were older, rural, culturally conservative, and religious. Despite many interviewees expressing fears related to the potential risks abortion seeking may pose to their interpersonal relationships, those with religious friends and family, or those facing social or financial disadvantage or marginalisation (of which there were few) appeared to be most fearful. These findings align with the broader evidence base, which indicates strong but complex associations between an individual's social context and community's characteristics with perceived abortion stigma (Biggs et al., 2020). Furthermore, some interviewees expressed awareness of the role and power of health providers gatekeeping (enabling, delaying, or preventing) abortion access, and anticipating potential negative reactions to abortion seeking from healthcare providers. This was evidenced, for example, in the stories of women who avoided their regular GPs when seeking abortion referrals. Even so, most interviewees shared the assumption that they would be able to access an abortion, irrespective of their location of residence and previous healthcare experiences, should they need or want one.

Despite their anticipation and perceptions of abortion stigma, the six abortion seekers interviewed described only rare instances of interpersonal stigmatisation in in-person interactions with friends and family. Research in the US has similarly found the majority of interpersonal abortion disclosures are met with positive or mixed reactions (Cowan, 2017). In contrast, and as Australian research has shown, stigma and discrimination in health care settings appears to be relatively common (Hulme-Chambers et al., 2018). Judgment and service refusal by health providers, primarily not abortion providers, appears to be enabled by unnecessarily burdensome health systems and referral pathways requiring multiple appointments with multiple practitioners to secure abortion access (Cleetus et al., 2022; Vallury et al., 2023). This characteristic of the Australian health system means that abortion seekers may be required to see multiple health services for

referrals and tests prior to securing medication or surgical abortion care[22]. The impact of complex health pathways on abortion seekers' autonomy and stigma experiences became evident across interviewees stories. For example, the abortion seekers I spoke with appear to be able to anticipate and avoid stigmatising interactions with friends and family by being selective with when and to whom they talk about their abortion experiences. In contrast, in instances when they have limited control over when and who to disclose their abortion seeking to, their risk of experiencing abortion-related judgment and stigmatisation appears to increase. As described below in Section 7.3.4, young interviewees' autonomy over their abortion seeking journeys and related abortion disclosures appears to be mediated by their social and financial capital. The exceptionalisation of abortion in the Australian health care and legal systems, and the resulting systemic complexities and differential treatment of abortion seekers versus other health care consumers, are thus particularly likely to impact young people experiencing socio-economic marginalisation (Baird, 2023; Healthdirect, 2022; Millar, 2023).

One of the only quantitative studies of enacted abortion stigmatisation related to abortion disclosures provides further insight into the way stigma experiences are patterned by autonomy over disclosure. Cowan (2017) found that the likelihood of abortion seekers (and men as conception partners in abortion experiences) receiving (perceived) positive, mixed, or negative reactions to abortion disclosures varies based on the reason for and recipient of an abortion disclosure. They found that abortion disclosures made to close friends and people known to have had abortions, and which occur in general conversation or to garner support, receive more positive reactions (Cowan, 2017). In contrast, abortion disclosures to family members and made by young people are most likely to receive negative (or less consistently positive) reactions. Cowan (2017) also found that more frequent disclosure results in reduced likelihood of receiving solely positive responses. Of note, Cowan did not explicitly refer to abortion disclosures and responses in health care settings. These findings nevertheless support my interpretation that a lack of control over abortion and pregnancy disclosures, which is likely to be particularly salient for young people who are emotionally and materially reliant on others for abortion information and access (Chor et al., 2019), increases the risk of abortion-related stigmatisation and discrimination.

7.3.2 Imported stigma

Interviewees' narratives commonly indicated that much of their abortion knowledge, and perceived and anticipated abortion stigma, were the result of narratives and norms imported from the US,

[22] None of the abortion seekers I spoke to had sought care in the one-day public abortion services available in Adelaide and Darwin, or through the Royal Women's Hospital in Melbourne. Thus, I was unable to compare the stigma experiences across service types.

which they were exposed to via popular and social media. Their experiences provide insights into the role of transnational discourses in shaping local stigma experiences. There is a range of research describing the way abortion-related social and legal movements and technologies have flowed transnationally for many decades (Calkin, 2019; Daire et al., 2018; Mason, 2019). Although some of this speaks directly to the flow of religion-based anti-abortion movements, advocacy and political strategies and messaging (Machado et al., 2022; Mancini & Rosenfeld, 2018), little research has explored the flow of stigma explicitly (beyond its function as a tool of anti-abortion movements), and in particular in relation to the Australian context and experience[23].

American popular and social media content was a key source of the enculturation of interviewees into narratives that position abortion as contested and stigmatised. Almost all of the young people I spoke with were aware of increasing structural stigmatisation of abortion in the US via increasing abortion criminalisation and ongoing contests over the restriction of abortion provision at state and national levels (Biggs et al., 2020). Many interviewees consciously and explicitly denied political or cultural similarities between Australia and the US. However, many also appeared to have internalised the narratives they had seen online which had in turn informed their anticipation and perceptions of abortion stigma in their Australian contexts. Interviewees' accounts indicated that the significant impact of online, particularly American, abortion-related media content on their understandings of abortion was enabled by the lack of exposure to local abortion-related discourse and content. Few interviewees, for example, could recall seeing Australian abortion-related news or social media content. Those who had explained that it focused on religious refusal and anti-abortion protestors and was presented awkwardly and formally. Similarly, while few interviewees had received any information about abortion in formal educational settings, those who had described how it perpetuated rather than challenged stigmatising narratives about abortion. The Australian medical curriculum has been described as a "powerful" source and site for the perpetuation of abortion exceptionalism, whereby abortion is treated differently to other areas of medicine, and thus enacted abortion stigma (Millar, 2023, p.261). The complexity of the health system and of abortion care pathways that result from abortion exceptionalism facilitates abortion stigma and discrimination. Interviewees in this study perceived there to be a 'social silence' about abortion in many of the social and learning contexts they moved through. The combative and contested content and debate they saw online, juxtaposed with limited and stigma-perpetuating local content or discussion about abortion they did experience, reinforced the belief that when abortion *is* spoken about it is polarising and problematic. As a result of the lack of local abortion stories and education, relative to American abortion-related stories and information, most interviewees were aware of the re- criminalisation of abortion in Texas, but few knew the abortion laws in states and territories in which they lived.

[23] I note there has been research on shared/transnational features of abortion decriminalisation campaigns in Ireland and Poland by Cullen and Korolczuk (2019).

Further speaking to the power of online discourse in influencing young Australians' understandings of abortion-related social norms and narratives, many interviewees characterised (online) abortion discourse as a heated and combative debate which perpetuates a false dichotomy of abortion views. Primarily religious (usually Christian) anti-abortion activists were seen to generate a narrative that places anti-abortion views at the centre of understandings of what being 'religious' or 'Christian' is, thus creating a false sense that people who identify with Christianity are widely opposed to abortion. This was reflected in interviewees' anticipation of negative responses to a hypothetical or experienced abortion from religious friends and family members. In contrast, many interviewees described receiving supportive reactions from religious friends and family to abortion disclosures, as well as having productive and respectful in-person conversations about abortion, including with people who express anti-abortion views. Such conversations appear to undermine the narrative of a religious-atheist binary of pro- vs anti-abortion beliefs, and the idea that most people have absolutist abortion beliefs.

The 'false dichotomy' of abortion beliefs presented online is an inaccurate and unrepresentative representation of the diversity of beliefs people hold in relation to abortion (Pew Research Center, 2022; McCoyd, 2010). Even in the US where this binary appears to be most pronounced and politicised, the majority of the population support abortion legality in most or some cases (Baird, 2014; Osborne et al., 2022; Pew Research Center, 2022). Nevertheless, the false binary narrative has become a valuable tool and feature of identity politics and partisanship in the US (Hout et al., 2022; Osborne et al., 2022). Some interviewees alluded to understanding that the online debate represented a view of abortion as more polarised than they know or believe it to be in Australia: American media content nevertheless generated a 'fear' of engaging in abortion related discussion or debate. Evidently, stigmatising online narratives and debate appear to silence nuanced and pro-choices perspectives, preventing young people from "straying too far from a perceived dominant narrative" (Purcell et al., 2020, p.1361). Furthermore, they result in the exclusion of young people from local and international abortion conversations by teaching them that abortion discussions and disclosures are socially risky.

"Stigma power" has been the term ascribed to the way stigma is used as a tool to keep "other people down, in or away" to achieve the "aims of stigmatisers with respect to the exploitation, management, control or exclusion of others" (Link & Phelan, 2014, p. 1). Link and Phelan suggest stigma power is most effective when used subtly and indirectly, hidden in "taken-for-granted cultural circumstances", as with other forms of symbolic power (Link and Phelan, 2014, p. 2). Young people in this study, in particular those who had not had abortion experiences, talked about the ways that abortion stigma prevents disclosure, enables misinformation, prevents engagement in abortion-related discourse and thus maintains the false dichotomies they are exposed to in the media. Link and Phelan (2014), however, primarily described mechanisms by which stigma power is enacted from stigmatisers onto the stigmatised through interpersonal interactions or self-

regulation. As was identified previously by Hoggart (2017), in this study interpersonal interactions were commonly found to be protective against abortion stigma and to challenge stigmatising norms. Interpersonal interactions facilitated the creation of cultures of support within families and peer groups and enable education and information sharing. In contrast, stigma power enacted via social discourse through online platforms appears to be relatively effective in keeping some young people silent and away from abortion-related public discourses. Even so, the supportive nature of positive responses to abortion (disclosures) interviewees experienced face-to-face meant some felt more confident and likely to engage in online 'debate'/discussions about abortion after their experiences. Drawing on "non-negative" and positive abortion experiences appears to enable some young people to participate in actively challenging abortion stigma online, stigma resistance thus becoming self-perpetuating (Purcell et al., 2020, p.1354).

7.3.3 Feeling lucky: The exceptionalisation of positive abortion experiences

Most of the abortion seekers I spoke with described themselves as 'lucky', based on experiences of social support and positive reactions they received, their ease of decision making, and their relatively easy access to abortion services. Narratives of luck were used to contrast what interviewees perceived to be relatively easy abortion experiences with what they believed was often a more challenging experience for other abortion seekers, both in Australia and overseas. Prior research has similarly found feelings of surprise and luck at having positive abortion experiences have been framed relative to abortion seekers' awareness of international abortion accessibility and rights (Baum et al., 2020; Purcell et al., 2020).

At an individual level, these findings could be explained by the psychological concept of the 'personal-group discrimination discrepancy' (PGDD). PGDD has been described as a tendency of members of a disadvantaged or stigmatised group to perceive that their group in general faces higher levels of discrimination than they have personally experienced (Quinn & Rosenthal, 2012). "When judging how much discrimination they experience personally, individuals compare their own experiences to the experiences of the ingroup members; when judging how much discrimination is experienced by their group, however, individuals compare their group's experiences to the experiences of other groups" (Quinn & Olson, 2003, p. 223). This form of social comparison has been shown to occur across a range of marginalised population groups (Quinn & Olson, 2003). This could explain, at a psychological level, why interviewees interpreted even negative aspects of their own abortion experiences as relatively positive and lucky in comparison to what they expect other abortion seekers (i.e., members of their stigmatised 'group') experience. Some research has suggested this may be a psychological protection mechanism which may help disadvantaged individuals feel more in control of their experiences and to avoid feeling the need to advocate against injustice (Quinn & Rosenthal, 2012).

Zooming out, the ‘lucky narrative’ may rather, or also, suggest a lack of a rights-based framework among young Australians understandings and narratives of abortion, and/or their acceptance of abortion exceptionalisation. While many interviewees alluded to abortion as a right, or to the right to bodily autonomy at various times throughout the interviews, those who had sought abortion commonly spoke of access to abortion as a privilege, or enabled by privilege, and felt lucky to have that privilege. Their internalisation of the characterisation of abortion as beyond the bounds of what they expect from other forms of healthcare demonstrates how narratives of abortion exceptionalism have permeated the imaginations of even distinctly pro-choice young people. Similar observations have been made by Purcell and colleagues in the UK, who found rights and justice-based framings of abortion to be notably absent among abortion seekers’ and online abortion narratives (Purcell et al., 2020).

Abortion seekers in this study, who were all middle-class, described their own abortion experiences as exceptional: exceptionally lucky. This somewhat contrasts previous research, which has found abortion seekers frequently position their abortion decisions as exceptional in order to distance themselves from stereotypes they believe apply to ‘other’ abortion seekers (McCoyd, 2010; Nickerson et al., 2014; Ralph et al., 2022). Prior research finding abortion seekers cope with and resist stigma by explicitly, discursively distancing themselves from abortion stereotypes while legitimising the applicability of stereotypes to ‘other’ abortion seekers, was not supported by the stories presented in this research. Of note, many interviewees’ middle-class accounts of the characteristics of abortion seekers and the social “worlds” in which abortions occur do indicate that they perceived abortion to be primarily experienced by a working class ‘other’ (noting the term ‘class’ itself was not used). Abortion experiences, however, were learning experiences that taught some “privileged” young interviewees that anyone from any “world” may need or seek an abortion. Abortion experiences thus challenged stereotypes about the characteristics of people who experience abortion. For some abortion seekers, positive experiences talking about their abortions meant their understandings of Australians’ abortion views, which were previously informed by stereotypes and seeing anti-abortion protesters, were also reframed. These abortion seekers were subsequently less likely to perceive anti-abortion beliefs are the norm in Australia. Prior research has found that education about abortion can help people navigate prior exposure to anti-abortion narratives (Mollen et al., 2018). There is limited quantitative research, however, describing the association between abortion experiences and perceived or anticipated stigma specifically.

7.3.4 The social stratification of abortion stigma

Findings relating to interviewees' understandings and experiences of abortion stigma and its impacts as socially and economically stratified provide insight into the intersectional, classed nature of the social production and function of stigma. The young people I spoke with represented a relatively homogenous group, in that most indicated a middle-class social positioning, were born in Australia, and raised in Christian or non-religious families. Their accounts of abortion stigma experiences, however, framed abortion stigma as a socially stratified experience. Interviewees rejected a sense of universality around abortion stigma, instead describing it as existing alongside and despite Australia's pro-choice majority views, in particular social groups and 'worlds'. Along with age, political, and religious values and identities, markers of identity related to, and material elements of social class and capital, were described as mediating abortion and abortion-stigma experiences.

Several interviewees characterised the 'types' of young people – particularly in the context of high school – who they perceived to be most likely to seek abortion as 'girls' who are also less likely to finish school or were engaged in other deviant social behaviours. Others described the social acceptability of gossiping about 'girls' in school who were thought or known to have had abortion experiences and who had less social capital, while the wealthier students were protected by 'unspoken' rules regarding discretion. However, there was an absence of narratives pertaining to abortion seeking and stigma experiences among lower socio-economic young people in this study. It is likely that the protection against gossip that interviewees perceived socio-economic privilege afforded abortion seekers was just that, a perception. Middle-class interviewees' narratives suggest that they projected classed and stereotypical narratives about abortion seekers onto marginalised young people. Either way, beliefs about and experiences of abortion stigma as classed align with research that suggests the stigmatisation of minority and/or oppressed population groups is a key feature of neoliberal capitalism. Leading stigma theorists posit that, in neoliberal capitalist systems, stigma is used to justify mistreatment of "those living at the bottom of the class structure" and thus to demonise poverty (Tyler & Slater, 2018, p. 734). This has been demonstrated in a suite of stigma literature (for example see; Choi & Miller, 2018; Keene & Padilla, 2010; Shildrick, 2018).

Abortion seekers talked about the ways their own economic and social privilege influenced their experiences of abortion stigma. Chloe described her economic privilege as facilitating her access to timely private abortion services, yet she struggled to reconcile having abortions with her identity as a privileged and academically successful young woman, speaking to both the roles of subjective and objective social class[24]. Chloe didn't appear to have examples to draw on to legitimise the

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[24] 'Subjective social class' has been defined as a person's interpretation of their position in a class hierarchy, and 'objective social class' as their access to and control of resources including healthcare, social networks, income, and education (Choi & Miller, 2018, pp. 764-765).

experience of abortion among people of her perceived and actual class, or who were from her 'world'. Experiencing an abortion, and more so two abortions, conflicted with an internalised notion of irresponsibility and failure of self-regulation associated with abortion seeking, which appeared not to align with her classed values of control and restraint regarding sex and fertility (Love, 2021; McRobbie 2015). While Chloe's story alludes to the complex interactions between identity, internalised stigma, and class, for most interviewees having access to middle-class social and financial capital appeared to be protective against abortion stigma experiences.

There is an increasing effort among stigma researchers and theorists to centre class and capital in understanding stigma as a form of oppression and social power (Baird & Millar, 2020; Parker & Aggleton, 2003; Scambler, 2018; Tyler & Slater, 2018). Even so, class has been only minimally addressed in abortion stigma literature. There is little research to draw on to explain Chloe's experiences of abortion stigma and shame, and the ways her self-regulation and middle-class values worked against her. McRobbie suggests that achieving the image and identity of 'the perfect' middle class woman is dependent on self-regulation and control (McRobbie, 2015). In this regard, Chloe can be seen to have struggled to embed abortion into her identity as she understood it to represent a failure of self-control and thus the antithesis of middle-class success (McRobbie, 2015). Love has described abortion stigma as a "regulatory technology of the self' that is enabled by middle-class practices of self control" (Love, 2021, p. 317). Thus, abortion stigma can be seen to be a mechanism through which neoliberal middle-class values of self-responsibility are upheld. A suite of research has positioned middle-classness as protective against abortion stigma. Women have been found to resist and negotiate stigma by constructing abortion as a tool of achieving middle-class goals, such as those associated with education, motherhood, and the ideal woman (Love, 2021). Thus, abortion seekers who are able to draw on middle-class narratives and identities are seemingly more often able to resist abortion stigma (Allen, 2013; Beynon-Jones, 2017; Hoggart, 2017; Love, 2018; Ralph, 2022). Younger and 'working class' women, who may be perceived to be less able to raise children, less financially secure, or as more irresponsible, are therefore likely to experience abortion and stigma differently (Love, 2021). A number of the interviewees in this study spoke to this, describing women with less social capital as more likely to experience abortion and teenage pregnancy related stigma and discrimination. Cowan found that in the US, the lowest income abortion-seekers are least likely to perceive solely positive responses to abortion disclosures, while middle-income respondents are most likely to perceive solely positive responses (Cowan, 2017).

As described above in Section 7.2.5, young people's experiences of abortion stigma and discrimination appear to be patterned around their autonomy over their abortion seeking journeys and abortion disclosures. Previous research has found that reproductive autonomy broadly, and autonomy regarding abortion disclosures specifically, is mediated by young people's social and financial capital. Previous research has found that abortion seekers desire abortion care that is

discreet, and value confidentiality as it affords them the ability to avoid abortion stigma and discrimination (Altshuler et al., 2017; also see Chapter 3 Section 3.4.4). Unwanted abortion disclosures, which were shown to be associated with increased likelihood of experiencing abortion related judgment in this research, has been found to be associated with symptoms of depression, anxiety, and stress (Biggs et al., 2023). Of note, unwanted disclosures have also been found to be particularly salient for abortion seekers experiencing financial barriers and delays to accessing abortion care (Biggs et al., 2023). Among the small numbers of abortion seekers in this study, in contrast, it was systemic rather than individual characteristics (noting all women appear to have had access to the money necessary to pay for their abortion care), such as the requirement to attend multiple appointments, conscientious objecting health professionals and the need to justify leave requests, that drove unwanted abortion disclosures. Despite a lack of data describing the abortion seeking and stigma experiences of marginalised young Australians, the exceptionalisation of abortion appears to be particularly likely to impact young people experiencing socio-economic marginalisation. Previous quantitative research in several countries has pointed to greater experiences of abortion stigma among younger (versus older) women, and those with higher educational attainment (Cockrill et al., 2013; Oginni et al., 2018). It appears, therefore, that the intersection between young age and class/social capital is a particular axis of risk and vulnerability that warrants further research attention, both in and beyond Australia. More research is needed to explore the experiences of young abortion seekers from lower income, migrant, and culturally diverse groups and thus to facilitate a better understanding of the intersections of marginalisation and abortion stigma and discrimination in the Australian context.

7.4 Limitations

There are a number of limitations to be acknowledged in relation to this interview study. Firstly, despite an attempt at maximum variation sampling, I struggled to recruit interviewees opposed to abortion. While they are a small minority among Australian young people, gaining a more in depth understanding of their perceptions and experiences of abortion stigma will be important in informing an improved understanding of the interactions between stigma experiences, religion, and abortion beliefs. Furthermore, the interviewees were relatively homogenous in regard to class, socio-economic and cultural backgrounds. Thus, the findings of this research are particularly relevant to understanding young, white, middle-class Australians' experiences, perceptions of and beliefs about abortion and abortion stigma. Notably, conclusions drawn about relationships between social class, broadly, and particular markers of class such as educational attainment and abortion stigma primarily reflect the perspectives of relatively socio-economically privileged young people. Participants who spoke about culture and cultural community norms associated with their families' experiences as migrants referenced culture, religion, and social norms as central to how

they experienced and perceived abortion stigma. Cultural and class-based variations in stigma experiences thus warrant further and explicit research attention, particularly given the findings of previous research indicating abortion stigma may be most salient among cultural and racial minority and lower income abortion seekers.

Several researchers have described the potential and actual effects of conducting research on abortion stigma. Some have spoken about potential of the interview process to lead participants to reframe or reconsider their own experiences of abortion stigma (Makleff, 2023; Ratcliffe et al., 2023). Others have described abortion stigma research as potentially performative with the potential to impact stigma experiences (Baird & Millar, 2020; Makleff, 2023). I attempted to mitigate any negative risks associated with the conduct of the research by not asking questions directly about perceptions of stigma, and by not introducing the word stigma until the later part of interviews. Some interviewees did, however, describe having reflected on their experiences (through the lens of stigma) in preparation for their interviews while considering the information provided in the Participant Information Sheet. As a further effort to reduce the potential for this study to assume the universality of and thus over-state or reinforce abortion stigma, I explicitly searched for and relayed normalising as well as stigmatising experiences and discursive elements throughout the coding and analysis processes.

The self-selecting nature of the recruitment process used in this study had the potential to result in a sample of interviewees with un-representatively strong views on abortion or had had particularly stigmatising abortion experiences (Makleff, 2023). This did not appear to be the case. While some participants expressed a particular interest in the topic due to work or personal experiences (as midwives and medical students, for example), there were also many participants who had had relatively normalised abortion experiences, and participants who expressed a diversity of experiences, opinions, and even ambivalence about abortion. The diverse case sampling process, wherein I had a relatively large potential sample from whom to select interviewees based on a range of characteristics, further mitigated the risk of a biased sample.

7.5 Conclusion

The results of this interview study suggest that abortion stigma is dictated, driven, enforced, and maintained at the level of meta-structures, systems, social discourses, and norms. This juxtaposes conceptualisations of abortion stigma that position interpersonal interactions as the primary site of stigma, finding social discourse and health systems to be primary sites of stigma operationalisation and perpetuation. Interviewees' awareness of systemic characteristics and manifestations of abortion stigma, even when they were external to and in conflict with their own beliefs, experiences, and communities, inevitably impacted their reproductive health experiences. Even

when young people completely rejected stigmatising narratives and had normalised understandings of abortion, they believed there are social risks associated with abortion. Thus, while stigma was contested, it was present – albeit in varying ways and to varying degrees – in all interviewees' narratives. Of note, the meta-themes explored in this chapter are further unpacked, explored, and contextualised in Chapter 8 in reference to the quantitative study findings.

CHAPTER EIGHT: AN INTEGRATED DISCUSSION OF THE QUANTITATIVE AND QUALITATIVE FINDINGS

This chapter provides an integrated analysis and discussion of the data and findings of all components of this research in reference to the research aims and objectives, and the global abortion stigma evidence base. It proposes agendas for future theoretical and intervention development and abortion stigma research. Furthermore, it offers an interpretation of abortion stigma that more fully aligns with the scope of Australian abortion stigma experiences and drivers than previous research has done, the achievement of which was the final objective of this doctoral work.

Section 8.1 synthesises data and findings from the quantitative and qualitative studies and considers how they address the overarching aims of this research. Taken together, these findings offer a more complete picture of the prevalence, predictors, and drivers of abortion stigma in Australia than either component of the research provides alone. In Section 8.2 the implications of this research for abortion stigma theory, intervention design, health systems and practice, and research are described. Section 8.3 then offers personal reflections on the survey implementation and interview processes.

8.1 The extent, predictors and drivers of abortion stigma and its salience in Australia

Based on a comparative examination of the qualitative and quantitative research data and findings, and in line with the research aims and objectives, this section provides original insights into the nature and drivers of abortion stigma. It describes:

- the extent of perceived and anticipated abortion stigma among people in Australia aged 16 years and over;
- key predictors of perceived and anticipated abortion stigma among the general population, and thus priority population groups that are most likely to experience abortion stigma; and
- young peoples' experiences of and beliefs about abortion and abortion stigma, and drivers of stigma experiences among this priority population.

8.1.1 The extent and salience of abortion stigma

Through developing, validating, and implementing The Australian Abortion Stigma Survey, the quantitative phase of this research provides a foundational understanding of two domains of abortion stigma - anticipated and perceived - which have not previously been measured explicitly among a general community sample. Previous measures of community level abortion stigma have primarily assessed individuals' beliefs and judgments about abortion, and the anticipation of secrecy and 'divine punishment' related to abortion seeking (Cutler et al., 2021; Shellenberg et al., 2014; Sorhaindo et al., 2016). Abortion-related attitudes, however, form just one element of the stigmatisation of abortion (Stangl et al., 2019).

Nine out of 10 TAASS participants support abortion legality and accessibility in most or all circumstances, along with the public provision and funding of abortion services in Australia[25]. This affirms that Australia is among the countries with the most abortion supportive attitudes globally (Boyon, 2022). The same proportion of participants perceive other Australians to be pro-choice, indicating low levels of perceived community abortion stigma. In contrast, most participants anticipated that both abortion seekers and providers are likely to experience a range of social consequences, including judgment and harassment. Notably, four out of five participants anticipated abortion providers in Australia experience harassment or violence due to their work. These statistics indicate that abortion stigma in Australia is contested, complex, and dynamic.

The interview component of this research provides explanations for the differences identified by TAASS between anticipated and perceived abortion stigma. For example, young interviewees anticipate 'religious' and 'conservative' communities and individuals are the primary sources of abortion stigmatisation. Young people also anticipate experiencing judgment or harassment when engaging with abortion-related content, or in response to abortion disclosures (wanted or unwanted) online. Online abortion conversations were described as combative and key sites of abortion stigmatisation. One interviewee, Asheni, talked about the internet facilitating the targeting of abortion researchers. She described how a family member involved in medical abortion research in England,

> was targeted, like she was threatened. She was named on a couple of pro-life sites, as you know, a person of you know, what do you call like, you know, an antagonist kind of, on those sites.

Previous research has described the substantive role and power of social media in abortion activism. Kissling (2017, p.78) described how people discussing abortion (experiences) online "may not be prepared for the harassment, name calling, and even death threats that many who

[25] Consistent with earlier sections in this thesis, all descriptive statistics pertain to unweighted TAASS data, while predictor/regression statistics are provided in relation to weighted data.

speak out [about abortion online] are subjected to". Even though most young people I spoke with perceive low levels of abortion stigma among Australians broadly, abortion stigma enacted stigma by a 'religious' friend, family or community member, face to face or online, is commonly anticipated. The interview study indicates that the globalised nature and online presence of abortion stigma results in the widespread anticipation of abortion stigmatisation in Australia, irrespective of individuals' personal beliefs and experiences, and the beliefs held by their immediate social and familial groups.

Anticipation of abortion-related stigmatisation in health care settings was relatively low among TAASS participants, relative to in other contexts. Almost all survey respondents reported expecting abortion providers to be friendly and supportive. Around a third anticipated that abortion seekers may experience negative treatment from their regular healthcare provider or GP due to an abortion experience. Previous research has found the anticipation of negative treatment from healthcare providers results in healthcare avoidance, a preference for self-managed abortion, and even (attempted) self-induction of abortion using non-medical and often unsafe methods (Aiken et al., 2018; Bras et al., 2021; Broussard, 2020; Grossman et al., 2010; Harris, 2012; Kerestes et al., 2021). In contrast to TAASS findings, experiences of enacted stigma and discrimination described by interviewees occurred most often in healthcare settings. Interviewees who had abortion experiences spoke about attempting to actively manage and prevent enacted stigma through their disclosure, discursive and practitioner choices. However, they struggled to predict likely sources of stigma and thus to avoid stigmatisation during their abortion-seeking journeys. Two abortion seekers in the interview study reported avoiding their regular GPs when seeking abortion referrals. Both experienced judgment and denial or delays of care from the unknown GPs they had consulted, subsequently returning to their regular GPs where they received affirming, timely referrals, and care. Another interviewee described misinforming her doctor about her reasons for seeking an abortion, hoping to avoid an unpleasant interaction, later realising it was unnecessary. Within and beyond healthcare interactions, selective disclosure was described as a tool of self-determination and reproductive autonomy. While undeniably driven by anticipation of stigma, selective disclosure is protective against enacted abortion stigma (Cockrill & Biggs, 2018). It can offer young people a sense of control in contexts in which they may otherwise be at the mercy of complex and uncompassionate systems and practitioners. In instances where abortion seekers' control over abortion disclosures was limited or removed, they described experiencing judgment and discrimination from parents, educational institutions, and healthcare professionals. Therefore, the (health care) systems and referral processes for abortion seeking, and abortions seekers' ability to navigate these systems and maintain control over their abortion-disclosures, appear to be primary determinants of the likelihood and salience of experiencing stigmatisation. In contrast, enacted abortion stigma was rarely experienced outside of or after the abortion seeking process, or in interactions with abortion providers themselves.

8.1.2 Predictors and drivers of abortion stigma

The combined findings of this research provide insights into populations that are most likely to experience and be impacted by the stigmatisation of abortion in Australia. The findings also elucidate characteristics of adolescence that make it a pivotal stage for learning about, being enculturated into, or rejecting stigmatising abortion narratives (Earnshaw et al., 2022). "Abortion does not stigmatise individuals equally even within specific geographical locations, and stigmatising discourses and subject positions appear alongside those that are normalising and non-stigmatising" (Millar, 2020, p. 6). The impacts and experiences of stigma change across the life course and are likely to have differential impacts on health (Earnshaw et al., 2022; Hatzenbuehler, 2016). Similarly, the way stigma shapes trajectories to abortion care are likely to vary across locations and life stages (Strong et al., 2023).

Age, abortion-related beliefs and attitudes, and knowledge most strongly predict anticipated and perceived abortion stigma, as shown by TAASS. Other predictors include religiosity, political preference, abortion and parenting experiences, and sexism, although their relative predictive strength is negligible when other variables are held constant. The direction of some of the relationships between these variables and abortion stigma appear to differ significantly from the findings of prior research in other countries. In particular, the general trend of non-religious, pro-choice, and politically left-leaning people being most likely to anticipate abortion stigma, despite being least likely to perceive community stigma and having the highest levels of abortion-related knowledge, was unexpected. In line with prior research however, young people are most likely to experience and anticipate abortion stigma (Cockrill et al., 2013; Cowan, 2017; Deeb-sossa & Billings, 2014; Ekstrand et al., 2009; Kruss & Gridley, 2014; Makleff et al., 2019; Ushie et al., 2019), despite abortion-supportive attitudes and relatively high levels of abortion related knowledge.

The forms of abortion stigma measured by TAASS make the findings difficult to compare to previous community level abortion stigma research that has primarily measured stigmatising attitudes and beliefs. Regression analyses of TAASS data, and prior research finding correlations between religiosity, partisanship, and abortion attitudes, indicate that abortion attitudes and beliefs likely mediate and diminish the strength of the relationships between other variables and abortion stigma (Adamczyk et al., 2020; Jacobs et al., 2023; Osborne et al., 2022). In the absence of more directly comparable research findings, explanations for the unexpected quantitative results can be drawn from the qualitative research findings.

8.1.2A Religiosity, anti-abortion beliefs and abortion stigma

One potential explanation for the unexpected quantitative finding that pro-choice Australians are more likely than anti-abortion Australians to anticipate abortion stigma relates to the perceived sources of abortion-related judgment and harassment. Most interviewees believed that abortion related judgment and harassment were most likely enacted by people who were religious, older, and conservative. These beliefs align with the findings of research in the United States and New Zealand, which show that older age, higher levels of religiosity, and conservatism are negatively correlated with support for abortion (Osborne et al., 2022). For many interviewees, the perception that anti-abortion beliefs and stigma are concentrated among these specific communities was informed in part by seeing, in person or in the media, anti-abortion protestors and their religious anti-abortion messaging. Several young women described personal experiences with anti-abortion protestors. Chloe, for example, shared:

> when I was actually going through the abortion, like I think a week before I walked past an abortion clinic. And I know that because the protesters were outside, and that really hit me like when I walked past these protesters, and like, you know, with their fucking stupid signs, and like, I just, that really made me feel a lot of shame, I think.

In contrast, a study in the UK found anti-abortion protestors believe their own actions to be supportive and expressly *not* harassment, despite strong evidence of physical and verbal harassment of staff and abortion seekers (Lowe & Hayes, 2019, p.340). In Australia, “anti-abortion protesters have described themselves as sidewalk counsellors seeking to render assistance to women” (Sifris, 2018, p.320). Thus, interpretations of the intent of anti-abortion activism, at least in regard to anti-abortion clinic protestors, varies substantially. This may explain why Australians opposed to abortion are less likely than others to anticipate abortion-related harassment and judgment. This also raises questions about the measurement of abortion-related stigma, including harassment and discrimination, in research, given varying interpretations of anti-abortion activist behaviours. Further qualitative work to identify ways to effectively measure abortion stigma across groups engaged in abortion activism may be enhance the accuracy of future population-level abortion stigma measurement.

Another potential explanation for why anti-abortion Australians anticipate less abortion-related stigma and discrimination than their pro-choice counterparts lies in the global emergence of pro-woman narratives in anti-abortion discourse. These narratives frame women who have abortions as uninformed victims of abortion providers and coercive family members (Gleeson, 2017; Koralewska & Zielińska, 2022; Lambert et al., 2023; Osborne et al., 2022; Ziegler, 2013). This is evidenced on the website of the Australian Christian Lobby, Australia’s most prolific anti-abortion organisation, which states:

> Young women experiencing an unexpected pregnancy are also very vulnerable. The decision to end a pregnancy is a devastating one, with far reaching consequences for both the mother and of course, the unborn child (ACL, N.D.).

Finally, it is possible that people with anti-abortion views believe the commonality of abortion means it is socially unproblematic, explaining low levels of anticipated abortion stigma. There is a widespread myth that abortion is frequently used as a form of contraception. An article in the Sydney Morning Herald in 2012 characterised people who have more than one abortion as "reckless" and unchecked, labelling them "The terminators" (Berry, 2012). This anti-abortion narrative assumes that women often seek abortions without thought or social consequence. There are therefore a number of potential explanations for the relative lack of anticipated stigma identified among TAASS respondents most opposed to abortion.

8.1.2B Why young people anticipate abortion stigma

While TAASS found that young people were most likely to anticipate abortion stigma, the interviews indicate their anticipation of abortion stigma varies substantially based on social context and characteristics. While all interviewees regarded the stigmatisation of abortion seekers was likely, even inevitable, in particular socio-cultural contexts, they also all anticipated it was unlikely in others. Thus, a sense of universality around abortion stigma was rejected (Millar, 2020). Interviewees who had sought abortions described being most concerned about telling peers and family members who were religious, struggling with infertility, and/or pregnant about their abortion experiences, and anticipated broadly positive responses from all others. Those who had not had abortion experiences anticipated the stigmatisation of abortion seekers was unlikely in many settings and communities, such as among peers in university settings, among male and/or wealthy school communities, among non-religious family units, and in urban areas.

TAASS indicated that young people were particularly concerned about abortion related gossip, relative to the wider participant group: three quarters of young TAASS participants anticipated most abortion seekers are likely to be gossiped about, versus under half of participants aged 25 years and over. Young survey respondents were also more likely to anticipate abortion-related harassment and rejection from social and family groups than older participants. Young interviewees agreed that gossip was a likely response to abortion disclosure, even "guaranteed" as Gina described, particularly in school and university settings. However, it was not seen to be malicious, particularly concerning, nor generally anti-abortion in nature. In fact, gossip was described as common among even pro-choice peers and "liberal circles" (Camila), and something that would "cycle away pretty quickly" (Liv).

More serious/impactful harassment, discrimination and/or rejection related to abortion seeking was perceived to be less common, likely primarily in rural areas and where religious, or 'conservative'

values predominate. Two interviewees, Belle and Ellie, described experiencing and witnessing firsthand social and familial rejection, discrimination and religious excommunication as a result of abortion (and miscarriage) experiences.

Other interviewees were particularly worried about the potential for unwanted disclosure of abortion and related judgment or harassment and being ‘piled on’ when engaging in abortion-related dialogue online. Research has found that online abortion storytelling and disclosure are more likely to result in solely negative reactions than in-person disclosures (Woodruff et al., 2020). Online abuse is also used to threaten, harm, and attempt to deter abortion providers (McLeod et al., 2022a; Rosen & Ramirez, 2022a). Thus, socio-cultural context and setting (physical/online) mediate both the anticipated likelihood and severity of abortion stigma experiences.

Previous research identified that having had an abortion experience is associated with lower levels of perceived abortion stigma (Rice et al., 2017, Shellenberg and Tsui, 2012). In TAASS, less than one in 10 young people (aged 16-24 years) reported having had abortion experiences, compared with around a third of participants aged 25 years and over. Abortion experience emerged as a significant predictor of perceived but not anticipated abortion stigma. Interviewees indicated their abortion experiences were often protective against perceived *and* anticipated stigma: positive healthcare experiences and positive reactions from friends, family and others were described as normalising experiences that reduced stigma. The relationship between abortion experience and stigma experiences thus warrants further research.

The interviews described a range of factors that together create a particularly enabling environment for abortion stigma experiences among young Australians. Interviewees described receiving no formal education about abortion in school, and very limited education about abortion in health-related University-level courses. This aligns with research that has found that abortion is treated as exceptional to other forms of reproductive health care and is rarely addressed in Australian medical/health training programs (Millar, 2023; Mollen et al., 2018). Interviewees also reported having limited to no exposure to Australian abortion-related news and media content, along with a sense of avoidance or awkwardness among teachers, parents, and news presenters when referring to abortion. This perceived ‘silence’ about abortion (in Australia) was juxtaposed with, and appeared to be filled by combative, emotive, and unrepresentative abortion discourse and debate, often originating from the US, that interviewees saw online. Stigmatising narratives were imported and often uncontested by more trustworthy or locally relevant sources.

8.1.2C Abortion stigma in the Australian socio-political context

Characteristics of the Australian social, cultural, and political context likely explain contradictions between some TAASS findings and US abortion stigma research. Abortion is not apolitical in Australia (Baird & Millar, 2020; Coleman, 1988), yet abortion beliefs and attitudes are more supportive of abortion and less divided along partisan lines than in the US (Baird & Millar, 2020; Blazina, 2022; Center, 2022; Osborne et al., 2022). TAASS findings confirm this. Abortion has been described as a primary predictor of voting preference and political ideology in the US (Osborne et al 2022). “This is in contrast to Canada, the UK, Australia, and New Zealand where there is broad popular support for liberal access to abortion… and anti-abortion movements are largely distractions rather than major political forces” (Millar, 2017, in Baird & Millar, 2020, p. 2). Interviewees in this research described an awareness that abortion is more contested and politicised in the US than in Australia. Australia is therefore not unique in its contrast to the US, with many other high-income countries similarly experiencing decriminalisation of abortion and increased public provision and public support for abortion (Berer, 2017; Norris et al., 2020). It is in fact the withdrawal of legal and practical access to abortion care and rights in the US that goes against global trends (Kaller et al., 2023; Ralph, 2022). Findings from TAASS, while unexpected based on previous abortion stigma research, undoubtedly reflect the attitudinal, legal, and political Australian context. Given the strong link identified in TAASS between abortion beliefs/attitudes and stigma, generalising US-based research beyond the US, despite the American domination of abortion-related research and discourse, is therefore problematic. In contrast, this research, as one of the first studies of its kind in a high-income country context outside of the US, may be useful in understanding abortion stigma in countries with shared legal and political characteristics.

8.1.2D Class, financial privilege, identity and abortion stigma risk and avoidance

This research occurred over a period of seven years, during which time I have witnessed significant evolution in (abortion) stigma theory. The first part of this research primarily identifies individual level predictors of abortion stigma. TAASS found that country of birth and Aboriginality, described variably as a race, descent, and/or a shared cultural identity (Australian Law Reform Commission, 2010; Williams, 2014), are not meaningful predictors of anticipated and perceived abortion stigma in Australia. However, it offers limited insight into the interaction between socio-economic status, class, and other forms of marginalisation with abortion stigma. In contrast, interviewees referred, unprompted, to the role of financial privilege, social capital, and markers of class in determining abortion and abortion stigma experiences. They described wealth as enabling timely access to abortion care, discretion, and avoidance of unwanted disclosure, in line with research in the US (Biggs et al., 2023). A male school student spoke about the ability of his financially privileged male peers to deny paternity and to buy girls’ silence, should they ever be involved in the conception of a pregnancy. Middle-class narratives and norms prioritising education and careers offered discursive tools to abortion seekers to construct their abortions as morally

sound and thus protecting them against irresponsibility stereotypes (Belfrage et al., 2022; Hoggart, 2017; Love, 2021). Chloe's story, however, reflects what Walkerdine (2003) has described as tensions between middle-class values of conservative femininity, the value placed on striving for upward class/financial mobility, and creating identities of success in neoliberal capitalism. Chloe talked about experiencing internalised, perceived, anticipated, and enacted abortion stigma as her two abortion experiences conflicted with notions of respectability, contraceptive responsibility, and success. Several young women expressed expectations that financial privilege and knowledge should enable the avoidance of teenage pregnancy. Therefore, while abortion can facilitate the middle-class goal of upward mobility, it also symbolises irresponsibility and fecklessness (Saunders, 2021). Chloe's experience illuminates the complex interactions and ongoing relevance of research into the embodiment of classed identities and neoliberal norms (which promote individualised responsibility and blame for health experiences), socioeconomic status, and abortion stigma. It appears that while the material consequences of stigma may be particularly salient for people facing financial or social marginalisation (see Chapter 3 Section 3.4.5), identity-related impacts may be particularly relevant to middle-class abortion seekers.

Identification with class among the general population has declined significantly yet understanding and interrogating the ways people come to understand and manage themselves as responsible neoliberal[26] subjects still have relevance in stigma research (Scambler, 2018; Walkerdine, 2003). This research has demonstrated financial capital and class are understood (by young Australians) to drive and mediate various abortion stigma experiences, this requires significantly more research attention. Whether class or other classifications of privilege and oppression, are most useful to understanding the abortion stigma concept and experience are yet to be determined. Furthermore, research exploring the experiences and perceptions of abortion stigma among socially and economically marginalised Australians is needed.

8.1.2E Sex, gender, and abortion stigma

Last but certainly not least, the quantitative and qualitative components of this research found variable results regarding relationships between sex and gender with abortion attitudes and stigma experiences. The Australian Abortion Stigma Study identified that sex is not a significant predictor of either anticipated or perceived abortion stigma. In contrast, the interview study indicated that gender may be an important determinant of young peoples' exposure to normalising abortion narratives, their ability to resist and avoid abortion related stigma and discrimination, and of their likelihood of anticipating and perceiving abortion related stigma. Young men's narratives rarely included descriptions of diverse and normalising abortion-related conversations with family members or peers, which were common in young women's stories. Furthermore, absent from most

[26] Walkerdine (2003, p.239) defines, "the neo-liberal subject [as] the autonomous liberal subject made in the image of the middle class".

young men's experiences were concerns about experiencing abortion stigma or discrimination if they were involved in the conception of a pregnancy that resulted in abortion. In contrast, the anticipation of abortion stigma was almost universally present in women's accounts.

Quantitative findings pertaining to the relationship between sex, gender, and abortion stigma in the global literature are ambiguous (Osborne et al., 2022). Studies in the US have found males are more likely to experience negative responses to abortion disclosures and to hold stigmatising attitudes towards abortion than females (Cowan, 2017; Cutler et al., 2021). Similarly, global and longitudinal research has found that women tend to hold more abortion supportive attitudes than men (Carter et al., 2009; Loll & Hall, 2019). A suite of other research has identified small and inconsistent differences in abortion attitudes by gender (Osborne et al., 2022). Researchers have noted the unexpectedness of variable and inconsistent findings related to the intersections of gender and abortion stigma, given the gendered nature of the norms and narratives that underpin abortion stigma (Osborne et al., 2022). It is widely agreed that gender norms and stereotypes fundamentally underpin abortion stigma, and the power inequities that facilitate and drive it (Opondo, 2022; Osborne et al., 2022). This is evident, for example, in the narratives of women who have had abortions who construct narratives of abortion as enabling loving, inevitable motherhood (Becker, 2019; Kumar et al., 2009; Opondo, 2022). It is further evidenced in the strong correlations identified between gender role attitudes and sexism with abortion attitudes and stigma (Osborne et al., 2022; Wu et al., 2023). As well as being a symptom and tool of gender inequities, abortion stigma has also been described as weakening progress on gender equality by undermining the inclusion of abortion related activities in international efforts to address gender inequity (Hessini, 2014). There is a need to establish a more comprehensive evidence base in regard to the mechanisms and intersections through which gender, sex, and abortion stigma intersect. Without this knowledge, and without addressing gender inequity broadly, abortion stigma prevention and mitigation efforts will likely struggle to achieve sustainable and widespread change. As Goldberg (2017, p.478) described, health stigma "will not be resolved through individual encounters because such encounters do not address the social structures that fuel and sustain stigma".

8.2 Implications for theory, intervention, and research design

This research offers valuable contributions to the development and refinement of abortion stigma theory, and may be valuable in informing health practice, intervention design, and future abortion stigma research. These contributions are articulated in the following sections.

8.2.1 Theory

The first contribution of this doctoral research to abortion stigma theory pertains to how we understand the very nature of abortion stigma. The research findings support efforts by Parker and Aggleton (2003), Scambler (2018), Love (2018), and Millar (2020), among others, to reconceptualise (abortion) stigma as a social process that is primarily enacted and maintained via socio-political structures, systems, norms, and narratives. In 2006, Campbell and Deacon described stigma as, "a quintessentially social psychological topic: a phenomenon rooted in the individual psyche, yet constantly mediated by the material, political, institutional and symbolic contexts referred to above" (Campbell & Deacon, 2006, p.416). Abortion stigma has also been described as a "product of interaction" (Smith et al., 2022, p.890) that is locally produced and reproduced and shaped by contextual factors (Cockrill & Hessini, 2014). I would argue that instead, abortion stigma is primarily formed, perpetuated, and enacted at the level of politics, institutions, systems, and meta narratives and mediated by individual characteristics, experiences, beliefs, capital, and interpersonal interactions. The interview study demonstrates how abortion stigma manifests and is resisted through interpersonal encounters, and how these encounters mediate the salience of stigmatising abortion narratives that are driven by and enacted within social discourses, norms, laws, and health systems. Social discourses and norms are undeniably being shaped by the priorities of transnational (pro- and anti-) abortion activists via social media, which is further changing the very nature of 'interpersonal' interactions and their power in the stigma process. The limited predictive strength of the multivariable models identified via TAASS and previous quantitative abortion stigma research (such as Sorhaindo et al., 2016), suggests there is a suite of factors beyond the individual influencing one's likelihood of experiencing anticipated and perceived abortion stigma. This research supports a future focus on incorporating, understanding, and addressing the macro/socio-political elements of abortion stigma.

The risks of not shifting to more socially and structurally focused and intersectional conceptualisations of abortion stigma include a lack of knowledge about, and an inability to harness, the power of institutions, systems, and political structures to prevent, resist, and undo the harms caused by abortion stigma. Abrams (2014, p.300) framed the perpetuation of "a culture of deviancy around abortion" as the result of a lack of acknowledgment in US political discourse of the commonality of abortion. Thus, political discourse has the power to both stigmatise and normalise abortion at the level of laws, policies, and discourse (Melville, 2022). In contrast to this, Saunders notes that under neoliberal capitalism, individuals are held responsible for their reproductive health experiences (Saunders, 2021). Abortion is positioned as rare, a symbol of irresponsibility and 'working classness', and thus deserving of differential treatment, regulation, stigmatisation and even punishment, reducing empathy and compassion (Saunders, 2021; Scambler, 2018). Individualising abortion stigma "may serve to reinforce an autonomous neoliberal subject, erasing the forms of inequality that position us differentially in relation to reproductive

choices and outcomes" (Millar, 2020, p.6). Furthermore, failure to conceptualise abortion stigma intersectionally is likely to mean we are unable to effectively "respond to multifaceted attacks" on abortion, gender and sexuality, and reproductive rights (Ross, 2017, p.292).

The second contribution of this research to abortion stigma theory, and stigma theory more broadly, is that it presents a case for the inclusion of anticipated and perceived stigma as distinct experiences or domains. With distinct and conflicting response patterns and predictors, when conflated into a single category of 'felt' or 'perceived' stigma, stigma theorists and researchers risk conflating and confusing mechanisms and impacts of abortion stigma. In turn, research and frameworks that rely on this evidence-base will inevitably lack accuracy, undermining their value in informing policy and practice. This distinction between these domains of abortion stigma has been reported, though not explicitly named, in prior abortion stigma research (Cockrill et al., 2013; Cutler et al., 2021) and articulated in the wider stigma literature (Earnshaw & Chaudoir, 2009; Moore et al., 2013; Quinn & Chaudoir, 2009; Turan et al., 2017). Parker and Aggleton (2003, p.14) noted,

> While it is important to recognize that stigma and discrimination are characterized by cross-cultural diversity and complexity, one of the major factors limiting our understanding of these phenomena may well be less their inherent complexity than the relative simplicity of existing conceptual frameworks.

Increasing the complexity of conceptual frameworks of abortion stigma will ensure they more closely reflect the complexity of the stigma concept. They will in turn inform the development of increasingly specific research measures and enhance the translation of research findings into effective intervention and practice (Turan et al., 2017).

8.2.2 Interventions

As shown in the interview component of this research, elements "of abortion circulate in the social sphere and are absorbed by individuals regardless of their specific identities" (Baker et al., 2023, p.39). Thus, to be effective, prevention efforts should seek to identify and address the "socio-historical and political forces that produce stigmatising categories" and facilitate the stigmatisation of abortion in systems (Millar, 2020, p. 6; Brown et al., 2022). To counter the socially-constructed narrative of non-normativity underpinning the exceptionalisation and stigmatisation of abortion, normalisation is a – or perhaps the most – critical element. "Normalisation is a pivotal piece of the power/knowledge structure, because it supersedes a system of law or personal power. Norms are established by social institutions for social cohesion, the creation of wealth, and the establishment of knowledge" (Foucault, 1977 and Foucault, 1978 in Crawford, 2022, p.91). I propose several recommendations for abortion stigma interventions and normalisation in health and education

systems and the media that avoid placing the onus of stigma resistance and reduction on stigmatised abortion seekers and providers.

Firstly, in contextualising these recommendations, it is vital to note the dearth of structural-level abortion stigma interventions involving laws, policies and/or institutions (Sorhaindo & Loi, 2022). To date, abortion stigma interventions have been primarily interpersonal and educational in nature, addressing attitudes, knowledge, and empathy, offering counselling and peer support for abortion seekers and/or providers, and encouraging storytelling (Sorhaindo & Loi, 2022). There have been no abortion stigma intervention studies in high-income countries beyond the US and Spain (Sorhaindo & Loi, 2022). Individualistic stigma interventions have been described as "surface level", failing to address complex processes of identity formation, and "the structures of inequality" to which stigma is bound (Millar, 2020, p. 5; Parker & Aggelton, 2003; Tyler & Slater, 2018). Individual level and attitudinal stigma interventions have been shown to fail when conducted in environments with high levels of structural stigma (Reid et al., 2014, in Hatzenbeuhler, 2016). While community-level and equity-based approaches to abortion stigma are undeniably needed, focusing solely on the population groups most impacted by abortion stigma risks perpetuating individualistic approaches that make the stigmatised responsible for stigma reduction ((Braveman 2014; Hatzenbeuhler 2016; Morgan et al., 2021; Parker & Aggleton, 2003).

As expected, this research indicates there is a strong relationship between abortion beliefs and attitudes with abortion stigma in the Australian context. Unexpectedly, anticipated stigma is most common among Australians with pro-choice beliefs. Perceived stigma was found to be substantially less common than anticipated stigma and is therefore unlikely to be a priority for abortion stigma interventions in Australia.

8.2.2A Simplifying abortion care pathways to minimise stigmatising experiences

This research supports calls for health system reform pertaining to abortion provision, which is likely to influence abortion stigma (Children by Choice, 2022b; Commonwealth of Australia, 2023; LaRoche et al., 2021; Makleff et al., 2019; Mazza, 2023; Millar, 2023). Structural stigma has been shown to impact the accessibility and quality of health care (Livingston, 2020). The provision of abortion care in Australia has been described as fragmented, inconsistent, and inequitable (Commonwealth of Australia, 2023; Mazza, 2023; Melville, 2022). The simplification of complex abortion pathways through the provision of ready access to discreet, affordable, and timely abortion services, referrals, and necessary tests would likely reduce exposure to enacted stigma.

Interviewees' narratives, and research in the US, indicate that autonomy over abortion disclosures is protective against experiences of interpersonal-level enacted stigma (Cowan, 2017). As in previous Australian research, interviewees in the current study described how the abortion seeking experience, including seeking referrals and navigating multiple appointments and conscientious

objectors, exposed them to judgment and denial of care (Cleetus et al., 2022; Deb et al., 2020). In contrast, health professionals directly involved in abortion provision were described as non-judgmental and affirming, normalising abortion and undermining abortion stigma. The provision of abortion in all major public hospitals is therefore one way to improve equity of access to, and to simplify, abortion care pathways, as recommended by the recent Senate Enquiry into universal access to reproductive health care (Commonwealth of Australia 2023). Access to dedicated abortion and sexual and reproductive health clinics can similarly be protective against stigmatising experiences for abortion seekers and providers[27,28] (Cashman et al., 2021; Cleetus et al., 2022; Jennifer Dressler et al., 2013; Gallagher et al., 2010; LaRoche et al., 2021a). Access to free or affordable abortion services is vitally important for young people who may otherwise be reliant on caregivers as gatekeepers to money and other forms of material support, and others facing financial and logistical barriers to SRH care access and autonomy (Children by Choice, 2022b; Doran & Hornibrook, 2016; Shankar et al., 2017; Sifris & Penovic, 2021).

Online maps of abortion supportive healthcare providers may also help to mitigate abortion stigma and its impacts. Online maps of health services offering abortion services and referrals currently exist in Queensland and Victoria (Children by Choice, 2022b; 1800MyOptions, 2023). Over a third of TAASS participants anticipated abortion seekers may be treated poorly by their regular healthcare providers due to an abortion experience. Interviewees described avoiding and lying to regular health providers due to uncertainty about their abortion views. Resources that support the identification of pro-choice health providers may therefore reduce the anticipation of stigmatisation in health care settings, health care avoidance, and experiences of enacted stigma and discrimination.

8.2.2B Abortion normalisation through the media

A recent review of the structural determinants of stigma (broadly) identified the media and marketing as key determinants of stigma that may be amenable to public health intervention (Bolster-Foucault et al., 2021). Activists commonly use mass media to engage with “niche audiences… develop collective identity… to effect cultural change and improve their political legitimacy” (Rohlinger, 2019, p.132). The media is already a key site of abortion stigma resistance and offers immense opportunities for interventions and activities to this effect (Kissling, 2017). In *From a Whisper to a Shout,* Kissling (2017, p. 77) argues that visibility and reach of positive and

[27] The literature review also showed that abortion and sexual and reproductive health specific clinics/services, particularly where protestors are not present - in Australia this is due to safe access zone laws - are also protective against stigmatisation for abortion providers (Bennett 2021; O’Donnell et al., 2011; Summit et al., 2020; Harris et al., 2011).
[28] The World Health Organization (2022) recommends the integration of abortion and other SRH services where possible.

pro-choice abortion-related content on social media achieves “the first step of changing the cultural narrative”, making “it harder to ignore abortion” and replacing norms of silence around abortion.

Interviewees described diverse forms of media as sites of both abortion stigmatisation and abortion normalisation and stigma resistance. Embedding normalising abortion narratives from diverse narrators across all media platforms and formats may help to challenge anti-abortion, US-based, combative abortion content and stigmatising social norms, stereotypes, and myths that are prevalent and perpetuated online (Baird & Millar, 2019; Belfrage et al., 2022). Several interviewees spoke about exposure to normalising discourses on social media and in the news, television, and movies as underpinning their understandings about the social acceptability of abortion from a young age, as has also been described by Danner (2022). Research has found that exposure to media content about abortion can lead to improvements in abortion-related knowledge and comfortability with abortion, but the impact is mediated by pre-existing belief systems and cultural norms (Sisson & Kimport, 2017). Interviewees described conversations about abortion among families and peer groups that occurred in (or even before) the early teenage years that appear to be formative and protective against internalised and anticipated stigma. Therefore, exposure to normalising abortion media content at younger ages may be particularly effective in generating normalising beliefs, perceptions of, and norms associated with abortion.

8.2.2C Locating stigma reduction efforts in educational settings

High/secondary school and university settings may serve as critical sites for abortion stigma intervention. The qualitative phase of this research suggests it is in these settings that young people learn about abortion norms and discourses and begin to anticipate and perpetuate abortion stigma, even in the absence of formal abortion-related education. In fact, multiple interviewees described a lack of formal acknowledgement of and education about abortion in school and university settings as evidence of the stigmatisation of abortion stigma in Australia. Research has found that the teaching of abortion in medical higher education in Australia as unstructured, not standardised, insufficient, aligning with interviewees experiences (Millar, 2023, p.1; Cheng et al., 2020). It is often primarily focused on ethical and legal considerations and singled out “from other areas of medicine on the grounds that it is special, different or more complex or risky than is empirically justified, representing a form of ‘stigma-in-action’” (Millar, 2023, p.1; see also Cheng et al., 2020). Sex education in schools has similarly been described as inconsistent and does not commonly include education about abortion (Ezer et al., 2022; Ezer et al., 2019). Interviewees pointed out that failure to sufficiently address abortion in formal educational settings perpetuates narratives of abortion as non-normative and contested, leaving knowledge gaps that are often filled by unreliable, biased sources.

Interviewees described that the times around their first sexual experiences, along with during and after a pregnancy scare, were when they often first researched or talked with peers or partners

about abortion. Australian data indicates that over a third of high school students have had sexual intercourse by Year 10 of high school (Fisher, 2019). High schools are therefore an optimal site for the establishment of abortion normalising narratives.

8.2.2D Responding to the weaponisation of abortion stigma by the anti-abortion movement

The role and 'weaponisation' of fear and stigma in legitimising and justifying the activities and goals of anti-abortion groups is being increasingly recognised (Cullen & Korolczuk, 2019; Millar, 2020; Norris et al., 2011; Scambler, 2018). The extent of anticipated abortion stigma relative to the extent of stigmatising attitudes identified in TAASS shows the reach and pervasiveness of anti-abortion messaging. As one interviewee Natalia described, "I think, the anti- anything are always the most vocal in things. Even though potentially they are the minority…". In TAASS and globally, strong anti-abortion sentiments have been found to be isolated primarily among people who identify as pro-life and are moderately or highly religious (Baker et al., 2023, p. 47). Nevertheless, the anti-abortion movement has seemingly achieved a level of social control via the normalisation of stigmatising abortion beliefs, laws, policies, and health systems (Foucault, 1980, in (Crawford, 2022). US adults were recently found to endorse judgment and discrimination against abortion seekers, whose mistreatment they deemed an appropriate response to the perceived violation of law, gender roles and religious doctrine that abortion was believed to represent (Baker et al., 2023). Interviewee Belle described how, "some of my friends have been harassed by a lot of like pro-life people [online] as well, and it's like, the fear tactics that they use I think might be ingrained a little bit as well. Even if we choose not to listen to them, I think subconsciously there might be something there." As a result, interviewees described avoiding engaging in abortion-related dialogue, from both pro-choice and anti-abortion perspectives. The notion of abortion as contested effectively silences diverse voices and reduces the potential of productive and nuanced abortion-related conversations. In response, intentional efforts to counter stigmatising narratives are needed.

Bauman (2006) described three kinds of fears, all of which appear to be weaponised by the anti-abortion movement and reflected in perceived and anticipated abortion stigma: "those that pose a threat to our bodies and wealth, those that endanger the social order, and those that can undermine our position in society and the hierarchy" (in Matera & Matera, 2022, p. 456). Both anti-abortion and pro-choice social movements have been shown to intentionally target messaging associated with these fears to garner support from community members based on the unique concerns and priorities of different population groups (Molek-Kozakowska & Wanke, 2019). However, given the role of abortion stigma in upholding the status quo, including pertaining to gender inequity and the individualisation of blame and responsibility for health, anti-abortion messaging is likely to hold particular social and cultural power (Scambler, 2018). In response, social and class mobilisation and activism have been described as necessary pillars of (abortion)

stigma alleviation efforts (Millar, 2020), though Scambler (2018) points to the challenges of achieving this in neoliberal societies. This is reflected in abortion seekers' framing of their experiences of relatively easy access to abortion care as a privilege rather than a right. Without widespread recognition of abortion care as a right, and when the internalisation of narratives associated with (ir)responsibility and abortion are widespread, extensive community advocacy for improved abortion access, for example, is unlikely.

Other areas of stigma intervention research indicate that approaches that are multi-level, operate across the life-course and begin at a young age, influence mass discourse, cultural norms, systems, and policy are likely to be most impactful (Brown et al., 2022). The vigour with which the anti-abortion movement weaponises abortion stigma must be matched by similarly intentional approaches to abortion normalisation. Normalisation can occur through non-negative framing of abortion as non-exceptional. This can be enabled by and reflected in the alignment of laws and policies related to abortion with other forms of pregnancy and reproductive health care, and widespread provision of abortion care in the public health system. It can also involve removal of barriers to medication abortion prescription, better management of conscientious objection to abortion provision, and standardised education about abortion in school-based and (relevant) higher education curriculums (Maxwell et al., 2021; Mazza, 2023; Melville, 2022; Purcell et al., 2020).

8.2.3 Research

This research raises a multitude of questions that require further investigation. Many of these research questions are posed in the previous discussion sections, Chapter 6 Section 6.6 and Chapter 7 Section 7.3. Significant gaps remain regarding our understanding of the abortion stigma experiences among youth and adults from a range of cultural and religious groups, of lower socio-economic status, and experiencing intersectional stigmas and marginalisation in Australia. Conflicting findings in TAASS related to the direction of relationships between knowledge and stigma variables require more detailed exploration and analysis, as the reason some knowledge questions predicted different stigma outcomes than others remains unclear. More advanced statistical modelling to identify mediators/relationships between predictors of abortion stigma, and qualitative research exploring the role of knowledge in abortion stigma formation in the Australian context may be particularly valuable.

More broadly, abortion stigma intervention research is needed in Australia where there has to date been none, along with intervention research globally in regard to systemic and other structural abortion stigma interventions. A focus on intersectional and justice focused abortion stigma research will align the abortion stigma evidence base with structural conceptualisations of stigma,

and the increasingly influential Reproductive Justice paradigm. There is limited evidence that structural abortion stigma research and conceptualisations have as yet been translated into policy, practice, and intervention design (Sorhaindo & Loi, 2022). Growing this evidence base would not necessarily require the development and testing of abortion stigma-specific interventions. Rather, they could include evaluating the impacts of existing activities, like online abortion provider maps and the planned integration of abortion education more broadly in medical education in Australia, on abortion stigma (Ratcliffe, 2022).

A journey to the heart of abortion stigma in Australia

This research highlights a suite of predictors of anticipated and perceived abortion stigma in Australia, however the relatively low predictive strength of the statistical models indicates there are a range of factors it did not account for. Broader stigma research has identified a range of predictors that warrant consideration in future abortion stigma studies. These include reproductive autonomy, geographical location and dimensions of neighbourhood advantage and disadvantage, socio-economic status, and class (identities and material components) (Cockrill et al., 2013; Cowan, 2017; Hatzenbuehler, 2016; Love, 2018; Mehta et al., 2019; Saxby et al., 2020; Shellenberg et al., 2011). The interviews suggest social media use, family-level religiosity and migrant status may influence stigma formation, experiences, and salience. An examination of the way "institutional forces such as racism, sexism, colonialism, poverty" as well as "immigration status, ability, gender identity, carceral status, sexual orientation, and age… influence people's individual freedoms in societies", their access to reproductive health care and experiences of abortion stigma is also needed (Ross, 2017, p.291). As Strong, Coast and Nandagiri (2023, p. 16) describe, "the lack of an intersectional lens in current abortion stigma conceptualisation exacerbates" tensions between simplistic abortion stigma conceptualisations and measurement tools with the complex reality of abortion stigma.

This research identified different response patterns between and predictors of anticipated and perceived abortion stigma. This indicates the importance of considering a wide array of predictors in quantitative abortion stigma research, as well as assessing multiple domains/forms of abortion stigma in individual abortion stigma studies (Cutler et al., 2021). Furthermore, it demonstrates the importance of moving beyond measuring stigmatising attitudes as a proxy for abortion stigma experiences. Domains of abortion stigma (i.e., internalised, anticipated, perceived, enacted) co-exist and influence each other (Cockrill et al., 2013). Identifying differences and relationships between various stigma experiences may be particularly helpful in specifying the mechanisms of stigmatisation that result in particular outcomes, and in priority setting for further research and practice (Quinn & Chaudoir, 2009; Turan et al., 2017). This can be achieved through the use of multiple tools in a single study, or the development of tools that measure multiple domains of abortion stigma (Cutler et al., 2021).

Measures of abortion stigma have recently been developed that distinguish among anticipated sources, frequency, centrality, and salience of stigma experiences (Quinn & Chaudoir, 2009; Ratcliffe, 2023). Ratcliffe (2023) developed tools to measure abortion stigma experiences within a range of participant groups that assess both the frequency and salience of various stigma experiences. Questions such as, "have you experienced X?" followed by, "how impactful was it?" can be asked in regard to all domains of abortion stigma. Such tools are complex yet helpful in understanding the salience of various elements of stigma. Furthermore, as described in Chapter 6, future quantitative research using more complex statistical analysis methods, such as causal mediation analysis or structural equation modelling, would be valuable in elucidating the interactions and mediating relationships among predictors to further highlight intervention priorities (for example, see: MacKinnon & Pirlott, 2015; Quinn & Chaudoir, 2009). Not enough is known about how to eliminate stigma in health care, and the pathways to, role and interaction of sexual and reproductive health stigmas and inequalities (Hussein & Ferguson, 2019). "If the elimination of stigma and discrimination is to become a public health imperative" (Hussein & Ferguson, 2019, p. 4) a more detailed understanding of these elements of abortion and sexual and reproductive health stigma processes is essential.

Finally, as mentioned in the introduction (Chapter 1 Section 1.6), the adoption of gender inclusive language when researching and discussing abortion has been slow in the research and academic realms. At the time the TAASS was developed, using "women" only language was the norm. However, the recent development of a suite of validated abortion stigma measurement tools (Ratcliffe 2023) establishes a precedent for gender-inclusive language in abortion stigma research. Furthermore, recent research suggests gender and sexual diversity are highest among young abortion seekers (compared with older abortion seekers, in the US) (Chiu, 2023). Moving forward, I encourage anyone who seeks to use TAASS or develop new abortion stigma measurement tools to consider replacing the word "women" with "people", or appropriate variations, and to avoid assuming heterosexuality in research and survey questions (Australian Bureau of Statistics, 2020b). Gender and sexuality inclusive language in abortion stigma research is critical to facilitating the collection of accurate data regarding abortion seekers and stigma experiences (Chiu, 2023). Its use will help to ensure abortion stigma research reflects the experiences of all abortion seekers, in turn equipping policy makers and health professionals with the evidence needed to develop more inclusive policies, services, and practice.

8.3 Methodological reflections

In this section I reflect on my experience of 'going viral' during recruitment for TAASS, and the implications for my wellbeing and for the conduct of online research more broadly. I then describe key aspects of my experience interviewing young people, the role of sensitive interviewing

techniques, and my attempts to redistribute power from myself as an interviewer to young interviewees and the challenges associated with this.

8.3.1 The experience of 'going viral'

Undertaking TAASS introduced me to a suite of relatively unique academic, personal, and ethical challenges related to 'going viral'. Going viral and the resulting dataset was unprecedented (at least among my supervisory team and University), and I was unprepared for it. It was not entirely unanticipated, however: my own anticipation of stigma related to my abortion stigma research meant I had acknowledged the possibility of experiencing backlash online, thus keeping myself anonymous on all study materials prior to recruitment. Given a lack of published accounts of similar experiences among researchers, I wrote a paper about the experience and its implications for researchers and research institutions, parts of which are included in this section (Vallury et al., 2021)[29].

As described in Chapter 4, the Facebook advertisement used to recruit participants for TAASS was shared thousands of times across Twitter and Facebook. This resulted in hundreds of disparaging comments and emails by both proponents and opponents of abortion, and a Freedom of Interest request submitted to the University by members of The Australian Christian Lobby. As a student, my name and most of the information requested was redacted, however the names of my supervisors and email communication between myself and my supervisors were provided, some of which were later published online by the ACL (Brohier, 2020). Coordinated attempts - as occurred with TAASS - by the ACL to undermine rights and evidence-based laws, policies, and programs, such as those pertaining to abortion, contraception, and LGBTQIA+ rights, are not uncommon in Australia (Maddox, 2014, 2021; Davey, 2016a, 2016b).

The speed and extent of recruitment achieved as a result of going viral led to a number of challenges. I was unprepared to manage, practically and emotionally, the hundreds of hostile emails that were received within a few days. Furthermore, safety concerns arose pertaining to best practices for keeping safe online and preventing disclosure of my personal details and home address. My supervisors and I were unsure about the precautions that ought to be implemented offline, or additional strategies likely to be used by lobby groups, and the University was unable to provide support in this regard. While it was deemed unlikely that the online harassment would translate into in person harassment or violence, a history of hostile activism and violence against abortion providers and supporters by anti-abortion activists, both locally and abroad, contributed to heightened anxiety and fear throughout the experience (Allanson, 2006; Sifris, 2018; Tozer, 2002). Glenza (2021) described the anti-abortion movement in the US as radicalised and posing an

[29] This paper was awarded a prize for the "Best HDR Student Publication 2022" at Flinders University.

increased threat. Similarly, the decriminalisation process and surrounding anti-abortion campaign occurring in South Australia, where the research team was located during the time of the research, increased perceived risks.

There is very little published material that describes similar experiences of other researchers. One US academic, Joshua Cuevas, has written about his experiences of online harassment in the hopes of giving a “voice to others who have been similarly harassed” (Silavent, 2018, n.p.; Cuevas, 2018). He stated, in a media interview, that after sharing his story he received “emails from more than 60 professors from all over the world telling stories of their own” (Silavent, 2018, n.p.). Research has found that “harassment often arises in spaces known for their freedom, lack of censure, and experimental nature” (Herring et al., 2002, p.374, in Lumsden, 2017). This suggests there is particular risk for academics who are inherently working in ‘experimental’ spaces (i.e., conducting research) *and* who may be conducting research with, or be members of, marginalised communities themselves.

Cyber bullying and harassment result in negative social, mental health, physical health, financial, and occupational consequences for victims, and these impacts are more commonly experienced by minority or marginalised individuals and communities, including women (Cassidy et al., 2015; Cuevas, 2018; Jenaro et al., 2018; Peled, 2019; Vaill et al., 2021). There are increased risks associated with conducting research on politically contested or otherwise sensitive topics, which are characteristic of many areas of health research (Dickson-Swift et al., 2007). Yet such risks, and particularly their relevance in online settings, have been insufficiently acknowledged in literature, policy, or practice (Vallury et al., 2021).

Attempts to prevent and undermine my research by attacking the research methodology and the research team’s legitimacy reflect the use of abortion stigma as a tool of anti-abortion advocates to prevent pro-choice, normalising abortion discourse, research, and outcomes[30]. Anticipated stigma resulted in my decision not to include my own and my supervisor’s names on study materials, which impacted the perceived legitimacy of the research and potentially dissuaded some potential respondents. Furthermore, the vitriol I experience when TAASS went viral triggered Generalised Anxiety Disorder which I still live with today. Enacted stigma meant I was unable, for health reasons, to participate in media interviews about the research, despite numerous requests from media outlets, effectively silencing evidence-based dialogue. The mental health, financial, and professional impacts I have experienced and continue to experience, three years later, due to the ACL’s anti-abortion lobbying behaviours speak to the salience of abortion stigma beyond abortion seekers and providers.

[30] Such intent was explicitly acknowledged in social media comments and emails to the study email address and the Social and Behavioural Research Ethics Committee.

For Joshua Cuevas, online attacks by white supremacists similarly had personal and professional implications. Cuevas reflected that,

> academia has been too timid in countering such movements. We should not have to speak in hushed tones when we condemn hate groups. We should not have to be apprehensive when we promote democratic ideals and equality (Cuevas, 2018, n.p.).

The opportunities created by 'going viral', in particular the very large dataset obtained, cannot be understated. Even so, acknowledging that this immense privilege came with sacrifice, due to the stigmatised nature of the research topic, is essential to a reflexive research process, and to informing understandings of abortion stigma experiences. Recommendations I developed in response to this experience, primarily for universities and other research organisations, are provided in the full paper (Vallury et al., 2021) in Appendix R.

8.3.2 Reflections on feminist and sensitive interviewing

In conducting the qualitative component of this research I actively worked to make the "research more accessible to people by bridging the distance between the researched and the researcher" (Rayaprol, 2016, p. 384). Holding a conscious awareness of and attempting to minimise power hierarchies during the interview process, in line with feminist research methodologies, is of particular importance when conducting interviews with young people and on sensitive topics (Liamputtong, 2007; Thwaites, 2017). To build rapport and empathy, and minimise unequal expectations of vulnerability, I chose to disclose my personal relevant experiences to interviewees when they shared particularly personal or sensitive stories (Liamputtong, 2007; Taylor, 2018; Thwaites, 2017). This meant that at times the boundary between researcher and fellow abortion seeker/woman was blurred, particularly given the interviewees ages and for some, clear lack of adult and social support in relation to their reproductive health experiences. After one particularly challenging interview with a vulnerable young person I wrote in my field journal, "I tried too hard to be a friend, shared my own stories naturally to try and share power, but wonder if inappropriate?". Such internal conflicts are not uncommon in such qualitative research processes, with previous authors noting researchers can be left feeling guilty for their honesty and wondering if they "are living up to the standards of an ideal interview" (Duncombe & Jessop, 2012, pp. 114-115; see also, Dempsey et al., 2016). There is irony in the juxtaposition of my experience being silenced by going viral and the extent to which I shared my personal experiences during individual interviews, more-so than is common.

To navigate the challenges of the interview process I engaged sensitive-interviewing techniques and relied on supervisor support to process conflicted feelings post interview (Dempsey et al., 2016; Dickson-Swift et al., 2007). One of my earliest interviews solidified my commitment to this

approach. Belle's screening questionnaire did not suggest particular areas of vulnerability or potential distress, yet throughout the interview she disclosed living with multiple forms of marginalisation and two distressing miscarriage experiences. Notes made in my field journal after my interview with Belle read,

> Belle looked down a lot when talking about hard topics – a sign of distress?... Debriefed with [Supervisor] as I felt bad for probing on sensitive topics –[Supervisor] reminded me to reflect on Belle's agency in choosing to participate and share stories. This helped me to feel at peace. A bit nervous to read the transcript – embarrassed I may have pushed too hard. Need to be more prepared for difficult stories, not get emotionally distracted.

At the end of another interview, I recommended a young woman seek medical care as she was experiencing pain many months after being pressured into accepting an IUD during her abortion. I provided another interviewee with information about local post-abortion counselling services, as she indicated it was care she might like to access. Offering interviewees help, advice or referral has been advised against in traditional methodology texts (Liamputtong, 2007). However, in supporting young people to understand their rights and ways to access medical and counselling care, I was able to maximise the potential benefits of participating in interviews for the interviewees (Bergen, 1993; Liamputtong, 2007).

Dickson-Swift and colleagues (2007) have described the blurring of boundaries between researcher, friend, counsellor, and therapist is inherent to sensitive interviewing. Several interviewees wrote to me after we spoke and expressed how their interview experiences were positive. They described how the process enabled them to talk through experiences they had not otherwise been able to discuss in a safe environment.

8.4 Conclusion

Throughout this chapter I have demonstrated the value of mixed methods research in uncovering nuance and generating research findings pertaining to abortion stigma that contribute meaningfully to theory, practice, and future research priorities. Together, the quantitative and qualitative research findings demonstrate that in the Australian context, characterised by widespread support for abortion and abortion decriminalisation, anticipated abortion stigma is nevertheless common. This research shows that abortion stigma experiences vary significantly in likelihood, salience, and impact, dependent on the domain of stigma in question and on individual and community characteristics. Abortion stigma is undeniably contested and the narratives underpinning it are widely rejected.

The unprecedentedly large sample size of TAASS, statistical procedures employed to ensure the sample represents the Australian population, and confirmation and expansion of the quantitative findings through interviews, mean the findings of this research are reliable and generalisable (at the very least within Australia). This research is the first national study of perceived and anticipated abortion stigma among a general community sample globally. It therefore has the potential to significantly contribute to global abortion stigma research, theory, intervention design, and health system re-design. The generalisability of the findings to countries and communities with similar socio-political characteristics warrants exploration.

In the following and final chapter, I reflect on the strengths, limitations, and original contributions of this research, and summarise the conclusions of this thesis in light of my hopes for future abortion stigma research, theory, and practice.

CHAPTER NINE: CONCLUDING REMARKS - STIGMA POWER IN PRO-CHOICE AUSTRALIA

I conclude by summarising how the research findings address the aims and objectives, and briefly describing the strengths, limitations, and implications of this research. In section 9.1 the research findings in relation to the research aims and objectives are briefly summarised. Their implications and original contributions to knowledge are then synthesised in section 9.2. Sections 9.3 offers an appraisal of the strengths and limitations of this research, before proposing a future abortion stigma research agenda in Section 9.4. Finally, the concluding remarks in section 9.5 harbour my hopes for the impact of this research and abortion access in Australia, including and beyond the de-stigmatisation of abortion.

9.1 The research findings elucidate the drivers, predictors, experiences, and extent of abortion stigma in Australia

This study aimed to explore the extent and predictors of felt abortion stigma in Australia and to elucidate the experiences and drivers of abortion stigma among young people. The findings indicate that anticipated and perceived abortion stigma are distinct domains with different predictors and response patterns, despite their conflation in prior research and thus in the initial research aims. I found perceived abortion stigma, that is awareness of negative stereotypes and stigma associated with abortion, is relatively uncommon in Australia. In the image of their own beliefs, almost all survey participants and interviewees understand that the Australian population is predominantly pro-choice. Anticipated stigma - the anticipation of enacted stigma or discrimination - appears to be prevalent, however. Most Australians (four out of five) anticipate the stigmatisation of health professionals who provide abortion services, and more than half anticipate abortion seekers are likely to experience harassment. In line with previous research, I found higher levels of religiosity, lower levels of knowledge about the safety of abortion, and anti-abortion beliefs and attitudes predict higher perceived stigma scores. Unexpectedly, and in contrast to this finding, pro-choice, young, and politically left-leaning people in Australia are most likely to anticipate social consequences associated with abortion seeking and provision. Consequently, this thesis elucidates variations in stigma experiences across a suite of attitudinal, demographic, and value-based variables, and not always in line with the way these variables have previously been found to interact with abortion-related attitudes and stigma.

Young people's beliefs and experiences elucidate a range of structural factors that appear to generate and reinforce abortion stigma in Australia. These factors contribute to the normalisation of

the stigmatisation of abortion among new generations of Australians, irrespective of their own beliefs and experiences. They include a lack of formal education about abortion, awkwardness and perceived avoidance of abortion-related conversations and content (such as news content), and exposure to American media content that is polarising, combative, and unrepresentative of diverse abortion experiences and beliefs. Many young people seemingly reject stigmatising narratives about abortion while simultaneously anticipating the inevitable stigmatisation of abortion seekers by religious, conservative, and/or 'older' friends, family and/or community members. Social media, a key site of young peoples' exposure to transnational abortion discourses and movements, appears to create a sense of universality around the politicisation of and opposition to abortion, shaping personal and local Australian experiences and beliefs. While interviewees believed anti-abortion sentiments, stigma and harassment are likely contained to specific social contexts and enacted by specific individuals, they imagined the reach of anti-abortion beliefs and actions to be widespread. In contrast to their expectations, young abortion seekers' primarily described experiences of interpersonal enacted abortion stigma 'during encounters with health professionals. They seldom recounted experiencing judgment or harassment from friends, family, or community members. Their limited interactions with people with anti-abortion beliefs, outside of their own religious communities where applicable, were in online settings and with anti-abortion protestors. Social media, online discourses, and protestors therefore hold substantial power in shaping abortion stigma and individuals' understandings of the social nature and implications of abortion.

Middle-class interviewees perceived their social and financial privilege to be protective against anticipated and enacted abortion stigma. Nevertheless, Chloe's story indicates that middle-class privilege can make it difficult for young abortion seekers to integrate abortion experiences into their identities as responsible middle-class subjects, with implications for their mental and social wellbeing. Despite feeling privileged in her ability to afford, and thus to access, private and timely abortion care for her two abortions, Chloe appears to have embodied negative messaging about irresponsibility associated with unexpected pregnancies and abortion seeking. She felt shame because abortion was not something that happened to people in her privileged "world". Interestingly, several interviewees described abortion as something that doesn't happen in their "worlds". It was classed and gendered norms of responsibility, including assumptions that her privilege should have enabled her to avoid an unintended pregnancy, that drove Chloe's abortion stigma experiences. This included feeling like she was putting on a "facade of like the perfect private school girl and the perfect life and the perfect this and the perfect that", her reality as an abortion-seeker making her markedly imperfect.

The quantitative and qualitative phases of this research also identified a strong relationship between religion and abortion stigma experiences. The interviews revealed that abortion stigma is most salient for young people who have religious friends and families. TAASS identified religiosity as a significant predictor of perceived and anticipated abortion stigma. Simultaneously, pro-woman

narratives adopted by some anti-abortion religious organisations appear to protect some religious young people from anticipating abortion stigma, as they perceive anti-abortion messaging and activities to be protective of women.

Abortion stigma in Australia is both intentionally and inadvertently perpetuated in and by a range of systems and structures, with implications for health service quality, accessibility, and abortion seekers' health and wellbeing.

9.2 Original contributions to knowledge

Prior to the commencement of this research there was a scarcity of abortion stigma focused research in Australia. Research describing abortion stigma in Australia has focused primarily on stigma as a barrier to provision of and access to abortion care in rural communities. This research addresses this significant knowledge gap. In generating the first national mixed-methods dataset pertaining to perceived and anticipated abortion stigma in Australia, this research may be of benefit to policy, practice, and intervention design. In particular, it holds relevance for policy and practice concerned with improving equitable access to, and health and life outcomes associated with, abortion care and experiences. As TAASS amassed 58,000 complete responses, it offers an unprecedently large and thus particularly robust dataset through which abortion stigma experiences and predictors can be modelled and understood. The findings of this research contrast with the pre-existing US-dominated evidence base and offer new ways to measure and understand abortion stigma. Furthermore, they offer specific insights into how abortion stigma forms, is shared, and gains power in a pro-choice society, and highlight aspects of the stigma process that may be amenable to intervention.

This thesis presents a validated abortion stigma measurement tool that is appropriate for use in the Australian context, and likely in countries with similar socio-political contexts. It is the first quantitative survey tool (of which I am aware) that specifically enables the measurement of anticipated and perceived stigma among a general community sample. This research has demonstrated the importance of researching a range of abortion stigma domains, particularly given there are different predictors - and thus different risk factors - associated with each.

The qualitative component of this research describes a perfect storm of the absence of formal abortion education, paucity of nuanced Australian media content and discourse, complex and non-compassionate health systems, the weaponisation of stigma by anti-abortion groups, and the relative proliferation of American abortion-related media content, which together teach young people that abortion carries social risks, online and offline. As Ralph (2022, pp. 216-217) described, when abortion seekers, providers, and supporter "remain silent about their abortions,

those hostile to abortion rights are adept at filling the vacuum". Young Australians appear to anticipate abortion stigma even in pro-choice contexts, thanks to imported narratives of abortion politicisation and risk, which intersect with local systemic realities. Thus, "abortion stigma, while observable as a global phenomenon, is constructed locally through various pathways and institutions, and at the intersection of transnational and local discourses" (Cullen & Korolczuk, 2019, p. 6).

9.3 Examining the strengths and limitations of this research

This research has several major strengths, and a number of limitations, that warrant consideration when interpreting and implementing the findings. Firstly, the use of a sequential mixed methods design in response to the research aims, reflecting the complexity of the abortion stigma concept, has been a great strength. This research design allowed me to address questions that arose as the research progressed. I built into the initial design the requirement to tailor the qualitative component of the study to the findings, needs, and questions identified by TAASS. Further to my expectations, the flexibility to evolve the study's focus also enabled me to adapt and respond to the evolving abortion stigma evidence base and theory. As a result, at the end of this almost eight-year process the findings remain relevant, contextually and academically, maximising the potential impact of the research. In particular, as noted throughout the thesis, I have worked to embed an increasingly social and structural conceptualisation of abortion stigma into the qualitative phase of the study and the mixed methods analysis (guided by Millar, 2020). Nevertheless, implementation of the findings, in particular of TAASS, risks encouraging an individualistic focus on the predictors of abortion stigma. Limited inclusion of structural variables in TAASS limited its ability to identify aspects of economic wellbeing, class, policies, laws, systems, and mass-discourse, which may have also undermined the predictive strength of the statistical models. Furthermore, while a sequential rather than exploratory (whereby qualitative research precedes quantitative research) mixed methods design met the needs of this research project, it did mean elements of the stigma experience identified through the interview study are not reflected in TAASS. It is for this reason that survey development is often informed by and undertaken after qualitative research activities (for example see, Cockrill et al., 2013). Further item development and validation work in future studies may beneficially extend the scope and relevance of TAASS within the Australian context.

Another undeniable strength of this research, which was entirely unexpected, was the unprecedent large dataset achieved by TAASS. While the quantitative study was initially expected to be modest in size and was intended to be used primarily to inform the qualitative research focus, it has instead become a central component of this thesis. Large sample sizes can generate results that better represent population parameters and that are more precise than smaller samples generate,

particularly when they are random/representative[31] (Asiamah et al., 2017). Consequently, and particularly in light of statistical procedures employed to mitigate potential negative effects of non-random sampling, the findings of TAASS are likely to be particularly robust and precise. The very large sample did, however, present unique challenges. For example, due to the very large sample, statistically significant relationships were found between almost all predictor variables with stigma. Even very small differences were found by standard tests to be statistically significant, resulting in the exaggeration of non-meaningful relationships, which is an expected outcome in research with very large samples (Faber & Fonseca, 2014). This required me to build a specific analytical skill set, with the support of expert statistician consultants, to support and enable a meaningful analysis of TAASS data. Even so, more complex modelling than I was able to achieve would have been beneficial, for example in elucidating causal relationships between variables.

While the survey achieved relatively proportional First Nations representation, participant groups for both the qualitative and quantitative components of this research did not otherwise reflect the full diversity of cultural, migrant, and language groups that comprise the Australian community. International evidence suggests that race, country of birth, and visa status or migrant experience can influence abortion stigma experiences (See Chapter 3 Section 3.4). While I was able to mitigate this to a degree using statistical procedures such as weighting of TAASS data, this was not possible in the context of the qualitative research. The qualitative findings therefore are likely to be particularly relevant to white European, middle-class Australians' experiences, and are unlikely to reflect the diversity of abortion and abortion stigma experiences and drivers present in the wider Australian community. Furthermore, despite several interviewees indicating they were broadly opposed to abortion (in most circumstances), young people with anti-abortion beliefs were particularly difficult to recruit for the interview study. As a result, experiences of abortion stigma among Australians who are unsupportive or only rarely supportive of abortion are not well represented in the qualitative findings, despite proportional (to population parameters) representation in the quantitative data. A future focus on understandings of the abortion stigma concept, its salience, and intersecting forms of oppression related to abortion experiences among the diversity of Australia's cultural and religious communities, and among Australians with diverse abortion related beliefs, is needed.

While a number of challenges emerged throughout the undertaking of this research, the findings nevertheless provide a robust foundation on which future research can build and deliver insights into elements of abortion stigma in Australia that have not previously been described.

[31] Limitations associated with the non-random recruitment method used for this cross-sectional survey are discussed in Chapter 4 Section 4.3.1.

9.4 Recommendations for future research

Further research is needed to confirm, build on, and expand the predictive strength and comprehensiveness of the findings generated by this research. This could include:

- Adaptation and validation of TAASS and/or its subscales to assess and improve its relevance to, and thus appropriateness for use in, culturally and linguistically diverse communities, among Aboriginal and Torres Strait Islander Australians, and in contexts outside of Australia.
- Embedding gender-inclusive terminology throughout TAASS.
- Further research into the implications of gender on abortion attitudes and stigma experiences in Australia.
- Research that distinguishes between and simultaneously measures multiple domains of abortion stigma to enable exploration of the interactions between internalised, anticipated, perceived, enacted and structural forms of stigma, and to identify the predictors of each.
- Australian research that considers a wider range of potential structural predictors and/or drivers of abortion stigma, which is likely to improve the predictive strength of statistical models and be particularly influential in driving structural and systems-level intervention and policy design. This could include research into the interactions between financial and social capital and class, identity, and various stigma experiences.
- Australian and international research into the health and life impacts of different stigma experiences to inform more targeted policy and intervention work.

9.5 Concluding remarks

At beginning of this thesis, in the context of my own abortion and miscarriage experiences, I posed the question: how and from where do narratives framing abortion as socially unacceptable derive their power, particularly in contexts of widespread pro-choice beliefs? Goffman would have us believe interpersonal, face-to-face interactions are at the heart of abortion stigma (Taylor 2018). Indeed, they are undeniably sites of enactments of abortion stigmatisation, discrimination, and resistance. However, this research finds that laws, policies, norms, structures, and systems drive and enact, rather than merely mediating, abortion stigma and discrimination in Australia. It demonstrates that abortion stigma exists even in contexts where people reject the gendered norms and stereotypes that underpin it and is used as a weapon of oppression and exclusion. Simple knowledge of the existence of abortion stigma appears to be enough to reinforce it, irrespective of its moral and gendered foundations, alluding to the power of transnational (social) media in shaping local realities.

With a recent Senate enquiry into universal access to reproductive health care in Australia, and extensive media coverage of the clawing back of reproductive rights in the US, abortion has been increasingly brought into the consciousness of everyday Australians. The findings of this thesis are consequently of greater public interest than was anticipated when I commenced my doctoral candidature. Given the potential salience and value of the research findings in a range of policy and practice settings, and the rapid evolution of abortion stigma theory during the last three years, the results warrant confirmation and expansion. I nevertheless feel hopeful that this research will achieve meaningful impacts as the first study of its kind. It is already being referenced in national academic, health, social sector, and media forums (Makleff, 2023; Ratcliffe, 2022).

“External control over other peoples’ reproduction is a tool of domination and oppression” (Ross, 2017, p. 292): abortion stigma is but one – albeit powerful - component of reproductive oppression. This research affirms that a key ingredient in the antidote to abortion stigmatisation is for abortion to be accepted as commonplace, essential, and normalised at the levels of systems, politics, norms, and mass-discourse (Cullen & Korolczuk, 2019; Millar, 2023). We must not rely on abortion seekers and providers to drive these necessary social and structural changes. Holding systems and structures to account will require collective action and activism, political leadership, and systemic champions who are willing to challenge oppressive, patriarchal structures and norms, and harness stigma power for good. Addressing abortion stigma and its drivers, facilitators, and impacts will be critical to minimising disparities in sexual and reproductive health care access and outcomes in Australia and ensuring universal access to all forms of reproductive health care.

At the heart of abortion stigma are socio-political systems and structures. At the heart of reproductive health equity is abortion normalisation.

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APPENDICES

Appendix A: Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
Title	1	Identify the report as a scoping review.	NA – thesis chapter titles
ABSTRACT			
Structured summary	2	Provide a structured summary that includes (as applicable): background, objectives, eligibility criteria, sources of evidence, charting methods, results, and conclusions that relate to the review questions and objectives.	NA – thesis structure
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known. Explain why the review questions/objectives lend themselves to a scoping review approach.	P.24 - 25
Objectives	4	Provide an explicit statement of the questions and objectives being addressed with reference to their key elements (e.g., population or participants, concepts, and context) or other relevant key elements used to conceptualize the review questions and/or objectives.	P. 24 & 26
METHODS			
Protocol and registration	5	Indicate whether a review protocol exists; state if and where it can be accessed (e.g., a Web address); and if available, provide registration information, including the registration number.	No protocol.
Eligibility criteria	6	Specify characteristics of the sources of evidence used as eligibility criteria (e.g., years considered, language, and publication status), and provide a rationale.	P. 26
Information sources	7	Describe all information sources in the search (e.g., databases with dates of coverage and contact with authors to identify additional sources), as well as the date the most recent search was executed.	P. 25-26
Search	8	Present the full electronic search strategy for at least 1 database, including any limits used, such that it could be repeated.	Appendix B
Selection of sources of evidence	9	State the process for selecting sources of evidence (i.e., screening and eligibility) included in the scoping review.	P. 26-27

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
Data charting process	10	Describe the methods of charting data from the included sources of evidence (e.g., calibrated forms or forms that have been tested by the team before their use, and whether data charting was done independently or in duplicate) and any processes for obtaining and confirming data from investigators.	P. 27
Data items	11	List and define all variables for which data were sought and any assumptions and simplifications made.	P. 27
Critical appraisal of individual sources of evidence§	12	If done, provide a rationale for conducting a critical appraisal of included sources of evidence; describe the methods used and how this information was used in any data synthesis (if appropriate).	Not done.
Synthesis of results	13	Describe the methods of handling and summarizing the data that were charted.	P.27
RESULTS			
Selection of sources of evidence	14	Give numbers of sources of evidence screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally using a flow diagram.	P.27
Characteristics of sources of evidence	15	For each source of evidence, present characteristics for which data were charted and provide the citations.	P.30
Critical appraisal within sources of evidence	16	If done, present data on critical appraisal of included sources of evidence (see item 12).	NA
Results of individual sources of evidence	17	For each included source of evidence, present the relevant data that were charted that relate to the review questions and objectives.	In narrative due to large no. included studies
Synthesis of results	18	Summarize and/or present the charting results as they relate to the review questions and objectives.	p.33-54
DISCUSSION			
Summary of evidence	19	Summarize the main results (including an overview of concepts, themes, and types of evidence available), link to the review questions and objectives, and consider the relevance to key groups.	p.54-56
Limitations	20	Discuss the limitations of the scoping review process.	p.57
Conclusions	21	Provide a general interpretation of the results with respect to the review questions and objectives, as well as potential implications and/or next steps.	P.57-58

JBI = Joanna Briggs Institute; PRISMA-ScR = Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews; Checklist from Tricco et al. (2018)

Appendix B: Full search strategy

Copy of the full search strategy as run in CINAHL database on 10th May 2016:

(abortion* OR "terminat* pregnan*" OR mifepristone*)

AND

(attitude* or belief* or opinion* or culture or religio* or "compassion fatigue" or stigma or pro-life or pro-choice or "conscientious objection" or perce* or harassment OR access* or availab* or barrier* or obstacle or enabl* or facilitat* or restrict* or utili?ation)

AND
(Austria* or Belgium or Croatia* or Cyrpus* or "Czech* Republic*" or Denmark* or Estonia* or Finland* or France* or German* or Greece or Hungar* or Iceland* or Ireland* or Italy* or Latvia* or Lithuania* or Luxembourg* or Malta* or Netherlands* or Norway* or Poland* or Portugal* or Slovakia* or Slovenia* or Spain* or Sweden* or Switzerland* or Australia* or Canad* or Japan* or "New Zealand*" or "United States*" or USA or "United Kingdom*" or "Great Britain*" or England OR “developed countr*”)

Appendix C: Ethical approval notices

AC.1 Ethical approval – Research Phase 1, TAASS

Kari Vallury

From:	Human Research Ethics
Sent:	Thursday, 5 July 2018 12:42 PM
To:	Kari Vallury; Darlene McNaughton; Paul Ward
Subject:	7962 SBREC Final approval notice (5 July 2018)

Dear Kari,

The Chair of the Social and Behavioural Research Ethics Committee (SBREC) at Flinders University considered your response to conditional approval out of session and your project has now been granted final ethics approval. This means that you now have approval to commence your research. Your ethics final approval notice can be found below.

FINAL APPROVAL NOTICE

Project No.:	7962
Project Title:	Perceptions, Experiences and Impacts of Abortion Stigma in Australia
Principal Researcher:	Ms Kari Vallury
Email:	Bowl0047@flinders.edu.au

Approval Date:	5 July 2018	Ethics Approval Expiry Date:	30 January 2021

The above proposed project has been approved on the basis of the information contained in the application, its attachments and the information subsequently provided with the addition of the following comment(s):

AC.2 Ethical approval – Research Phase 2, Interview Study

HUMAN RESEARCH ETHICS COMMITTEE

APPROVAL NOTICE

Dear Ms Kari Vallury,

The below proposed project has been **approved** on the basis of the information contained in the application and its attachments.

Project No:	2743
Project Title:	Australian Abortion Stigma Study
Primary Researcher:	Ms Kari Vallury
Approval Date:	18/02/2021
Expiry Date:	28/02/2022

Please note: *Due to the current COVID-19 situation, researchers are strongly advised to develop a research design that aligns with the University's COVID-19 research protocol involving human studies. Where possible, avoid face-to-face testing and consider rescheduling face-to-face testing or undertaking alternative distance/online data or interview collection means. For further information, please go to https://staff.flinders.edu.au/coronavirusinformation/research-updates.*

Appendix D: Invitation letter – expert panellists

Dear ,

I am writing to (formally) introduce Kari Vallury, who is a PhD student in the College of Medicine and Public Health at Flinders University.

Kari is undertaking a mixed methods study on *public perceptions, experiences and impacts of abortion stigma in Australia,* the first large, national study of abortion stigma in Australia.

As an expert in this field, we seek your support and contribution to the development of a questionnaire, using the Delphi method. Specifically, we are seeking feedback on the items to be included in the survey and we anticipate this would involve a total of 4-6 hours of your time (across no more than 4 occasions). Contact will be primarily over email with phone or video conferencing available if required. This process will begin as soon as we have received confirmation from a sufficient number of expert advisors/participants.

Your expertise and understanding of XX would be incredibly valuable and help ensure the tool is inclusive of a variety of perspectives and sufficiently represents, the relevant aspects of abortion stigma. If there is anyone else from your team or your networks that you think could contribute to this study on abortion access, attitudes and stigma we would be grateful for their details so we may extend a formal invite.

The associated information sheet and consent form are attached.

Any enquiries you may have concerning this project should be directed to me by telephone on +61 7221 8476, or e-mail; darlene.mcnaughton@flinders.edu.au

To confirm your availability please contact Kari directly on 0433 773 061, or at kari.vallury@flinders.edu.au.

Thank you for your time and assistance.

Yours sincerely

Dr Darlene McNaughton

Social Anthropologist-Senior Lecturer, Coordinator of the Doctorate of Public Health

College of Medicine and Public Health

Flinders University, South Australia

Appendix E: Information Sheets

AE.1 Expert Panel – Stage 1 TAASS testing

inspiring achievement

INFORMATION SHEET

Title: Public perceptions, experiences and impacts of abortion stigma in Australia

Researcher

Mrs Kari Vallury, College of Medicine and Public Health, Flinders University, Kari.vallury@flinders.edu.au

Supervisors

Dr Darlene McNaughton, College of Medicine and Public Health, Flinders University, Tel: (+61 8) 7221 8476

Professor Paul Ward, College of Medicine and Public Health, Flinders University, Tel: (+61 8) 7221 8415

Description of the study

This study is part of a larger mixed-methods research project exploring *abortion stigma in Australia.* In its entirety, the study will measure the extent and types of stigma that exists broadly, and explore – in a more in-depth way – people's experiences and the impacts of abortion stigma. We will be implementing a national, quantitative survey to gain a broad understanding of the extent and types of perceived abortion stigma and stigmatising attitudes that exist in Australia, and how they vary between communities and population groups. We will then conduct a series of in-depth interviews with impacted individuals to explore their experiences and impacts of abortion stigma (interviewees TBC, to be informed by survey findings).

Purpose of the study

Through this particular process we aim to refine and finalise a questionnaire/survey tool that will be used to measure the extent and types of stigmatising attitudes, and perceived abortion stigma, among the Australian general public (ages 16+). The draft questionnaire has been informed by abortion stigma theory, and developed using items borrowed or adapted from pre-existing and validated tools, as well as items developed from an in-depth literature review. We hope to reduce the number of items in the survey, ensure all aspects of each variable we are seeking to measure are fully addressed, and increase the quality of all retained items (wording, etc).

What will I be asked to do?

You will be asked to respond to a survey-style document on between one and three occasions (the number of rounds will depend on the level of consensus and the feedback received from each round). This document contains a 'draft' questionnaire, and asks you to respond regarding the value/usefulness of various items, to indicate any issues/topics we may have missed, and provide any other feedback, based on your knowledge and experience, to help ensure the tool is as comprehensive and accurate as possible. Specific instructions about what we are asking you to do are provided at the beginning of each section of the document. =

The number of rounds and total time commitment will be dependent on the level of consensus and specifics of the feedback we receive after the first (and subsequent) round(s). This process will be conducted primarily over email. This said, we are happy to meet with Adelaide-based respondents or talk on the phone if you'd prefer to work through the document in this way.

What benefit will I gain from being involved in this study?

We anticipate the findings from this study (and the validated questionnaire) will be useful to many working in this space in Australia, given the current dearth of research regarding the extent, types and impacts of abortion stigma (including impacts on service accessibility) locally. Full acknowledgement will be given to all expert contributors in resulting publications.

Will I be identifiable by being involved in this study?

Given your permission, all advisors who contribute to the development of this tool will be acknowledged in resulting/relevant publications, the PhD thesis, etc. If you would prefer that we do not use your name then of course we will accommodate that.

Are there any risks or discomforts if I am involved?

The researcher anticipates few risks from your involvement in this study, given your existing work in this or a similar field.

If any emotional discomfort is experienced and you would like to speak to someone. you can call any of the numbers below for pregnancy and birth related, free counselling services and options.

Australia-wide

Lifeline 13 11 14 – 24/7 crisis support

Call *Pregnancy, Birth and Baby hotline* (7am-12pm) on 1800 882 436

State-based pregnancy counselling services:

South Australia: Pregnancy Advisory Centre on (08) 8243 3999

Victoria: Pregnancy Advisory Service on (03) 8345 3061

New South Wales: Family Planning NSW Talkline on 1300 658 886

Queensland: Children by Choice on 1800 177 725

Western Australia: Sexual Health Quarters on (08) 9227 6177

Northern Territory: Family Planning NT on 08 8948 1044

Tasmania: Women's health Tasmania on 1800 675 028

How do I agree to participate?

Participation is voluntary. You agree to participate by completing the tasks outlined above and returning your feedback to Kari. You may refuse to answer any questions, and you are free to withdraw from the study/process at any time without effect or consequences.

How will I receive feedback?

On the completion of each round of feedback, the research team will collate and make changes to the questionnaire. They will email you for clarification if there are any queries arising from your feedback/responses, with your permission. The panel then will be emailed with a description of the key findings of/changes made in each round and an outline of anticipated next steps.

Thank you for taking the time to read this information sheet

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project number: 7962).

For more information regarding ethical approval of the project only, the Executive Officer of the Committee can be contacted by telephone on (08) 8201 3116, by fax on (08) 8201 2035, or by email to human.researchethics@flinders.edu.au

AE.2 Cognitive interviews – Stage 2 TAASS testing

inspiring achievement

INFORMATION SHEET

Title: Perceptions, experiences and impacts of abortion stigma in Australia

Researcher

Mrs Kari Vallury

College of Medicine and Public Health

Flinders University

Kari.vallury@flinders.edu.au

Supervisors

Dr Darlene McNaughton

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Flinders University

Tel: (+61 8) 7221 8476

Professor Paul Ward

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Tel: (+61 8) 7221 8415

Description of the study

This study is part of the project titled *Perceptions, experiences and impacts of abortion stigma in Australia.* This project will investigate the validity and reliability of a tool to measure abortion stigma

and attitudes. This project is supported by Flinders University, College of Medicine and Public health.

Purpose of the study

This project overall aims to find out Australian attitudes to abortion, as well as the types, extent and effects of abortion stigma in the community. This component of the study is specifically designed to test the readability and validity of a questionnaire items that we have developed to measure abortion attitudes and stigma. This testing phase will be followed by a larger online testing phase, and finally, by the release of the finalised questionnaire to the Australian public.

What will I be asked to do?

You are invited to sit with the primary researcher and comment on the wording and meaning of a suite of questions related to abortion attitudes, hypothetical scenarios and demographic/personal information. You will not be required to give answers to the questions, but rather read them and describe what they mean to you and if they are easy to understand or not, and why. We anticipate this will take between 1 and 2 hours. We will make notes based on what you say to us but will not audio or visually record the conversation.

What benefit will I gain from being involved in this study?

While direct, tangible benefits to participants may be minimal, you will have the opportunity to contribute to the testing of a tool that could provide valuable information to health, legal and community services about Australians' beliefs and preferences regarding abortion.

Will I be identifiable by being involved in this study?

None of the information you give us will be identifiable – it will contribute to adapting/rewording the questionnaire items (questions) only and your individual answers will not be published in a way that would identify you (we may publish examples of the process. E.g. *Participant 1 noted that question 3 was difficult to understand for X reason*). We will complete the 'interview' at a private location (i.e.. A private meeting room or office) on the University campus.

Are there any risks or discomforts if I am involved?

The researcher anticipates few risks from your involvement in this study, particularly given you will not be required to answer the questions directly. However, given the nature of the topic, some participants could experience emotional discomfort. If any emotional discomfort is experienced and you would like to speak to someone (free of charge) please contact 8201 2118 between 8.45am and 5pm or email counselling@flinders.edu.au and leave your full name, phone number and student ID and a counsellor will contact you by phone. If you have any concerns regarding anticipated or actual risks or discomforts, please raise them with the researcher during the interview.

Alternately, you can call any of the numbers below for pregnancy and birth related, free counselling services and options.

Australia-wide

Lifeline 13 11 14 – 24/7 crisis support

Call *Pregnancy, Birth and Baby hotline* (7am-12pm) on 1800 882 436

State-based pregnancy counselling services:

South Australia: Pregnancy Advisory Centre on (08) 8243 3999

Victoria: Pregnancy Advisory Service on (03) 8345 3061

New South Wales: Family Planning NSW Talkline on 1300 658 886

Queensland: Children by Choice on 1800 177 725

Western Australia: Sexual Health Quarters on (08) 9227 6177

Northern Territory: Family Planning NT on 08 8948 1044

Tasmania: Women’s health Tasmania on 1800 675 028

How do I agree to participate?

Participation is voluntary. You may refuse to answer any questions, and you are free to withdraw from the interview at any time without effect or consequences. A consent form accompanies this information sheet. If you agree to participate, you will be asked to read and sign the form before the interview begins.

How will I receive feedback?

On project completion, the outcomes of the project will be published in academic journals, and key findings provided on the project Facebook page. Furthermore, once this testing phase is completed, a link to the final survey will be posted on the project Facebook page, which you are welcome to view and/or complete.

Thank you for taking the time to read this information sheet.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project No. 7962).

For more information regarding ethical approval of the project only, the Executive Officer of the Committee can be contacted by telephone on (08) 8201 3116, by fax on (08) 8201 2035, or by email to human.researchethics@flinders.edu.au

AE.3 Reliability Study - Stage 3 TAASS testing

inspiring achievement

INFORMATION SHEET

Title: Abortion attitudes and stigma in Australia

Researcher

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Supervisors

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Flinders University

Tel: (+61 8) 7221 8476

Professor Paul Ward

College of Medicine and Public Health

Flinders University

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Description of the study

This study is part of the project about *abortion attitudes stigma in Australia.* This project will investigate the validity and reliability of a tool to measure abortion attitudes and stigma. This project is supported by Flinders University, College of Medicine and Public health.

Purpose of the study

This project overall aims to find out Australian attitudes to abortion, as well as to those who have and provide abortions. This component of the study is specifically designed to test the reliability and validity of a questionnaire that we have developed to measure abortion attitudes and stigma. Once we have tested and amended the questionnaire we will be able to release a final version to the public for data collection.

What will I be asked to do?

You are invited to complete the same online questionnaire twice, with a two week gap in between. Participation is entirely voluntary. The questionnaire will take about 30 minutes to complete. Once you have completed it twice, any identifying information you provide (email, FAN) will be removed and your answers will not be identifiable.

What benefit will I gain from being involved in this study?

While direct, tangible benefits to participants may be minimal, you will have the opportunity to contribute to the testing of a tool that could provide valuable information to health, legal and community services about Australians' beliefs and preferences regarding abortion.

Will I be identifiable by being involved in this study?

We do not need your name and you will be anonymous. Any identifying information (such as your FAN) will be removed once the survey has been completed twice, and your comments will not be linked directly to you. All information and results obtained in this study will be stored in a secure way, with access restricted to relevant researchers.

Are there any risks or discomforts if I am involved?

The researcher anticipates few risks from your involvement in this study, however, given the nature of the project and topic, some participants could experience emotional discomfort. If any emotional discomfort is experienced and you would like to speak to someone (free of charge) please contact 8201 2118 between 8.45am and 5pm or email counselling@flinders.edu.au and leave your full name, phone number and student ID and a counsellor will contact you by phone. If you have any concerns regarding anticipated or actual risks or discomforts, please raise them with the research team on the contact information above.

Alternately, you can call any of the numbers below for pregnancy and birth related, free counselling services and options.

Australia-wide

Lifeline 13 11 14 – 24/7 crisis support

Call *Pregnancy, Birth and Baby hotline* (7am-12pm) on 1800 882 436

State-based pregnancy counselling services:

South Australia: Pregnancy Advisory Centre on (08) 8243 3999

Victoria: Pregnancy Advisory Service on (03) 8345 3061

New South Wales: Family Planning NSW Talkline on 1300 658 886

Queensland: Children by Choice on 1800 177 725

Western Australia: Sexual Health Quarters on (08) 9227 6177

Northern Territory: Family Planning NT on 08 8948 1044

Tasmania: Women's health Tasmania on 1800 675 028

How do I agree to participate?

Participation is voluntary. You may refuse to answer any questions, and you are free to withdraw from the questionnaire at any time without effect or consequences. A consent form accompanies this information sheet. If you agree to participate you will be asked to tick a box saying you have read and agree with the conditions at the beginning of the questionnaire.

Recognition of contribution / time / travel costs

If you would like to participate, in recognition of your contribution and participation time, you will be entered into a draw to receive one of 5 $25 Westfield vouchers. If you would like to go in the draw, please leave your email address when prompted at the end of the questionnaire. Please note, we will separate the email address from your answers as soon as we can to ensure you answers are not identifiable.

How will I receive feedback?

On project completion, the outcomes of the project will be published in academic journals, and key findings provided on the project Facebook page. Once this testing phase is completed, a link to the final survey will be posted on the project Facebook page, which you are welcome to view and/or complete.

Thank you for taking the time to read this information sheet.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project No. 7962).

For more information regarding ethical approval of the project only, the Executive Officer of the Committee can be contacted by telephone on (08) 8201 3116, by fax on (08) 8201 2035, or by email to human.researchethics@flinders.edu.au

AE.4 TAASS Data Collection

inspiring achievement

INFORMATION SHEET

Title: Abortion attitudes and stigma in Australia

Researcher

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Supervisors

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Professor Paul Ward

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Flinders University

Tel: (+61 8) 7221 8415

Description of the study

This study is part of a project exploring *abortion attitudes and stigma in Australia.* This project will specifically explore Australians' attitudes to abortion and towards people who have and provide abortions. This project is supported by Flinders University, College of Medicine and Public health.

Purpose of the study

This study aims to explore Australians' attitudes to abortion, to those involved in abortion, and to understand how participants think other people in their community and country feel about abortion. How people feel about, and think other people feel about abortion can have impacts on individual and community health and wellbeing. Very little research has been done on this topic in Australia, and it is important that Australians' opinions and preferences are understood.

What will I be asked to do?

You are invited to complete an online questionnaire, answering questions about your attitudes to abortion, thoughts about people who have and provide abortions, as well as giving some demographic information. We anticipate this will take between 30 and 45 minutes to complete.

What benefit will I gain from being involved in this study?

This study will provide valuable information to health, legal and community services about Australians' beliefs and preferences regarding abortion. You will have the opportunity to share your opinions on the topic, although there may not be a direct, immediate benefit to individual participants.

Will I be identifiable by being involved in this study?

You are invited to complete this questionnaire anonymously. No personal information is required that would allow us or anyone to identify you, and no information will be published that could lead to your identification.

You will be invited to leave you email address at the end to go in the draw to receive one of 25 $25 Westfield vouchers, but we will separate your email from your answers as soon as data collection is complete. Your email address will be stored in a secure location and deleted as soon the winners have been drawn.

Are there any risks or discomforts if I am involved?

The researcher anticipates few risks from your involvement in this study. However, given the nature of the topic, some participants could experience emotional discomfort. If any emotional discomfort is experienced, please contact one of the numbers below for support / counselling that may be accessed free of charge by all participants. If you have any concerns regarding anticipated or actual risks or discomforts, please feel free to get in contact with the primary researchers at kari.vallury@flinders.edu.au.

If at any time you are feeling upset or distressed, and/or would like to speak to someone about a pregnancy, please call one of the numbers below for free, confidential counselling.

Australia-wide

Lifeline 13 11 14 – 24/7 crisis support

Call *Pregnancy, Birth and Baby hotline* (7am-12pm) on 1800 882 436

State-based pregnancy counselling services:

South Australia: Pregnancy Advisory Centre on (08) 8243 3999

Victoria: Pregnancy Advisory Service on (03) 8345 3061

New South Wales: Family Planning NSW Talkline on 1300 658 886

Queensland: Children by Choice on 1800 177 725

Western Australia: Sexual Health Quarters on (08) 9227 6177

Northern Territory: Family Planning NT on 08 8948 1044

Tasmania: Women's health Tasmania on 1800 675 028

How do I agree to participate?

Participation is voluntary. You may refuse to answer any questions, and you are free to withdraw from the study at any time without effect or consequences. A consent form will be shown at the start of the questionnaire. If you agree to participate, you will be asked to read and sign the form before beginning.

Recognition of contribution / time / travel costs
If you would like to participate, in recognition of your contribution and participation time, you are invited to include your email address at the end of the questionnaire and will go in the draw to receive one of 25 $25 Westfield vouchers (which can be used online or in store). The winner will be drawn as soon as data collection closes and notified by email.

How will I receive feedback?

On project completion, the outcomes of the project will be published in academic journals, and key findings provided on the project Facebook page. If you would like a copy of the study findings you are welcome to get in contact via the Facebook page or the email address above and we will share the findings once they are available.

Thank you for taking the time to read this information sheet, and we hope that you will accept our invitation to be involved.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project No. 7962).

For more information regarding ethical approval of the project only, the Executive Officer of the Committee can be contacted by telephone on (08) 8201 3116, by fax on (08) 8201 2035, or by email to human.researchethics@flinders.edu.au

AE.5 – Consent form – Phase 1B, TAASS Data Collection

CONSENT FORM FOR PARTICIPATION IN RESEARCH

(by questionnaire)

Abortion attitudes and stigma in Australia

I ……..

being over the age of 18 years hereby consent to participate as requested in the letter of introduction for the research project on abortion attitudes and stigma in Australia.

1. I have read the information provided.
2. Details of procedures and any risks have been explained to my satisfaction.
3. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.
4. I understand that:

- I may not directly benefit from taking part in this research.
- I am free to withdraw from the project at any time and am free to decline to answer particular questions.
- While the information gained in this study will be published as explained, I will not be identified, and individual information will remain confidential.

WILL INCLUDE TICK BOX IN PLACE OF SIGNATURE

DATE WILL BE ELECTRONICALLY RECORDED

AE.6 - Information Sheet – Phase 2, Interview Study

inspiring achievement

Participant information sheet and consent form

The Australian Abortion Stigma Study (TAASS)

Key Contact

Professor Paul Ward

College of Medicine and Public Health

Flinders University

Tel: +61 8 7221 8415

Email: australianabortionstudy@flinders.edu.au

Description of the study

This project will investigate young peoples' experiences of abortion and abortion stigma in Australia. We are hoping to interview 20-30 young people from around the country who have and haven't had abortions to understand how they think and feel about abortion, its acceptability and (where relevant) their experiences of seeking and having an abortion.

Most interviews will be conducted online, although participants located in the Adelaide area will have the opportunity to have their interview in person. It is anticipated interviews will last around one hour, and participants are able to stop the interviews at any time. Interviews will be recorded and transcribed, the transcripts (written account of the interview) then provided to the participant to check and edit if they choose.

Participants will be entirely anonymous in all findings and related publications, and no details will be shared/published that allow any participant to be identified.

This project is supported by Flinders University, College of Medicine and Public Health.

Purpose of the study

This project aims to find out how young people in Australia, perceive, understand and experience abortion stigma. A recent national survey conducted by Flinders University found young people are more likely than others to perceive high levels of community disapproval of abortion and to anticipate negative consequences associated with having an abortion. However, very little research is available on this topic, and specifically none that explains why this is the case, and how it impacts young people's access to and ability to cope with abortion. Understanding young people's interpretations of social norms and anticipated consequences associated with abortion, as well as their experiences in accessing and talking abortion, could help inform health service delivery and improve equity of access to reproductive health services.

What benefit will I gain from being involved in this study?

The sharing of your experiences will help the research team to identify and explain how young people experience and think about abortion and abortion stigma. We hope this information will be helpful to policy makers, health services and health promotion projects that aim to combat stigma and ensure everyone has access to the abortion information and services they need. Young people in Australia can face many barriers to accessing abortion services, and there is little research that explains the role stigma plays in this. Capturing the perspectives of young people directly helps to ensure their voices are represented in decision making.

Talking about your experiences and thoughts may or may not be of benefit to you on an individual level, but you will be helping contribute to knowledge and theory in this area. Although our interviewers aren't trained counsellors, some people do find talking about their experience to have personal benefits, particularly if they haven't had the opportunity to speak openly about their thoughts and feelings before

Participant involvement and potential risk

If you agree to participate in the research study, you will be asked to:

- attend a one-on-one interview with a researcher that will be audio recorded, to be conducted either via Zoom (online) or in person for participants who live in or near Adelaide
- respond to questions regarding your views about (and experiences with, where relevant) abortion
- choose whether or not you'd like to review the interview transcript and make any edits before it is analysed by the research team

The interview will take about 60 minutes and participation is entirely voluntary.

Given the research topic, and particularly for those who have had abortion experiences, there is a chance that the research questions asking about your experiences and beliefs could cause some discomfort or mental distress. If you do experience feelings of distress as a result of participation in this study, please let the research team know immediately.

You can also contact the following services for support:

For general mental health/distress support:

- Lifeline – 13 11 14, www.lifeline.org.au
- Beyond Blue – 1300 22 4636, www.beyondblue.org.au

For abortion, sexual and reproductive health support and counselling:

- South Australia: Pregnancy Advisory Centre on (08) 8243 3999
- Victoria: 1800 My Options on 1800 696 784
- New South Wales: Family Planning NSW on 1300 658 886
- Queensland: Children by Choice on 1800 177 725
- Western Australia: Sexual Health Quarters on (08) 9227 6177
- Northern Territory: Family Planning NT on 08 8948 1044
- Tasmania: Women's health Tasmania on 1800 675 028
- ACT: Sexual Health and Family Planning ACT on 6247 3077

Withdrawal Rights

You may, without any penalty, decline to take part in this research study. If you decide to take part and later change your mind, you may, without any penalty, withdraw at any time without providing an August 2020 3 explanation. To withdraw, please contact the Chief Investigator or you may just refuse to answer any questions at any time. If you do decide to withdraw during to interview, you may decide whether data collected until that point can be used for the research or be securely destroyed.

Confidentiality and Privacy

Only a small team of 4 researchers have access to the individual information provided by you. Some researchers have been left off this form for safety/privacy reasons, however you will meet the lead researcher during your interview. Privacy and confidentiality will be assured at all times. The research outcomes may be presented at conferences, written up for publication or used for other research purposes as described in this information form. However, the privacy and confidentiality of individuals will be protected at all times. You will not be named, and your individual information will not be identifiable in any research products without your explicit consent.

No data, including identifiable, non-identifiable and de-identified datasets, will be shared or used in future research projects without your explicit consent.

Data Storage

The information collected may be stored securely on a password protected computer and/or Flinders University server throughout the study. Any identifiable data will be de-identified for data storage purposes unless indicated otherwise. All data will be securely transferred to and stored at Flinders University for at least five years after publication of the results. Following the required data storage period, all data will be securely destroyed according to university protocols.

How will I receive feedback?

Once we have finished transcribing your interview, you'll be invited to review the transcript and make any edits you feel necessary. This process is optional. On project completion, a short summary of the outcomes will be provided to all participants via email.

Queries and concerns

Queries or concerns regarding the research can be directed to the research team. If you have any complaints or reservations about the ethical conduct of this study, you may contact the Flinders

University’s Research Ethics & Compliance Office team via telephone 08 8201 3116 or email human.researchethics@flinders.edu.au.

Thank you for taking the time to read this information sheet. If you accept our invitation to be involved, you will be asked to check the appropriate boxes on the “Consent Form” that you’ll find at the beginning of the linked survey (link in email).

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project number: 2743).

For more information regarding ethical approval of the project only, the Executive Officer of the Committee can be contacted by telephone on (08) 8201 3116, by fax on (08) 8201 2035, or by email to human.researchethics@flinders.edu.au

AE.7 – Consent form – Phase 2, Interview Study

CONSENT FORM

Consent Statement

☐ I have read and understood the information about the research, and I understand I am being asked to provide informed consent to participate in this research study. I understand that I can contact the research team if I have further questions about this research study.

☐ I am not aware of any condition that would prevent my participation, and I agree to participate in this project.

☐ I understand that I am free to withdraw at any time during the study.

☐ I understand that I can contact Flinders University's Research Ethics & Compliance Office if I have any complaints or reservations about the ethical conduct of this study.

☐ I understand that my involvement is confidential, and that the information collected may be published. I understand that I will not be identified in any research products.

☐ I agree that information provided in the screening questionnaire is accurate, and that I am currently aged 16 years or over.

I further consent to:

☐ completing a screening questionnaire
☐ participating in an interview
☐ having my information audio recorded
☐ my data and information being used in this project and other related projects for an extended period of time (no more than 10 years after publication of the data)
☐ being contacted about other research projects

Appendix F: Document to collect expert panel feedback - Round 1

Round 1

Thank you for agreeing to participate in this process to refine and develop a quantitative survey tool that will be administered nationally in Australia to measure ***stigmatising attitudes to abortion*** and ***perceived/felt/anticipated abortion stigma.*** This tool will be completed by the Australian general public, ages 16+. To the best of our knowledge, abortion stigma has not previously been measured among the Australian population to this extent.

We hope to be able to use this questionnaire to identify sub-populations that may be particularly susceptible to high rates of perceived stigma and/or stigmatising attitudes in relation to abortion in Australia, and to inform the direction of the qualitative interview study that will follow this one.

Development and implementation of this questionnaire has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project no. 7962).

For the first round of this Delphi consensus-building process, we will be asking you to rate and comment on a number of categories of survey questions. Each section (7 in total) is preceded by specific instructions regarding that question set. Overall, we hope to reduce the number of items at the end of this round (particularly in the sections that currently have large numbers of proposed questions) and identify any topic areas/questions members of our expert panel believes are of importance and have been missed/inadequately addressed.

The questions have largely been borrowed and adapted from a number of surveys (published and unpublished) that have been developed and implemented in a range of settings (outside of Australia) to measure different aspects abortion attitudes and stigma. Other items were developed based on an extensive literature review and reflect the key themes identified in this review, and in abortion stigma theory. As it currently stands, the questionnaire is a first attempt at bringing together these items, and we look forward to working with you to refine the content and develop a useful, comprehensive (and eventually validated) tool that can be used in a range of settings.

If you prefer to fill in the questionnaire in hard copy, please feel free to do so and send us a scanned copy once completed. Otherwise, you're welcome to work in the word document.

If you have any questions at all please don't hesitate to get in contact with Kari on 0433 773 061, or email kari.vallury@flinders.edu.au at any time. We thank you again for agreeing to contribute to this process and look forward to working with you.

Sincerely,

Kari Vallury, Darlene McNaughton and Paul Ward

SECTION 1: General attitudes towards abortion (legality, funding, access)

Purpose: These items will primarily be used as independent variables to identify any potential relationships between general attitudes towards abortion and abortion stigma.

In this section we would like ***you*** *to:*

- Rate questions in regard to their level of importance in measuring participants' general beliefs about the morality and legality of, and access to abortion services in Australia. **(Please use the 3 columns on the right-hand side of the table and mark your preferred response to each item with an 'X'. This applies to following sections as well.)**
- Select your preferred item – 7 or 8
- *Please note – we do not necessarily need to reduce the number of items in this section, if all are deemed important by the panel.*

		YOUR RATING (*Mark with 'x'*)		
Proposed Questions	**Proposed Measurement**	**Very Importa nt**	**Somewh at Importan t**	**Not importa nt**
1. Do you think abortion should be	Legal in all cases/ legal in most cases/ illegal in most cases/ illegal in all cases			
2. Abortion should be legal and available	4 point Likert: (Strongly agree/ Agree/ Disagree/ Strongly Disagree)			
3. Abortion is a woman's right				
4. Abortion is always wrong				
5. The Government/Medicare should cover the costs of abortions.				
6. At what point in a pregnancy do you think an embryo/fetus becomes a baby?	Conception or fertilization/ implantation/ first movements/ viability/ birth			
7. Laws and policies that restrict access to abortion in Australia should be changed to allow easier access to abortions	Yes/ No			

8. Abortion laws vary across Australian States and Territories. Many people don't know that abortion is still criminalised under many circumstances in some states and territories. Do you think abortion should be legal for all women in Australia?	Yes, always/ Yes, sometimes/ No, never			
9. Have you ever known someone who had an abortion?	Yes/ No/ I don't know			

Preferred Item – 7 or 8, or other suggestions?

Do you feel any areas/topics have been missed?

Any other comments (wording, question types, other)?

SECTION 2: Views on contraception & responsibility

Previous research shows women are often perceived to be irresponsible for experiencing unplanned pregnancies, and primarily responsible for contraception. Abortion stigma researchers have also indicated that abortion stigma is intimately linked with other stigmas, such as those associated with unplanned and teenage pregnancies.

Purpose: With the following questions we hope to begin to identify, broadly, potential relationships between views towards unplanned pregnancy and contraceptive responsibility and abortion attitudes, and explore their gendered nature. We anticipate this will not be an entirely separate section in the final questionnaire, but instead hope to reduce this to 3-5 items that can be subsumed under another subheading.

In this section we would like ***you*** *to:*

- Rate questions as to how well you think they measure/address the idea of contraceptive responsibility and irresponsibility, from 'very well' to 'poorly'.
- (We aim to reduce the number of questions on this topic to just 3-5 items. *Question 10 would be considered to be 1 item.*)
- At the end we invite you to suggest any issues or questions you think should be removed and/or added

Proposed Questions	**Measurement**	**Very well**	**Adequately**	**Poorly**
10. Please rate how responsible/irresponsible you believe a woman in the following situations to be (broadly speaking)	Very irresponsible / irresponsible/ responsible/			

- Experiences an unwanted/unplanned pregnancy - Has an abortion - Experiences more than one unwanted/unplanned pregnancy - Has more than one abortion within a few years.	very responsible			
11. Women who have abortions should be more careful not to get pregnant	Strongly agree/ agree/ disagree/ strongly disagree			
12. Women who have multiple abortions probably don't use contraception				
13. It is a woman's responsibility to prevent unwanted pregnancy				
14. A woman who has more than one abortion is irresponsible.				
15. Women who experience more than one unplanned pregnancy are irresponsible.				
16. It is a man's responsibility to ensure his partner doesn't get pregnant if they don't want a baby.				
17. Who do you think is mainly responsible for ensuring contraception is used to prevent unwanted pregnancy?	Mainly the man/ mainly the woman/ both the man and the woman equally			
18. Once a woman has one abortion, she will make it a habit	Strongly agree/ agree/ disagree/ strongly disagree			
19. Women who have unplanned pregnancies brought the situation upon themselves				
20. Women who have unplanned pregnancies should take responsibility and have the baby.				
21. In your opinion, how irresponsible is a woman your age who has an abortion?				

22. In your opinion, how irresponsible is a woman your age who gets pregnant accidentally				

Do you feel any areas/topics have been missed?

Any other comments (wording, question types, other)?

SECTION 3: Abortion Knowledge

Studies have found a correlation between a lack of knowledge about abortion and abortion stigma. We would like to identify whether this correlation is also apparent in the Australian context.

Purpose: This section seeks to briefly explore perceptions and understandings about the frequency of, and women who seek, abortion in Australia. It will measure the extent of myths and misinformation among respondents. We do not need to reduce the number of items in this section if the panel agree all proposed questions are useful.

*In this section we would like **you** to*:

- Rate the questions' value/usefulness in exploring knowledge of abortion/ misinformation – whether you think each item will give a good indication of understanding of abortion (frequency and complications) among the Australian population.
- Suggest any questions or topics you feel may be important/commonly misunderstood and could be included in the final questionnaire. *(These questions were largely based on research into abortion knowledge in other countries, and we would love a local perspective on this.)*

Proposed Questions	**Measurement**	**Very useful**	**Somewhat useful**	**Not very useful**
23. To the best of your knowledge, what proportion of women do you think will have an abortion in their lifetime	1 in 3/ 1 in 5/1 in 10/ 1 in 40/ 1 in 100			
Please rate your response to the following questions, from strongly agree to strongly disagree: 24. Women who have abortions are more likely to be single 25. Women who have abortions are more likely to be young	4 point Likert: (Strongly agree/ Agree/ Disagree/ Strongly Disagree)			

26. Women who have abortions are more likely to be earning a low income				
27. The health of a woman who has an abortion is never as good as it was before the abortion				
28. Abortion is more dangerous to a woman's health than pregnancy/childbirth				
29. Women who have multiple abortions may not be able to have a child later in life.				
30. Abortion is risky for women's health				

Do you feel any crucial areas/topics have been missed?

Any other comments (wording, question types, other)?

SECTION 4: Stigmatising Attitudes

Purpose: The following questions/sections seek to ascertain the extent of stigmatising (and stigma-resistant) attitudes to abortion among the survey sample, along with aspects of enacted stigma. This addresses one of the primary aims of the study. This data will be used alone (descriptive) and as dependent variables to identify demographic/personal/community characteristics that may predict higher/lower levels of abortion stigma.

These questions are based largely on research from, and questionnaires developed for use in, countries other than Australia. As such, ascertaining their relevance locally, and identifying any concepts/questions/topic areas we've missed are goals of this Delphi process in regard to this section. We will only reduce the number of questions in this section if the panel agrees there are items that are not useful.

In this section we would like ***you*** *to:*

- Identify how useful you believe the proposed questions are in addressing/measuring the types and extent of stigmatising attitudes to abortion in Australia. Within this, please consider how relevant the questions are to the Australian context (if this aligns with your knowledge and experience).
- Identify any other areas/topics/questions that may be useful to include. (Please discuss below the table).

Proposed Questions	Measurement	Very useful	Useful	Not very useful
Stigmatising attitudes towards women: moral judgments	4 point Likert: (Strongly agree/ Agree/ Disagree/ Strongly Disagree)			
31. A woman who has an abortion is committing a sin				
32. Abortion is the easy way out of an unplanned pregnancy				
33. A decent woman would never have an abortion				
34. Women who have abortions are easy/will sleep with anyone				
35. Women who have abortions have done something wrong				
36. Women who have abortions usually have good reasons				
37. A woman who has an abortion is a bad mother				
38. Women who have an abortion do not deserve to have a family				
39. Women who have an abortion because they feel unprepared to have children are responsible				
Stigmatising attitudes towards women: Shame and discrimination	4 point Likert: (Strongly agree/ Agree/ Disagree/			
40. I would feel ashamed if a member of my family had an abortion				
41. If a man wants to marry a woman who has had an abortion, I would advise against it				
42. I have less respect for women who have abortions				

43. I would respect a woman who has an abortion – she should make the decision that's best for her	Strongly Disagree)			
44. Women who have abortions should feel badly about themselves				
45. Women who have abortions will probably regret their decision				
46. It is okay for a woman to feel relieved after having an abortion				
47. A woman who has an abortion should not be allowed to attend religious services				
Social Support	4 point Likert: (Strongly agree/ Agree/ Disagree/ Strongly Disagree)			
48. I would continue to be friends with someone if I found out that they had an abortion				
49. A woman who has an abortion should be treated the same as everyone else				
50. If a friend or family member had an abortion, I would not judge her				
51. I could support a woman who had an abortion even if I didn't agree with her decision				
52. I would defend someone who had an abortion if people were saying negative things about them in a social setting				
Attitudes towards abortion providers	4 point Likert: (Strongly agree/ Agree/ Disagree/ Strongly Disagree)			
53. Doctors and midwives who perform abortions are committing a sin				
54. I respect a doctor or midwife who helps women have a safe abortion				
55. Doctors and midwives who perform abortions are bad people				

56. Doctors and midwives who perform abortions are murderers				
57. Doctors and midwives who perform abortions are simply doing their job				
58. Doctors and midwives who perform abortions are just doing it for the money				
59. Abortion providers make a positive contribution to society				
60. Abortion providers should be proud of the work they do				

Do you feel any crucial areas/topics have been missed?

Any other comments (wording, question types, other)?

SECTION 5: Perceived Stigma

Purpose: This section addresses the second primary aim of the questionnaire – to measure the extent and types of 'perceived stigma' among the Australian population. Previous research has identified 3 key domains of abortion stigma - experienced/enacted, felt/perceived/anticipated, and internalised. This survey primarily seeks to measure perceived (also known as 'felt' or 'anticipated') stigma. These questions, therefore, are intended to provide a sense of how much and what types of values and attitudes people anticipate are/perceive to be present in their local, and the Australian community, and how these might impact on the social and personal lives of those who experience or provide abortions.

These questions are based on surveys measuring perceived abortion stigma from other locations, and an in-depth literature review. Very limited abortion stigma research has been conducted in Australia, and as such as are not certain about which measures will be more relevant and useful here.

In this section we would like you to:

- Rate how relevant the questions are to addressing/measuring perceived/anticipated abortion stigma. Within this, please consider how relevant the questions are to the Australian context
- As always, we welcome your suggestions of questions or issues you feel we have missed/are not currently adequately addressed (by the questionnaire).
- Comment on whether you believe we need more questions about gender norms/ ideals of womanhood

- We aim to reduce the number of questions in this section by around 25%.

Proposed Questions	Measurement	Very relevant/ useful	Some-what relevant/ useful	Not relevant/ useful
Anticipated community stigma				
61. Most people in Australia:	Strongly agree/ agree/ disagree/ strongly disagree			
- Support access to/legal abortions				
- Think abortion is a bad thing				
- Would think negatively about women who have had an abortion				
- Would think negatively about women who have had more than one abortion				
62. Most people in my town/local community are supportive of abortion/pro-choice				
63. People in small towns/country areas are less supportive of abortion than people in big cities				
64. People in my town/local community are probably less supportive of abortion than people in other parts of Australia				
65. Women are held more responsible for abortion than men are				
66. Most people are uncomfortable around women when they learn about their abortion				
67. When people know that a woman has had an abortion, they assume she is/will be a bad mother.				
68. People are less likely to experience judgment for abortions if they are for medical/health reasons of the woman or fetus				
Disclosure and secrecy				
69. I would willingly tell people about my views on abortion if it came up in a social setting				

70. I would willingly tell people about my views on abortion if it came up in a work setting	Strongly agree/ agree/ disagree/ strongly disagree			
71. I would happily tell a new partner about my (my partners') abortion history				
72. In general, telling others about an abortion is a mistake				
Anticipated discrimination				
73. Women are likely to be treated badly because of their abortion	Strongly agree/ agree/ disagree/ strongly disagree			
74. When people know that a woman has had an abortion, they look for flaws in her character.				
75. A healthcare professional/doctor would give you poor care if they knew you'd had an abortion or wanted to have an abortion				
76. I would expect abortion providers and staff in abortion clinics would be friendly and supportive				
77. I would be comfortable talking to my GP about my/ my partner's abortion				
78. If I or my partner had an abortion:				
A. I would worry that someone close to me would tell someone else about the abortion without my permission				
B. I would worry that people in my local community would find out				
C. I would probably have to lie to someone I am close with about the abortion				
D. I would be able to talk to the people I am close with about the abortion				
E. I would be open with my family about it				
F. I would worry people would react negatively towards me/us if they found out.				
G. I would worry that other people might find out about my/my partner's abortion				

H. I would worry that I would see protestors at the clinic	Strongly agree/ agree/ disagree/ strongly disagree			
I. I would worry that I/my partner would experience physical violence or harassment from a close friend or family member				
J. I would worry that I/my partner would experience violence or harassment from someone in the community				
K. I would worry that I/we would be gossiped about				
L. I would worry that people think I was a bad parent if they found out about an abortion				
M. I would receive support from most of friends/family members if asked for it/needed it				
N. I would be able to talk about the experience and feelings with friends and family				
O. I/we would be put off from getting an abortion because I/we would worry that people would think negatively about me/us				
P. I/we would try and go to another community/town/city for the abortion to avoid people in my/our community finding out				
Q. I would worry my family would experience harassment or judgment if people found out.				
R. I would worry that I would be kicked out of my house.				
79. Do you think women who have abortions:	Yes - always, yes - sometime			
A. are at risk of harassment/violence because of their abortion?				
B. are likely to receive negative or judgmental treatment from health/abortion providers?				
C. need to keep abortion a secret from close friends or family members?				

D. need to keep abortion a secret from other friends/ colleagues/acquaintances?	s, not often, never			
E. are likely to be excluded from their religious group?				
F. should avoid telling people in order to avoid judgmental reactions?				
G. are rejected from social or family groups				
H. are likely to be gossiped about				
I. Feel like less of a woman				
J. Should be more careful				
Abortion providers				
80. People who do abortion work *would not* want people to know about what they do	Strongly agree/ agree/ disagree/ strongly disagree			
81. I would expect most abortion providers in Australia have experienced some form or harassment or violence due to their work				

Do you feel any areas/topics have been missed?

Do you think gender norms/ideals of womanhood need to be measured to a greater extent than they are within the existing item pool?

Any other comments (wording, question types, other)?

SECTION 6: Demographics/ respondent characteristics

Purpose: These questions will form independent variables. We will conduct analyses to identify any associations with these factors and perceived abortion stigma. Many of these questions have been taken directly from the Census (some with adaptations). Many of the questions ask about characteristics that have been linked with abortion stigma in other studies/locations/populations.

In this section we would like you to:

- Comment more generally (unlike previous sections):Are there any characteristics that aren't included but that may be linked to abortion stigma/attitudes, given your knowledge and experience?
- Please also feel free to make any other observations/comments.

Proposed Questions	***Proposed Response Categories***					
82. Age	16-19	21-29	30-39	40-49	50-59	60-69 etc.
83. Gender	Male	Female	Non-binary	Other		
84. Are you currently	Married	Never married	Separated but not divorced	divorced	Widowed	
85. Are you of Aboriginal or Torres Strait Islander Origin? (tick all that apply)	No	Yes, Aboriginal	Yes, Torres Strait Islander			
86. In what country were you born?	Australia	England	New Zealand	India	Italy	Vietnam + Philippines + Other (please specify)
87. In what year did you first arrive in Australia to live here for 1 year or more?	Have been in Australia for less than 1 year	Date				
88. What is your religion?	No religion	Catholic	Anglican (church of England)	Uniting Church	Presbyterian	Buddhism + Islam + Greek Orthodox + Baptist + Hinduism + Muslim Other (please specify)
IF YES: 71.a) Apart from weddings and funerals, about how often do	More than once a week	Once a week	Once a month	Only on special holidays	Once a year	Less often +

you attend religious services these days?						Never/ practically never
89. What is the highest level of education you have completed?	Did not go to school	Year 7	Year 10	Year 12/ completed high school	Trade certificate/ apprenticeship	Bachelor Degree + Post-graduate degree
90. What political party do you values most align with	None	Don't know	Labour	Liberal	National Party	Australian Greens + Other (please write)
91. Please enter the postcode in which you currently live						
92. Have you given birth to, fathered or adopted any children?	No	Yes, one child	Yes, 2 children	Yes, 3 children	Yes, 4 children	Yes, 5 or more children
93. Are you currently, or have you ever, been a foster or stepparent?	Yes	No				
If yes to either 75 or 76: 76.a) Please tick the option that best describes you	Want to have more children	Do not want to have more children	Don't know whether I want to have more children			
If no to either 75 or 76: 76.b) Please tick the option that most applies to you	Want to have more children	Do not want to have more children	Don't know whether I want to have more children			
94. Have you or a partner:						
A. Ever had an abortion experience	No	Yes, once	Yes, more than once			
B. Ever had a miscarriage, stillbirth, or ectopic pregnancy	No	Yes, once	Yes, more than once			
C. Ever experienced infertility	No	yes				

D. Ever made an adoption plan?	No	yes				

Do you feel any characteristics/topics have been missed?

Any other comments (wording, question types, other)?

SECTION 7: Measuring sexism/patriarchal values

Research demonstrates a link between (ambivalent) sexism and abortion attitudes. We would like to establish whether this link exists in the Australian context.

To the best of our knowledge, the Ambivalent Sexism Inventory (ASI: Glicke and Fiske 1996) (and individual items from the scale) is most commonly used to measure levels of sexism in studies that have explored its relationship to abortion attitudes. While the instrument is validated as a whole (22 items), one 2014 study used just 10 of the items (5 each relating to benevolent and hostile sexism) with these short-form measures demonstrating good internal reliability, predictive validity and test-retest reliability over two years (Huang et al. 2014, pp.440-441)

Given the length of this questionnaire, we are concerned using the full scale will be asking too much of our respondents. We seek your advice on whether (and why) we should:

- Use the full scale (22 items) (please see below)
- Use the 10 items previously used by Huang 2014 (items 5, 8, 9, 11, 12, 14, 15, 16, 19, 22) – reflected in *italics* below.
- Don't use any items
- Other

ASI Items (Glick and Fiske 1996)

Item	**Measuring**
1. No matter how accomplished he is, a man is not truly complete unless he has the love of a woman	B
2. Many women are actually seeking special favors, such as hiring policies that favour them over men, under the guise of asking for "equality"	H
3. IN a disaster women ought not necessarily to be rescued before men	B
4. Most women interpret innocent remarks or acts as being sexist.	H
5. *Women are too easily offended.*	H
6. People are often truly happy in life without being romantically involved with a member of the other sex	B
7. Feminists are not seeking for women to have more power than men	H

8. *Many women have a quality of purity that few men possess*	B
9. *Women should be cherished and protected by men*	B
10. Most women fail to appreciate fully all that men do for the,	H
11. *Women seek to gain power by getting control over men*	H
12. *Every man ought to have a woman whom he adores*	B
13. Men are complete without women	B
14. *Women exaggerate problems they have at work*	H
15. *Once a woman gets a man to commit to her. She usually tries to put him on a tight leash*	H
16. *When women lose to men in a fair competition, they typically complain about being discriminated against*	H
17. A good woman should be set on a pedestal by her man	B
18. There are actually very few women who get a kick out of teasing men by seeming sexually available and then refusing male advances	H
19. *Women, compared to men, tend to have a superior moral sensibility*	B
20. Men should be willing to sacrifice their own well being in order to provide financially for the women in their lives	B
21. Feminists are making entirely reasonable demands of men	H
22. *Women as compared to men, ted to have a more refined sense of culture and good taste.*	B

H – Hostile Sexism; B – Benevolant Sexism

Comments:

Appendix G: Document to collect expert panel feedback - Round 2

Thank you for your participation in this process (Delphi/expert panel) to date.

We received 8 completed responses to Round 1 and the feedback was incredibly diverse and detailed. We have spent some time ensuring we have duly considered all feedback and recommendations, and incorporated these wherever we could and/or they were directly relevant to the aims of the study, and not addressed elsewhere. Some of the suggestions have been and will be incorporated into the qualitative study that will follow this questionnaire, noting this particular questionnaire will go to the Australian public broadly which limits the types of questions we can ask and topics we can explore.

Item inclusion/exclusion

We were quite strict with inclusion criteria, given the large number of items in the original draft survey.

Items that received 6 (75%) or more 'very useful/important' responses will be included in the final questionnaire.

Items were retained for re-evaluation in Round 2 if they received 5 'very useful/important' responses.

Items were removed if they received 4 or less (50% or less) 'very useful/important' responses.

Round 2

The priority for this round is ranking new items (in the same way we did in Round 1), along with re-ranking any items that did not reach consensus (many of which have been re-worked), based on more detailed descriptions of what we are trying to achieve with each section. After this round, the research team will then sit with the findings and remove repetition, address wording with preliminary testing, etc. We anticipate this will likely be the final round of feedback.

Along with rankings, we very much welcome any comments (general or item-specific) or suggestions.

A table with all items retained after Round 1 is in the Appendix at the end of the document. We would welcome comments in regard to these items (although this is not the priority for this round, above ranking new and re-worked items).

Please note, we will attempt to balance the framing (positive and negative) of statements in each section in the final document.

Section 7 has been removed: Based on feedback re. how to measure sexism, we are looking for just a few single items that can be used rather than using the whole 10 or 22 item scale included in Round 1. **If you are aware of or have used such items in the past we would welcome your suggestions.**

SECTION 1: General attitudes towards abortion (legality, funding, access)

<u>RESULTS: ROUND 1</u>

This section had 9 items in Round 1.

- While 6 items achieved 'consensus' to retain, several have been reworked based on qualitative feedback.
    - 3 have been retained (included in appendix)
    - 3 were reworked and included for feedback in Round 2
- 2 new items have been proposed by panellists/based on suggestions from panellists and are included for comment below

INSTRUCTIONS: We have decided to separate the concepts of legality and access, and have just one item measuring attitudes to each of these. Please state your preferred item from the options below, i.e. choose one from 1.a, b., c., or d.

1. To measure opinion on abortion legality.	
	a) Abortion should be legal under all circumstances b) Abortion should be legal for all women in Australia c) All women should have a legal right to abortion d) Abortion laws vary across Australian States and Territories. Many people don't know that abortion is still criminalised under many circumstances in some states and territories. Do you think abortion should be legal for all women in Australia?
2. *To measure opinion on women's right to access abortion services.*	
	e) All women should have access to abortion services. f) Abortion services should be available to all Australian women.

NEW ITEMS - INSTRUCTIONS: Please rate how important you believe each new item to be, in regard to assessing general acceptability of and support for abortion. Please place an 'X' in the most relevant column.

NEW Proposed Questions	***Proposed response categories***	**Very important**	**Somewhat important**	**Not important**
3. Women have the right to make decisions about their bodies	Strongly agree/agree/ disagree/ strongly disagree			
4. Women should act in their own self interest when deciding about abortion				

Comments:

SECTION 2: Views on contraception & responsibility

RESULTS: ROUND 1

This section had 13 items in Round 1.

- Just 1 item achieved 'consensus' to retain
- 8 items were removed
- 4 items received mixed responses from the panel

Abortion stigma intersects with multiple aspects of disadvantage and numerous other stigmas (related to gender, migrant status, income level, contraceptive use, sex, age, etc).

In this section, we are hoping to begin to unpack some of the conflation of stigmas related to unplanned pregnancy, the theme of women's *irresponsibility* when they experience unplanned pregnancies and/or have abortions, and abortion stigma. This is understandably a little messy, and agreement on items in this section in Round 1 was lower than for other sections. As such, we have reworked several questions and proposed a number of new ones, based on suggestions from the panel.

We are aware that contraceptive use/choices and abortion are separate and often unrelated issues, however they are commonly conflated in peoples imaginations and judgments towards women who have abortions, as demonstrated in prior research which points to a widely held assumption that women who have abortions are 'irresponsible'.

INSTRUCTIONS: We invite your comment and ranking as to how useful each proposed item is in measuring the concept of **responsibility/irresponsibility associated with abortion, contraceptive use and unplanned pregnancy**, and in contributing to unpacking and understanding this crossover/conflation.

Instruction to participants at the beginning of this section:

Assuming a man and woman are in a heterosexual relationship…

Comments	**Item**	**Proposed response options**	**Very useful**	**Somewhat useful**	**Not useful**
	ITEMS FROM ROUND 1 – CONSENSUS NOT ACHIEVED				
	5. A woman who has more than one abortion is irresponsible	Strongly agree/ agree/ disagree/ strongly disagree			
	6. A woman who has more than one unplanned pregnancy is irresponsible.				
	7. Who do you think is mainly responsible for ensuring contraception is used to prevent an unplanned pregnancy?	mainly the man/ mainly the woman/ the man and woman equally			
	PROPOSED NEW ITEMS				
Proposed follow up to Q 7.	**8.** Who do you think **should be** mainly responsible for ensuring contraception is used to prevent unwanted pregnancy (in a heterosexual relationship)?	mainly the man/ mainly the woman/ the man and woman equally			
	9. A woman who has an unplanned pregnancy is careless	Strongly agree/ agree/ disagree/ strongly disagree/ **unsure**			
Include the word 'frequently'?	10. Women **frequently** use abortion as a form of contraception.				

	11. A woman who has an abortion as a result of an unplanned pregnancy should have used contraception				
To facilitate comparison with abortion stigma questions in following sections	*12.* I would feel ashamed if a member of my family experienced an unplanned pregnancy	Strongly agree/ agree/ disagree/ strongly disagree/ **unsure**			
	13. It is mainly teenaged, unmarried women who experience unplanned pregnancies				

Comments:

SECTION 3: Abortion knowledge and myths

RESULTS: ROUND 1

This section had 6 items in Round 1.

- 4 items (66%) achieved consensus to retain
  - 3 of these have been retained as they were.
  - 1 has been reworked based on comments
- 1 item was removed entirely, based on panel rankings, and 1 removed as it was deemed repetitive.
- 12 new items have been included in Round 2, based on suggestions from the panel.

This section measures myths and misinformation. We hope to be able to identify whether myths and misinformation are correlated with stigmatising attitudes in the sample, as well as more broadly understand the extent of knowledge and misinformation among Australian adults on this topic.

INSTRUCTIONS: A large number of new items were proposed by our expert panel during Round 1. Please rank the items below, considering how relevant they are likely to be the population you work with or study/ the Australian population, and how important they are in measuring abortion and contraceptive/pregnancy knowledge. While there are myriad aspects of knowledge we could measure here, we are really looking for those the panel feels are most valuable and will be most relevant to a wide range of respondents.

NEW Proposed Questions	**Proposed Measurement**	**Very important / relevant**	**Somewhat important / relevant**	**Not very important / relevant**
14. To the best of your knowledge, what % of pregnancies do you think are unplanned?	10%/ 30%/ 50%/ 80%			

15. Approximately what % of pregnancies do you think end in abortion in Australia?	5%/ 15%/ 25%/ 50%/ 70%			
16. Reducing access to abortion services reduces the number of abortions that take place.	True/False/Unsure			
The original item has been reframed to be open-ended, so as not to lead participants. Please rank the proposed new item: 17. NEW: Some types of women are more likely to have abortions than others If Strongly agree or agree… Please describe which types of women you believe are more likely to have an abortion…	4 point Likert: (Strongly agree/ Agree/ Disagree/ Strongly Disagree OPEN ENDED			
18. Women experiencing domestic violence are more likely to experience an unplanned pregnancy	(Strongly agree/ Agree/ Disagree/ Strongly Disagree)			
19. Having an abortion increases a woman's risk of getting breast cancer	(Strongly agree/ Agree/ Disagree/ Strongly Disagree)			
20. Based on what you have heard, how safe is medication abortion?	Very safe/ somewhat safe/not too safe/ not safe at all/don't know			
21. Based on what you have heard, how safe is surgical abortion?	Very safe/ somewhat safe/not too safe/ not safe at all/don't know			
22. The public health system provides abortion services in most places in Australia	True/false/ I don't know			
23. Please indicate your preference for a or b by ranking each. a) Approximately how many women who have had abortions were using contraception when they got pregnant? Please tick the answer you think is most accurate.	(10%/20%/40%/60 %)			
OR b) More than half of all women who have abortions were using contraception when they got pregnant	True/False			

24. Young (under 20 years old), unmarried women are more likely to have abortions than other women.	Strongly agree/agree/ disagree/ strongly disagree			
25. Do you know the legal status of abortion in the state/territory you live in?	Yes, I know it/ I have some idea/ No, I don't know			
26. Would you say you understand the difference between medication and surgical abortions	Yes / Somewhat/ not at all			

Comments:

SECTION 4: Stigmatising Attitudes

RESULTS: ROUND 1

This section had 30 items in Round 1.

- 17 items (56.66%) achieved consensus to retain
- 5 new items have been included in Round 2, based on suggestions from the panel
- 5 items were removed based on Round 1 rankings.
- The panel disagreed on the importance of 8 items, which have been included again in Round 2.

This section aims to explore the types and extent of stigmatising attitudes to abortion in Australia. The final version will include a balance of positively and negatively framed statements. We hope that in balancing the framing of statements we can minimise the potential for the tool itself to perpetuate harmful stereotypes.

INSTRUCTIONS: We ask you to rank the value/usefulness of items below, which include a mix of items that did not reach consensus from Round 1 and new items. Please consider whether each item reflects an issue that you have encountered or would likely be relevant to the people/communities you work with/study, along with wording and general structure when 'scoring' each item. *This said*, if wording is your primary concern with an item, but you feel the concept is important, please rank it useful/very useful and make a note of this/any suggestions you have in the 'comments' section below.

Questions	Item origin	Measurement	Very useful/ relevant	Somewhat useful/ relevant	Not useful/ relevant
Stigmatising attitudes towards women: moral judgments		Strongly agree/ Agree/ Disagree/ Strongly Disagree			
27. A woman who has an abortion is committing a sin	From Round 1				
28. Abortion is the easy way out of an unplanned pregnancy	From Round 1				
29. Women are often thinking about the impact of another child on their family when they decide for abortion	NEW				
Stigmatising attitudes towards women: Shame and discrimination					
30. I would feel ashamed if a member of my family had an abortion	From Round 1				
31. Women who have abortions should feel badly about themselves	From Round 1				
32. A woman who has an abortion should still be allowed to attend religious services	From Round 1				
33. I would look down on a woman who had multiple abortions	New				
Attitudes towards abortion providers					
34. Health professionals who perform abortions are committing a sin	From Round 1				
35. Doctors and midwives who perform abortions are just doing it for the money	From Round 1				
36. Health services that provide abortions are usually unsafe and unclean	New				

Comments:

SECTION 5: Perceived Stigma

RESULTS: ROUND 1

This section had 50 items in Round 1.

- 34 items achieved consensus to retain, the highest percentage of any section.
    - However, only 21 of these have been retained– see note below *. Several of these have been moved into other sections.
- 13 items received mixed responses – the 4 that were not removed (see note below*) are included for ranking a second time.
- 8 new items have been included in Round 2, based on suggestions from the panel.

This section will measure perceived/anticipated abortion stigma. This refers to people's anticipation/ beliefs about social norms and likely/potential experiences of stigma and discrimination people would receive based on their abortion experience or work.

INSTRUCTIONS: When ranking items, please consider the importance of each item, in your experience, including whether the question would likely be important or relevant to the people you work(ed) with/ study(ied).

Sub-section	*QUESTION*	**Proposed response categories**	**Very important**	**Somewhat important**	**Not important**
	ITEMS FROM ROUND 1				
Anticipated community stigma	37. People in small towns and country areas are generally less supportive of abortion than people living in big cities	Strongly agree/ agree/ disagree/ strongly disagree			
	38. People in my town/local community are probably less supportive of abortion than people in other parts of Australia				
	39. When people know that a woman has had an abortion, they assume she is/will be a bad mother.				
Disclosure & Secrecy	40. In general, telling others about an abortion is a mistake				
	NEW ITEMS				
(Most people in Australia…)	41. …would offer care and support if they found out a friend or family member had an abortion	Strongly agree/agree/ disagree/ strongly disagree			
Anticipated community stigma	42. Women are more likely to be judged if they have an abortion later in pregnancy (rather than earlier in the pregnancy/ in the first 12 weeks).				
Disclosure and secrecy:	43. *Do you think women who have abortions…* could lose their job if people at work find out about their abortion?				
	44. People often do not discuss their views on abortion due to the stigma				
	45. People often don't talk about their abortion experiences due to the stigma				
Abortion providers	46. Women may be deterred from having an abortion if they saw protestors outside of the abortion service				
	47. Most people would think more negatively of abortion providers than other types of doctors				

The following item achieved consensus to retain, however a query was raised as to its potential to be harmful to people who have (or have family members/children/friends) with genetic or health conditions. I'd appreciate your feedback as to whether you feel the item is appropriate, should be

deleted or amended. We are trying to assess 'types of abortions' differences in stigmatisation of 'social' vs 'medical' abortions.

48. People are less likely to experience judgment for abortions if they are for medical/health reasons (rather than for personal, relationship or financial reasons)

Comments:

SECTION 6: Demographics/ respondent characteristics

RESULTS: ROUND 1

This section had 19 items in Round 1. We did not ask for rankings individually, but for more general feedback.

Based on valuable feedback from panellists and consultation beyond the panel to experts in a range of field (such as inclusivity in recording gender in surveys), many of these have been reworked or altered.

This section will be used to help us determine characteristics that are correlated with particular aspects of abortion stigma, as well to understand how well our sample reflects the Australian population more broadly in regard to particular characteristics.

INSTRUCTIONS: We invite comments regarding the 'demographics' questions below. In particular, we would welcome feedback about the relevance/importance of the highlighted questions, including whether they should be removed entirely.

Question		**Comments?**
49. Age	Open ended	
50. Gender	Male/female/gender diverse or non-conforming/prefer not to answer	
51. Do you consider yourself to be?	Heterosexual or straight/ Gay or lesbian/	

	Bisexual or pansexual/ Prefer not to answer Other	
52. Are you currently	Married/ Defacto/ Never married or Single/ Separated but not divorced/ Divorced widowed	
53. Are you of Aboriginal or Torres Strait Islander Origin? (tick all that apply)	No/ Yes, Aboriginal Australian/ Yes, Torres Strait Islander Australian/ Aboriginal and Torres Strait Islander Australian	
54. In what country were you born?	Australia/ England/ New Zealand/ India/ Italy/ Vietnam Philippines Other (please specify)	
55. In what year did you first arrive in Australia to live here for 1 year or more?	Have been in Australia for less than 1 year/ Date	
56. The nationality I most identify with is	OPEN ENDED	
57. Do you identify as a member of a particular religion?	No religion/ Yes, Catholic/ Yes, Anglican (Church of England)/	

	Yes, Uniting Church/ Yes, Presbyterian/ Yes, Budhism/ Yes, Islam/ Yes/Greek Orthodox/ Yes, Baptist/ Yes, Hindu/ Yes, Muslim/ Other (please specify)	
IF YES: 58. a) Apart from weddings and funerals, about how often do you attend religious services these days?	More than once a week/ Once a week/ Once a month/ Only on special holidays/ Once a year/ Never – practically never	
59. Does your faith or religion affect your views about abortion?	Yes/no/Don't know	
60. What is the highest level of education you have completed?	Did not go to school/ Year 7/ Year 10/ Year 12 – completed high school/ Trade certificate or apprenticeship/ Bachelor degree/ Post-graduate degree	
61. What political party do you most align with	None/ Don't know/ Labour/ Liberal/ National party/	

	Australian greens/ Other (please write)	
62. Do you support same sex marriage?	Yes/ no/ Unsure/ Prefer not to answer	
63. a) Please enter the postcode of the suburb in which you live OR b) How would you describe the area in which you live?	OPEN ENDED OR Metropolitan-city /Outer Metropolitan - suburbs/ Rural/ Remote	**Preference?**
64. Have you ever given birth?	No NA Yes – 1 child Yes – 2 children Yes – 3 children Yes – 4 children Yes – 5 or more children	
65. Have you ever (biologically) fathered a child?	NO NA Yes – 1 child Yes – 2 children Yes – 3 children Yes – 4 children Yes – 5 or more children	
66. Have you ever parented a child you didn't give birth to/father biologically?	No NA Yes – 1 child Yes – 2 children Yes – 3 children	

	Yes – 4 children Yes – 5 or more children	
If **yes** to either 101 or 102: .a)Please tick the option that best describes you	Want to have more children/ Do not want to have more children/ Don't know whether I want to have more children/ NA	
If **no** to either 101 or 102: Please tick the option that most applies to you	Want to have more children/ do not want to have children/ don't know/ NA	
Have you or a partner:		
E. Ever had an abortion experience	No/ Yes, once/ Yes, more than once/ NA/ Prefer not to say	
F. Ever experienced an unplanned pregnancy?	No/ Yes, once/ Yes, more than once/ NA/Prefer not to say	
G. Ever had a miscarriage,	No/ Yes, once/ Yes, more than once/ NA/Prefer not to say	
H. Ever had a stillbirth	No/Yes/ Prefer not to say	
I. Ever had an ectopic pregnancy	No/Yes, once/ Yes, more than once/ NA/ Prefer not to say	
J. Ever experienced infertility	No/ Yes/ NA/ Prefer not to say	

K. Ever made an adoption plan?	No/ Yes/ NA/ Prefer not to say	
L. Ever had a baby stolen from you?	No/ Yes/ Prefer not to say	
67. Were you ever in the foster system as a child?	No/Yes/ Prefer not to say	
68. Were you adopted as a child?	No/Yes/ Prefer not to say	
69. Have you ever willingly relinquished a child into somebody else's care?	No/Yes/ Prefer not to say	
70. Have you ever known someone who had an abortion?	Yes/ No/ I don't know	

Comments:

Items to be retained based on Round 1 ratings

After Round 1 our panel agreed these items were important to keep. They received 6 or more (very important/useful) responses.

This said, if you have any suggested changes or issues with these items, please include these in the 'comments' column.

Questions that achieved consensus to retain:	Proposed measurement	Comments
SECTION 1		
71. Abortion is a woman's right	Strongly agree/ agree/ disagree/ strongly disagree	
72. Abortion is always wrong		
73. The Public health system should provide abortion services.*		
74. Medicare should cover the cost of abortion services*		
SECTION 2		
75. It is the woman's responsibility to prevent unwanted pregnancy	Strongly agree/ Agree/ Disagree/ Strong disagree	

SECTION 3		
76. To the best of your knowledge, what proportion of women do you think will have an abortion in their lifetime	1 in 3/ 1 in 10/ 1 in 50/ 1 in 100	
77. Women who have multiple abortions may not be able to have children later in life	Strongly agree/ agree/ disagree/ strongly disagree	
78. Abortion (**in the first 12 weeks of pregnancy)** is safer for a woman's health than continuing pregnancy and childbirth. (REFRAMED TO POSITIVE)		
SECTION 4		
SUB-SECTION: Stigmatising attitudes towards women: moral judgments		
79. Women who have an abortion have done something wrong		
80. Women who have an abortion usually have good reasons		
81. Women who have an abortion do not deserve to have a family		
82. Women who have an abortion because they don't feel ready to have children are responsible (or 'making a responsible choice')		
83. Women who have an abortion should be more careful		
84. Women who have an abortion probably feel like less of a woman		
SUB-SECTION: Stigmatising attitudes towards women- shame and discrimination		
85. I have less respect for a woman who has an abortion		
86. I would respect a woman who has an abortion –she should make the decision that's best for her		
87. It is okay for a woman to feel relieved after having an abortion		
SUB-SECTION: Social Support		
88. I would continue to be friends with someone if I found out that they had an abortion		
89. Reworded to a positive frame: A woman who has an abortion should be treated with the same level of respect as everyone else		
90. If a friend or family member had an abortion, I would not judge her		
91. I could support a woman who had an abortion even if I didn't agree with her decision		
92. I would defend someone who had an abortion if people were saying negative things about her in a social setting		

SUB-SECTION: Attitudes towards abortion Providers		
93. I respect a doctor or midwife who helps women have a safe abortion		
94. Doctors and midwives who perform abortions are bad people		
95. Doctors and midwives who perform abortions are simply doing their job		
96. Abortion providers make a positive contribution to society		
97. Abortion providers should be proud of the work they do		
SECTION 5		
SUB-SECTION: Anticipated community stigma		
98. *Most people in Australia:*		
99. Support access to/legal abortions		
100. Would think badly about women who have had an abortion		
101. Would think negatively about women who have had more than one abortion		
102. Most people in my local community are supportive of abortion/ pro-choice		
103. Women are held more responsible for abortion than men		
SUB-SECTION: Disclosure and secrecy		
104. I would willingly tell people about my views on abortion if it came up in a social setting		
105. I would willingly share my views on abortion with the people I work with if the topic came up		
106. *Do you think **most** women who have abortions:*		
a) are at risk of harassment/violence because of their abortion?		
b) would be able to talk openly about their abortion with close friends and family members?		
c) need to keep their abortion a secret from colleagues/acquaintances?		
K. are likely to be excluded from their religious group?		
d) should avoid telling people in order to avoid judgmental reactions?		
e) are rejected from social or family groups		
f) are likely to be gossiped about		
SUB-SECTION: Healthcare experiences		
107. I would expect abortion providers and staff in abortion clinics would be friendly and supportive		

108. Women may receive negative or judgmental treatment from their regular healthcare provider/GP when they find out about their abortion. (reworded slightly)		
SUB-SECTION: Abortion providers		
109. People who do abortion work *would not* want people to know about what they do		
110. I would expect most abortion providers in Australia have experienced some form or harassment or violence due to their work		

**(New items, based on recommendation to separate out original that addressed Medicare and public provision in one). Original item achieved consensus: 'The Government/Medicare should cover the costs of abortions'.*

Appendix H: Phase C reliability testing

Table H1: Kappa and Weighted Kappa scores

Questions	Kappa (t1 and t2)
1. Abortion should be legal and available to women in Australia	.899*
2. Medicare should cover the cost of abortion services	.662*
3. Women have the right to make decisions about their bodies	1*
4. The public health system should provide abortion services	.925*
5. Abortion is the same as murder (rc)	.51*
6. *It is okay for a woman to feel relieved after having an abortion	1
7. *Women who have had an abortion have done something wrong (Rc)	1
8. *Women who have an abortion usually have good reasons	1
9. *Women who have an abortion do not deserve to have a family of their own (Rc)	0.604**
10. *I would feel ashamed if a member of my family had an abortion (Rc)	0.65**
11. *I would think negatively about a woman who has had multiple abortions (Rc)	0.517
12. *Women who have an abortion because they don't feel ready to have children are making a responsible choice	0.521
13. *I would continue to be friends with someone who had an abortion	0.164**
14. *I would defend someone who had an abortion if people were saying negative things about her in a social setting	0.472
15. Health professionals who provide abortions are bad people (rc)	0.76**
16. I respect a health professional who helps women have a safe abortion	0.525**
17. Health professionals who provide abortions don't really care about the wellbeing of women (rc)	-0.036
18. Health professionals who provide abortions make a positive contribution to society	0.782
Most people in Australia:	
19. Believe abortion should be legal and available	0.661
20. Would offer support to a friend or family member who had an abortion	0.34
21. Think negatively about women who have had an abortion (rc)	0.39

22. Would think negatively about women who have had more than one abortion (rc)	0.429
23. Most people in my local community are supportive of access to safe and legal abortions/ are pro-choice	0.526
24. People in small towns and country areas are generally less supportive of abortion than people living in big cities (rc)	0.308
25. Women are more likely to be judged if they have an abortion later in pregnancy (rather than earlier/ in the first trimester)	0.782
26. Women are less likely to experience judgment for abortions that are for health reasons (rather than for personal/relationship/financial reasons)	0.651
Most women in Australia who have abortions are:	
27. Likely to be gossiped about	0.607
28. At risk of harassment because of their abortion	0.536
29. Rejected from social or family groups	0.495
30. Should keep their abortion a secret from their colleagues	0.714
31. Would able to talk about their abortion with close friends and family members	0.313
32. I would expect health professionals who provide abortion services to be friendly and supportive	0.664**
33. Women may receive negative or judgmental treatment from their regular healthcare provider or GP if they find out about their abortion	0.41
34. Women may be discouraged from having an abortion if they see protestors outside of the abortion service	0.521
35. Most health professionals who provide abortions *would not* want people to know about what they do	0.386
36. I would expect most abortion providers in Australia have experienced some form of harassment or violence due to their work	0.444
37. Most people think more negatively about abortion providers than about other types of health professionals	0.578
38. Domestic chores should be shared between husband and wife	0.651
39. Working women put a strain on the family (rc)	0.837
40. Boys and girls should play with the same toys	0.44
41. A husband should make the important decisions (rc)	1
42. Most women interpret innocent remarks or acts as being sexist	0.275
43. A mother who stays home and raises children is not the only ideal type of mother	0.344
44. Do you support same sex marriage	1**

**weighted kappa; ** non-binary (original) data used; RC = reverse coded*

Appendix I: Results of Principal Components Analysis

Table I1: PCA - Factor Loading and Cronbach's Alpha statistics

Item	Factor loading	Factor	Cronbach's Alpha
26. Safety surgical abortion	.854*	Knowledge - Safety	.693
25. Safety medication abortion	.839*		
19. Abortion and breast cancer risk	.661*		
24. % pregnancies in Australia unplanned	.757**	Knowledge – Commonality	.237
23. % women who have abortion experiences	.750**		
27. Abortion should be legal and available	.956	Beliefs	.950
28. Women have the right to make decisions about their bodies	.831		
29. The public health system should provide	.958		
30. Medicare should cover the cost of abortion	.912		
31. Abortion is the Same as Murder*	.925		
34. It is okay for a woman to feel relieved after having an abortion	.864	Attitudes	.952
35. Women who have had an abortion have done something wrong*	.876		
36. Women who have an abortion usually have good reasons	.825		
38. I would feel ashamed if a member of my family had an abortion*	.797		
39. I would think negatively about a woman who has had more than one abortion*	.722		
40. Women who have an abortion because they don't feel ready to have children are making a responsible choice	.839		
42. I would defend someone who had an abortion if people were saying negative things about her in a social setting	.765		
43. A woman who has more than one abortion is irresponsible*	.797		
44. Health professionals who provide abortions are bad people*	.867		
45. I respect a health professional who helps women have safe abortions	.870		
46. Health professionals who provide abortions make a positive contribution to society	.900		

51. Most women in Australia who have abortions are likely to be gossiped about*	.673	Anticipated Stigma	.781
53. Most women in Australia who have abortions are at risk of harassment because of their abortion*	.804		
54. Most women in Australia who have abortions are rejected from social or family groups*	.769		
58. I would expect most abortion providers in Australia have experienced some form of harassment or violence due to their work*	.678		
59. Most people think more negatively about abortion providers than about other types of health professionals*	.580		
47. Most people in Australia believe abortion should be legal and available	.803	Perceived Community Stigma	.778
50. Most people in my local community are supportive of access to safe and legal abortions/ are pro-choice	.731		
48. Most people in Australia would think negatively about a woman who has had an abortion*	.709		
49. Most people in Australia would think negatively about a woman who has had more than one abortion*	.660		
55. I would expect health professionals who provide abortion services to be friendly and supportive	.572		
51. Women are more likely to be judged if they have an abortion (for non-medical reasons) later in pregnancy, rather than earlier/ in the first trimester*	.703	Choice & Judgment	.609
52. Women are less likely to experience judgment for abortions that are for health reasons (rather than for personal/relationship/financial reasons)	.876		

**Item reverse coded*

Appendix J: The Australian Abortion Stigma Survey (TAASS): final version

Item	Response categories
Personal and demographic characteristics	
1. What age did you turn at your last birthday?	Open response box
2. What is your sex	Male (1), Female (2), Other-please specify (open response box) (3)
3. What state or territory do you currently live in?	New South Wales (NSW) (1) Victoria (Vic) (2) Queensland (QLD) (3) Western Australia (WA) (4) South Australia (SA) (5) Tasmania (Tas) (6) Northern Territory (NT) (7) Australian Capital Territory (ACT) (8)
4. How would you describe the area in which you live?	Metropolitan/city (1) Outer metropolitan/ outer suburbs (2) Rural (3) Remote (4)
5. Are you of Aboriginal or Torres Strait Islander origin?	No (1) Yes, Aboriginal Australian (2) Yes, Torres Strait Islander Australian (3) Yes, Aboriginal and Torres Strait Islander Australian (4)
6. In what country were you born?	Australia (1), Other (please specify) (2)
7. Which nationality or nationalities do you most strongly identify with? Please write all that apply.	Open response box

8. Do you identify as a member of a particular religion?	No (1) Yes, Catholic (2) Yes, Anglican (Church of England) (3) Yes, Uniting Church (4) Yes, Presbyterian (5) Yes, Budhism (6) Yes, Greek Orthodox (7) Yes, Baptist (8) Yes, Hindu (9) Yes, Muslim (10) Yes, Other (11)
9. Apart from weddings and funerals, about how often do you attend religious services these days?	More than once a week (1) Once a week (2) Once a month (3) Only on special holidays (4) Once a year (5) Never/ practically never (6)
10. Does your faith or religion affect your views about abortion?	Yes, significantly (1) Yes, somewhat (2) No, not much (3) No, not at all (4) Don't know (5)
11. What is the highest level of education you have completed?	Did not go to school (1) Completed primary school (2) Completed Year 10 (3) Completed High School (4) Trade, certificate or apprenticeship (5) Bachelor Degree (6) Post-graduate degree (7)
12. What political party do you most closely align with?	None (1) Don't know (2) Australian Labor Party (3) Liberal Party of Australia (4) The Nationals (5) Australian Greens (6) Other (Please write) (7)
Pregnancy, birth and parenting experiences	
13. Have you ever given birth?	No (1) Yes, 1 child (2) Yes, 2 children (3) Yes, 3 children (4) Yes, 4 or more children (5) Not Applicable (6)

14. Have you ever (biologically) fathered a child?	No (1) Yes, 1 child (2) Yes, 2 children (3) Yes, 3 children (4) Yes, 4 or more children (5) Not Applicable (6)
15. Have you ever parented a child or children that weren't biologically your own?	Yes (1) No (2)
16. Have you or a partner ever had an abortion experience?	No (1) Yes, once (2) Yes, more than once (3) NA (4) Prefer not to say (5)
17. Have you or a partner ever experienced an unplanned pregnancy?	No (1) Yes, once (2) Yes, more than once (3) NA (4) Prefer not to say (5)
18. Has someone you know (other than a sexual partner) ever told you about their abortion experience?	Yes (1) No (2) Don't know (3)
Knowledge	
19. Having an abortion increases a woman's risk of getting breast cancer (1)	Strongly agree (1) Agree (2) Disagree (3) Strongly disagree (4) Unsure (5)
20. The public health system provides abortion services in most towns and cities in Australia (2)	
21. Teenaged women/girls are more likely to have abortions than other women (3)	
22. Women experiencing domestic violence are more likely to experience an unplanned pregnancy (4)	
23. How many women in Australia do you think will have an abortion in their lifetime?	1 in 3 (1) 1 in 6 (2) 1 in 10 (3) 1 in 15 (4) 1 in 20 (6)
24. What % of pregnancies in Australia do you think are unplanned?	5% (1) 10% (2) 30% (3) 50% (4) 70% (5)
25. Based on what you've heard or know, how (physically) safe is medication abortion? (1)	

26. Based on what you've heard or know, how (physically) safe is surgical abortion? (2)	Very safe (1) Quite safe (2) Not very safe (3) Very unsafe (4) Unsure (5)
Beliefs and attitudes	
27. Abortion should be legal and available to women in Australia	Always (1) In most circumstances (2) In some circumstances (3) Never (4)
28. Women have the right to make decisions about their bodies	
29. The public health system should provide abortion services	
30. Medicare should cover the cost of abortion services	
31. Abortion is the same as murder	
32. When a man and woman are intimately involved, who do you think should take responsibility for ensuring contraception is used to prevent an unplanned pregnancy?	Mainly the man (1) Mainly the woman (2) The man and woman equally (3) Unsure (4)
33. I would feel ashamed if a member of my family experienced an unplanned pregnancy	Strongly agree (1) Agree (2) Disagree (3) Strongly disagree (4)
34. It is okay for a woman to feel relieved after having an abortion	
35. Women who have had an abortion have done something wrong	
36. Women who have an abortion usually have good reasons	
37. Women who have an abortion do not deserve to have a family of their own	
38. I would feel ashamed if a member of my family had an abortion	
39. I would think negatively about a woman who has had more than one abortion	
40. Women who have an abortion because they don't feel ready to have children are making a responsible choice	
41. I would continue to be friends with someone who had an abortion	

42. I would defend someone who had an abortion if people were saying negative things about her in a social setting	
43. A woman who has more than one abortion is irresponsible	
44. Health professionals who provide abortions are bad people	
45. I respect a health professional who helps women have safe abortions	
46. Health professionals who provide abortions make a positive contribution to society	
Stigma	
Most people in Australia… 47. Believe abortion should be legal and available	Strongly agree (1) Agree (2) Disagree (3) Strongly disagree (4)
48. Would think negatively about a woman who has had an abortion	
49. Would think negatively about a woman who has had more than one abortion	
50. Most people in my local community are supportive of access to safe and legal abortions/ are pro-choice (1)	
51. Women are more likely to be judged if they have an abortion (for non-medical reasons) later in pregnancy, rather than earlier/ in the first trimester (3)	
52. Women are less likely to experience judgment for abortions that are for health reasons (rather than for personal/relationship/financial reasons) (4)	
Most women in Australia who have abortions… 51. Are likely to be gossiped about	
52. Should keep their abortion a secret from their colleagues	
53. Are at risk of harassment because of their abortion	
54. Are rejected from social or family groups	
55. I would expect health professionals who provide abortion services to be friendly and supportive	

56. Women may receive negative or judgmental treatment from their regular healthcare provider or GP if they find out about their abortion	
57. Women may be discouraged from having an abortion if they see protestors outside of the abortion service	
58. I would expect most abortion providers in Australia have experienced some form of harassment or violence due to their work	
59. Most people think more negatively about abortion providers than about other types of health professionals	
Gender roles/ Sexism	
60. Domestic chores should be shared between male and female partners	Strongly agree (1) Agree (2) Disagree (3) Strongly disagree (4)
61. Working women put a strain on the family	
62. A husband/ male partner should make the important decisions	
63. Boys and girls should play with the same toys	
64. Do you support same sex marriage?	Yes (1) No (2) Unsure (3) Prefer not to answer (4)

Appendix K: Subscale mean score distributions

Figure K1. Knowledge subscale

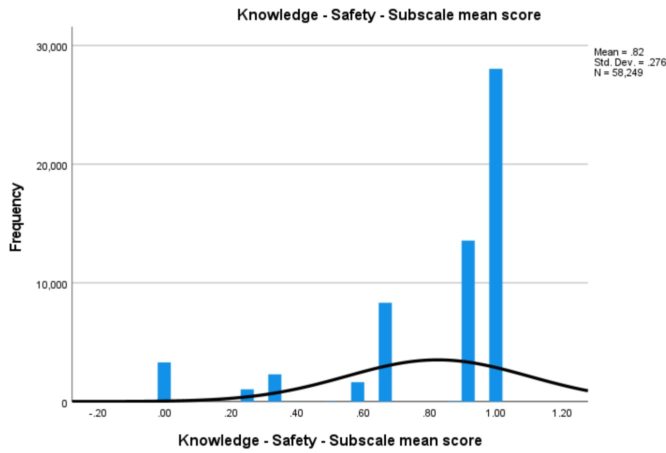


Figure K2. Beliefs subscale

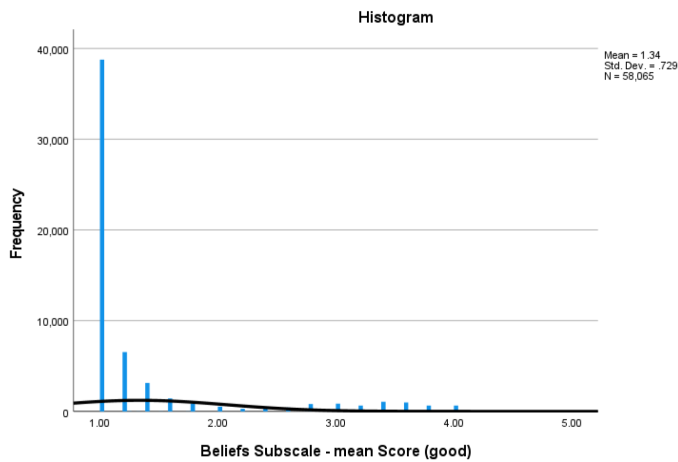


Figure K3. Attitudes subscale

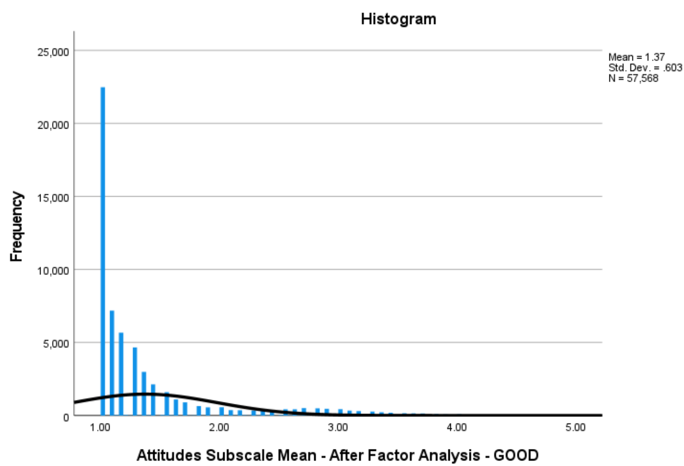


Figure K4. Anticipated Stigma (Social Consequences) subscale

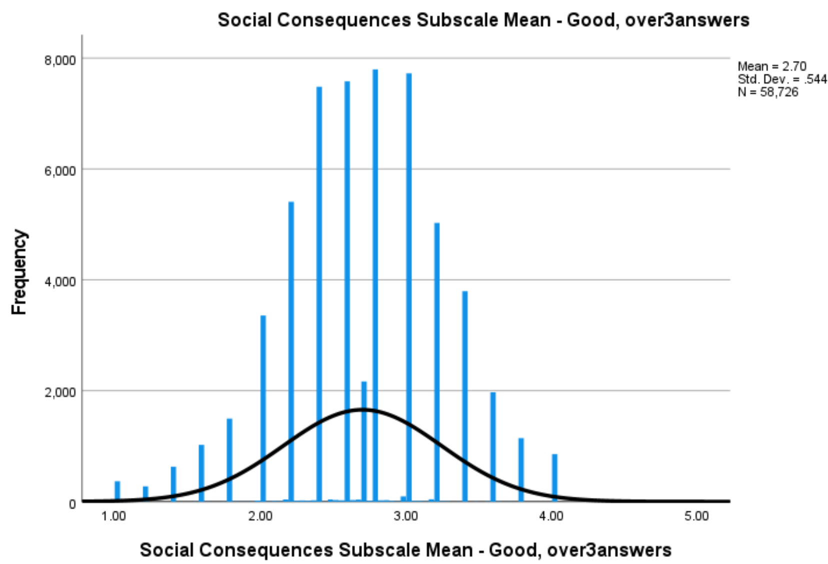
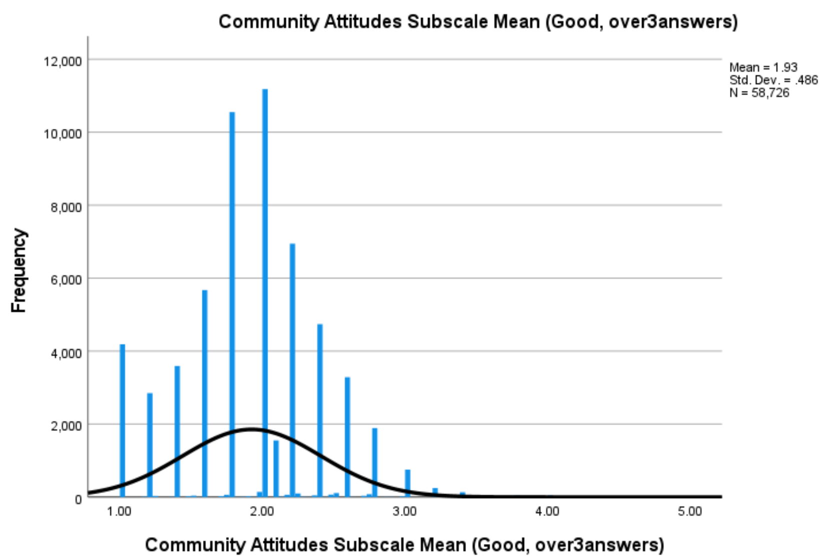


Figure K5. Perceived Community Stigma subscale



Appendix L: SPSS outputs - assessing regression assumptions

AL.1 Test of normality

Figure L1. Distribution of Anticipated Stigma scores

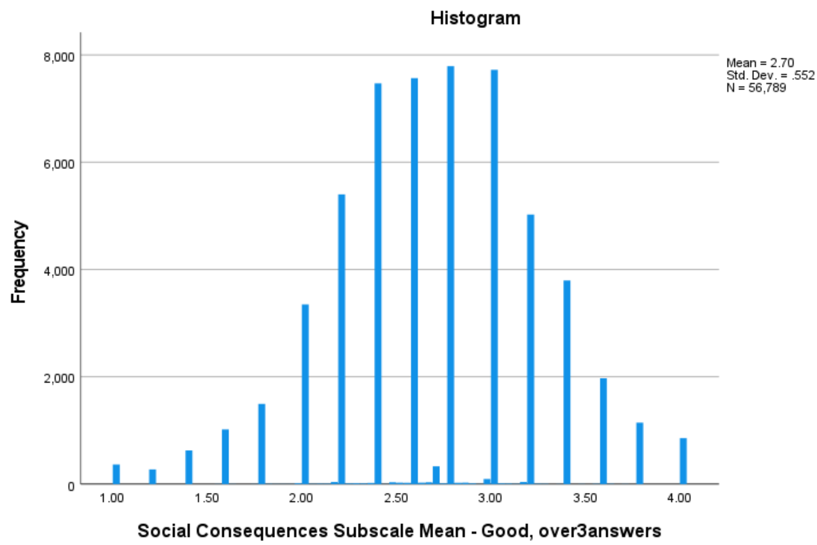


Figure L2. Q-Q Plot - Anticipated Stigma

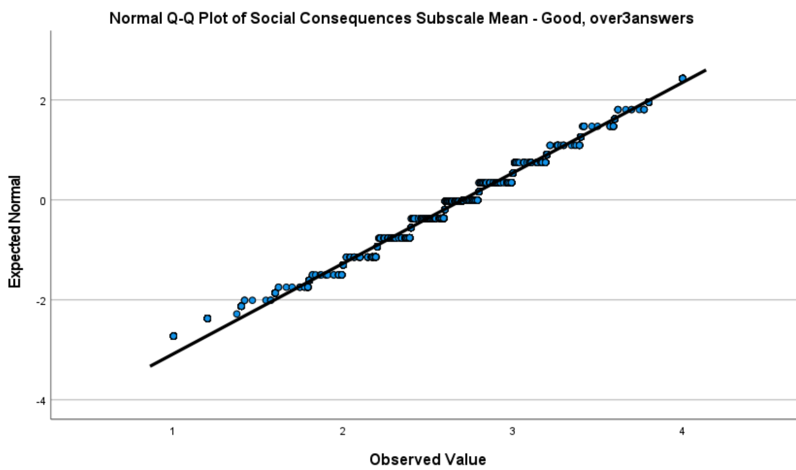


Figure L3. P-P Plot - Anticipated Stigma

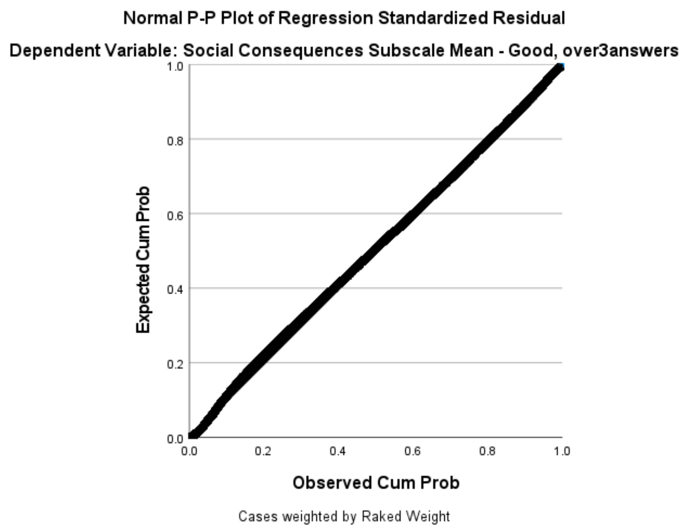


Figure L4. Distribution of Standardised Residuals – Anticipated Stigma

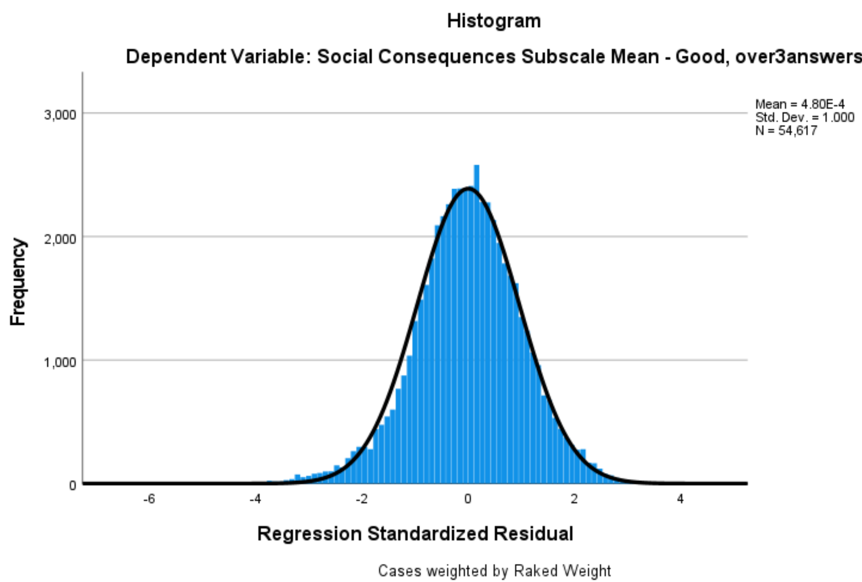


Figure L5. Distribution of Perceived Stigma scores

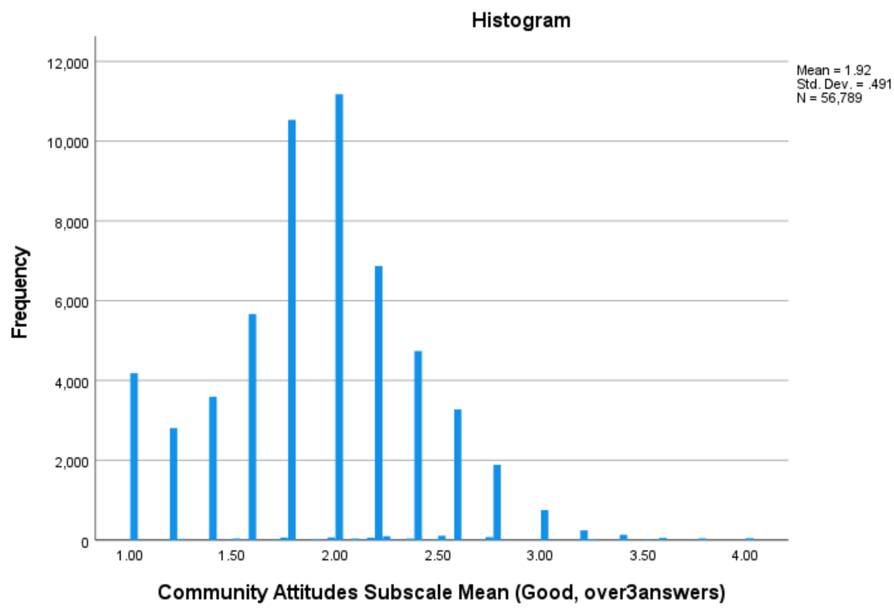


Figure L6. Q-Q Plot – Perceived Stigma

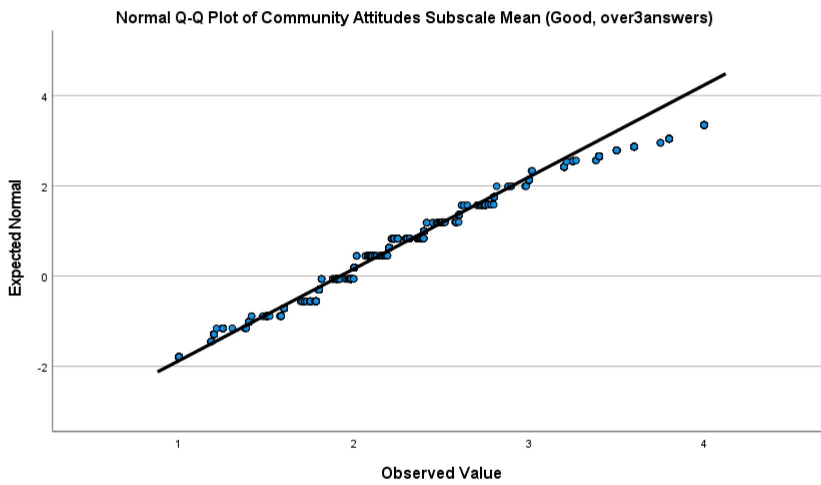


Figure L7. P-P Plot – Perceived Stigma

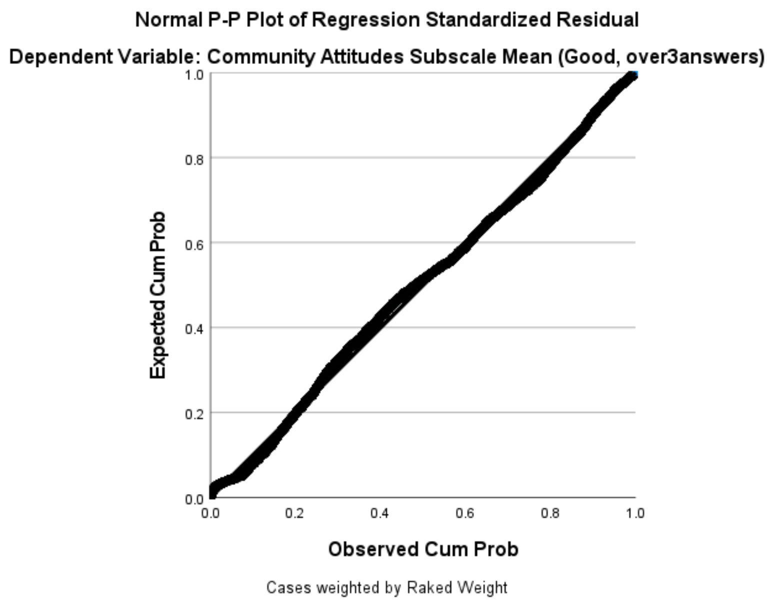
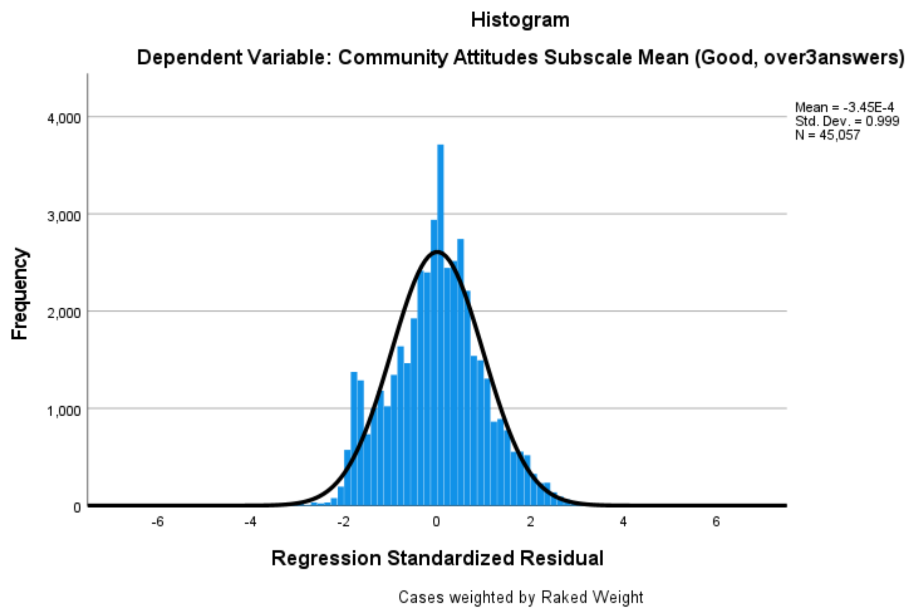


Figure L8. Distribution of Standardised Residuals – Perceived Stigma



AL.2 Tests of Linearity

Table L1: Correlation coefficients – dependent & independent variables

Independent Variable	**Correlation Coefficient (significance):** ***Social Consequences – Anticipated Stigma***	**Correlation Coefficient (significance):** ***Community Attitudes – Perceived Stigma***
Age	-.295 (*P*<.001)*	.029^ (*P*<.001)*
Sex	.094^ (*P*<.001)**	-.034^ (*P*<.001)**
Rural/Urban	.016^ (*P*<.001)**	.043^ (*P*<.001)**
ATSI	.032^ (*P*<.001)**	.004^ (*P*=.377)**
Country born	-.082^ (*P*<.001)**	.019^ (*P*<.001)**
Religion	-.158 (*P*<.001)**	.322 (*P*<.001)**
Religious Attendance	.224 (*P*<.001) **	-.369 (*P*<.001)**
Education	-.068^ (*P*<.001)**	-.071^ (*P*<.001)**
Political preference	-.112** (*P*<.001)**	.233 (*P*<.001)**
Biological Parent	-.197** (*P*<.001)**	.061^ (*P*<.001)**
Non-biological parent	-.033^ (*P*=.002)**	-.003^ (*P*<.001)**
Abortion experience	.002^ (*P*=.623)**	-.170 (*P*<.001)**
Unplanned pregnancy	-.064^ (*P*<.001)**	-.052^ (*P*<.001)**
Someone told you about their abortion	-.021 (*P*<.001)**	-.144 (*P*<.001)**
Knowledge - Safety	.113 (*P*<.001)**	-.446 (*P*<.001)**
Knowledge - Commonality	.056^ (*P*<.001)**	-.053^ (*P*<.001)**
Knowledge – Public provision	.173 (*P*<.001)**	-.087^ (*P*<.001)**
Knowledge – Violence	.201 (*P*<.001)**	-.019^ (*P*<.001)**
Knowledge - Teens	-.007^ (*P*=.143)**	-.223 (*P*<.001)**
Sexism	-.171 (*P*<.001)**	.409 (*P*<.001)**
Beliefs	-.212 (*P*<.001)*	.516 (*P*<.001)*
Attitudes	-.194 (*P*<.001)*	.561 (*P*<.001)*

*Pearsons correlation (sig. 2 tailed): ** Spearman's Rho (Sig. 2 tailed): ^ *Did not meet the coefficient cutoff of .1 and variable was therefore not included in the relevant regression(s).*

Figure L9. Scatterplot – Anticipated Stigma & Age

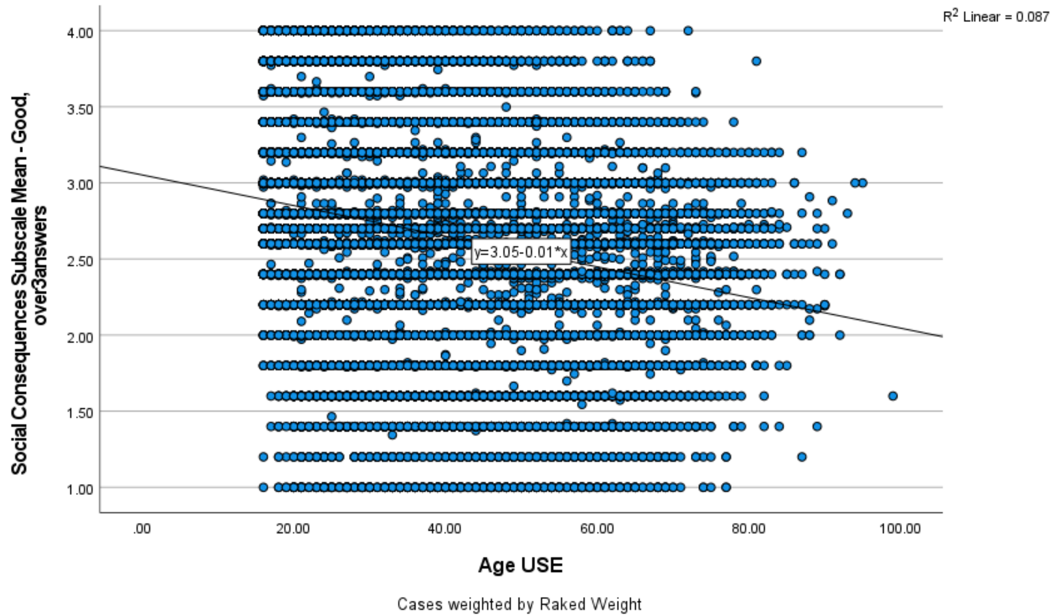


Figure L10. Scatterplot – Anticipated Stigma & Beliefs

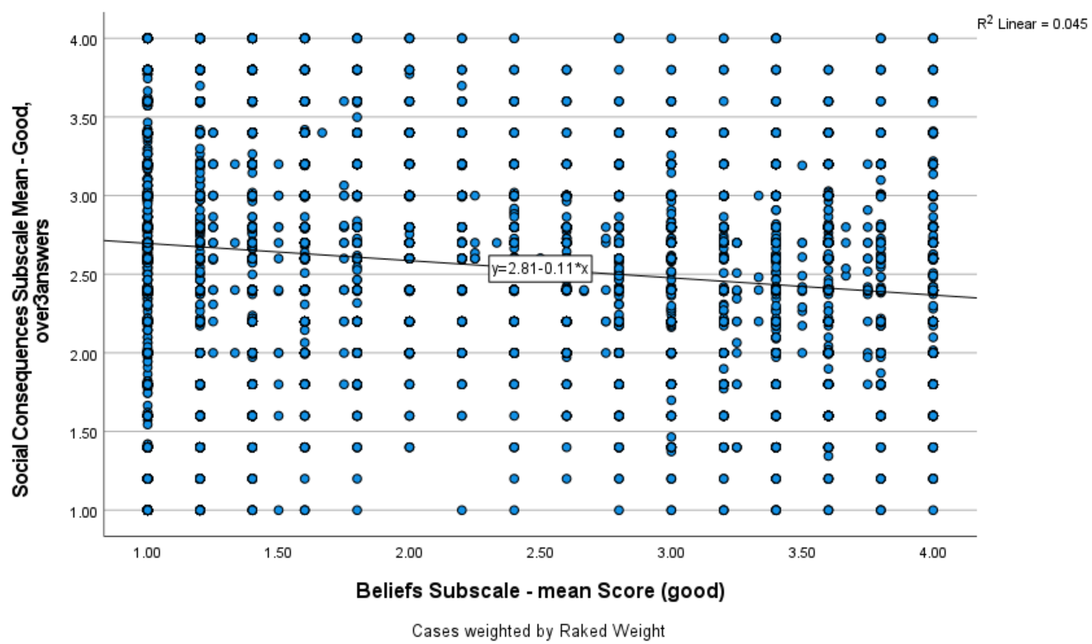


Figure L11. Scatterplot - Anticipated Stigma & Knowledge - Safety

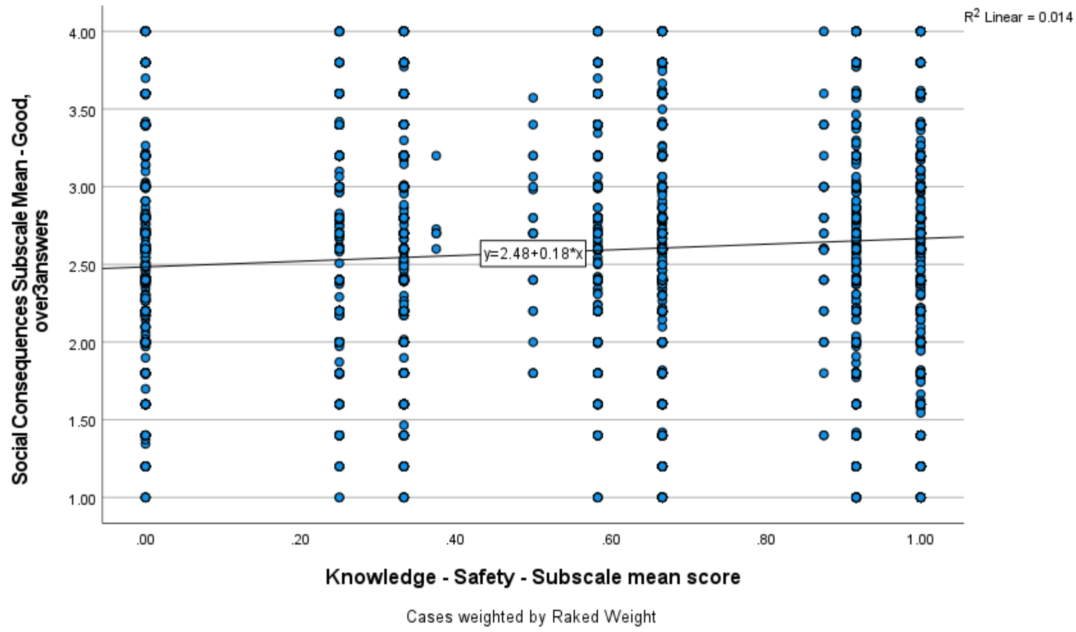


Figure L12. Scatterplot - Anticipated Stigma & Sexism

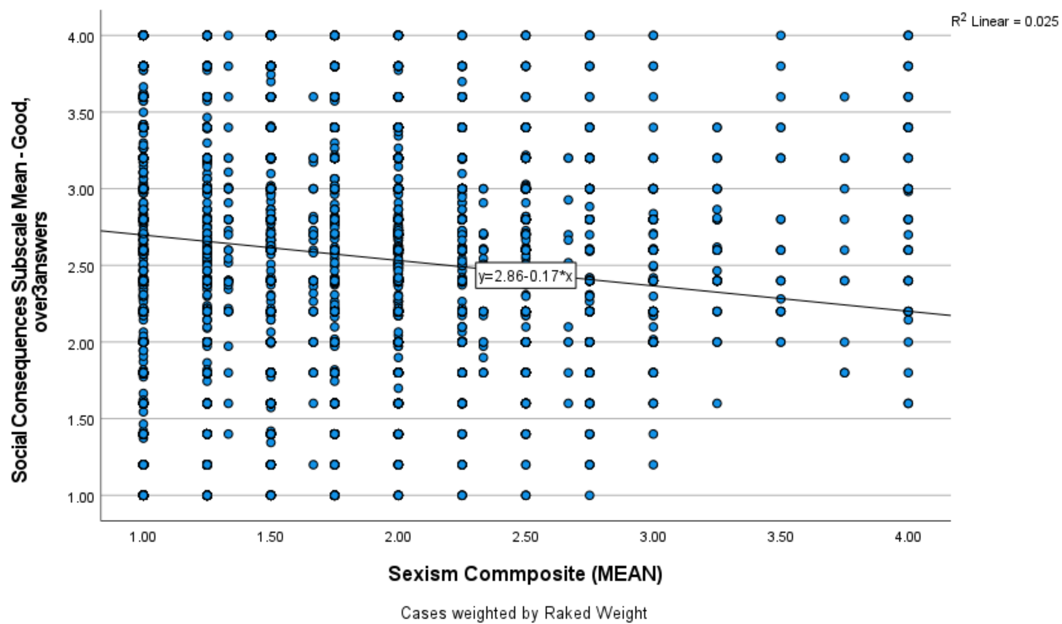


Figure L13. Scatterplot – Perceived Community Stigma & Attitudes

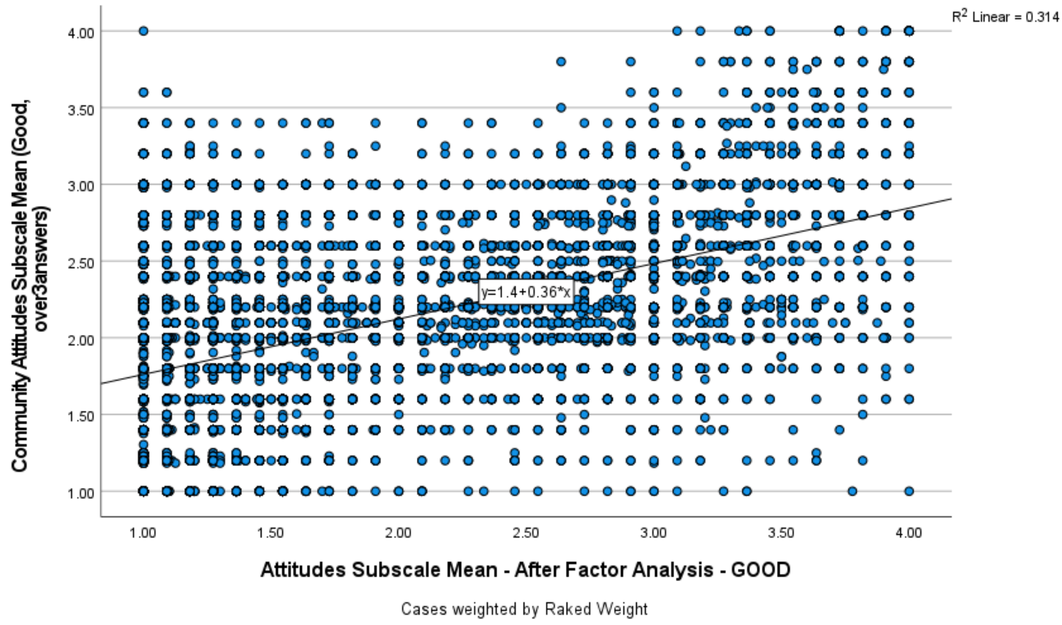


Figure L14. Scatterplot - Perceived Community Stigma & Age

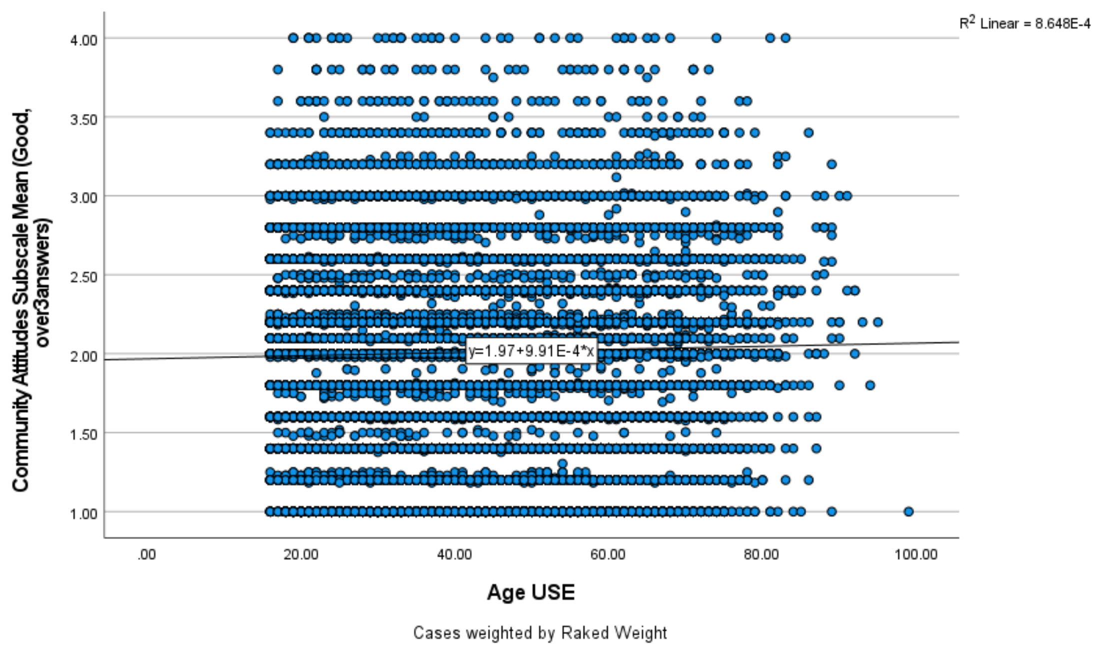


Figure L15. Scatterplot - Perceived Community Stigma & Knowledge - Safety

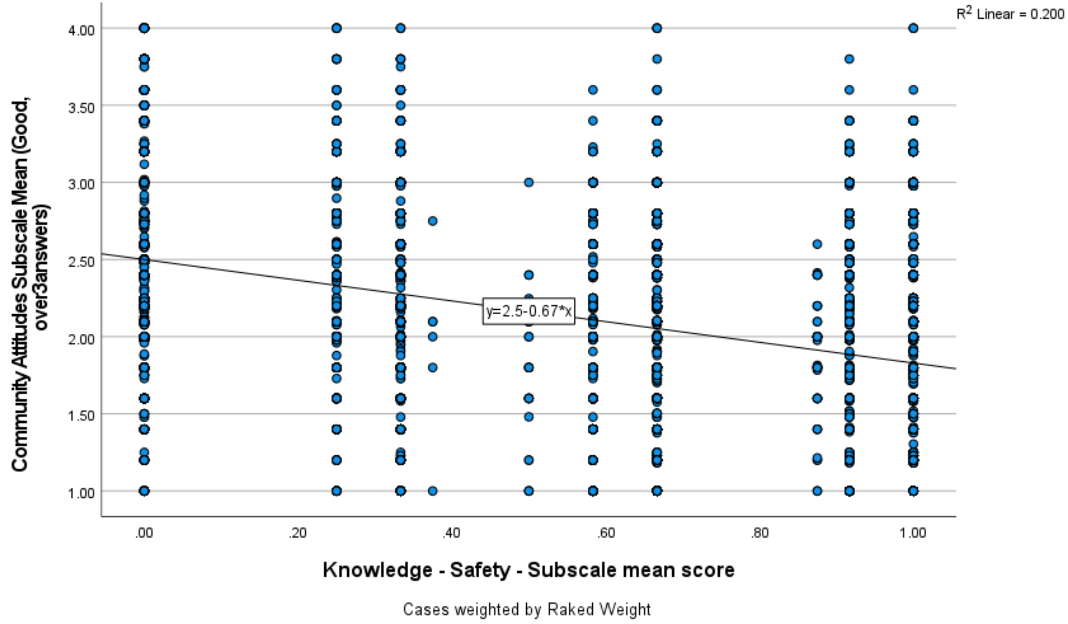
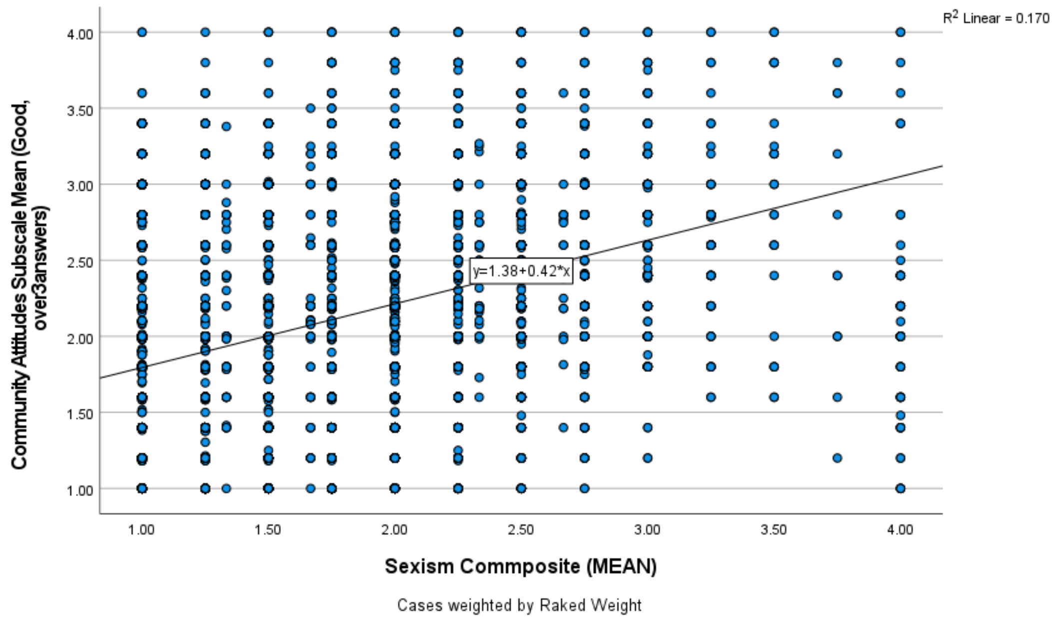


Figure L16. Scatterplot - Perceived Community Stigma & Sexism



AL.3 Tests of Multicollinearity

Figure L17. Coefficient and VIF scores, Anticipated Stigma model

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	95.0% Confidence Interval for B		Collinearity Statistics	
		B	Std. Error	Beta			Lower Bound	Upper Bound	Tolerance	VIF
1	(Constant)	3.032	.016		189.425	.000	3.000	3.063		
	Age USE	-.008	.000	-.221	-46.792	.000	-.008	-.007	.691	1.446
	Religious Attendance (4L) - Weekly or more	-.055	.009	-.043	-6.168	<.001	-.072	-.037	.322	3.106
	Religious Attendance (4L) - Semi-regularly	-.003	.008	-.002	-.379	.704	-.018	.012	.853	1.172
	Religious Attendance (4L) - Rarely/never	.006	.007	.004	.905	.366	-.008	.020	.909	1.100
	Education3point=High school or less	.117	.006	.081	19.973	<.001	.105	.128	.931	1.074
	Education3point=Trade or Cert	.064	.006	.044	10.904	<.001	.052	.075	.937	1.067
	USE_PoliticsNatLibTogether=Greens	.054	.009	.029	6.259	<.001	.037	.072	.709	1.410
	USE_PoliticsNatLibTogether=Labor	.032	.006	.028	5.276	<.001	.020	.044	.544	1.838
	USE_PoliticsNatLibTogether=Other	.017	.010	.007	1.680	.093	-.003	.038	.908	1.102
	USE_PoliticsNatLibTogether=None	.010	.007	.007	1.429	.153	-.004	.024	.722	1.384
	Biological Parent BIN _ New	-.052	.005	-.047	-10.175	<.001	-.061	-.042	.728	1.373
	Knowledge - Safety - Subscale mean score	-.158	.009	-.100	-17.108	<.001	-.176	-.140	.448	2.231
	Knowledge - Public Health provides abortions most towns (Value assigned)	.136	.005	.103	24.751	<.001	.125	.147	.896	1.116
	Knowledge - Violence and abortion (Value assigned)	.194	.005	.147	36.539	<.001	.184	.205	.958	1.044
	Sexism Commposite (MEAN)	.037	.006	.036	6.504	<.001	.026	.048	.512	1.952
	Beliefs Subscale - mean Score (good)	-.086	.004	-.162	-19.168	<.001	-.095	-.077	.216	4.623

a. Dependent Variable: Social Consequences Subscale Mean - Good, over3answers

Figure L18. Coefficients & VIF statistics, Perceived Community Stigma model

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	95.0% Confidence Interval for B		Collinearity Statistics	
		B	Std. Error	Beta			Lower Bound	Upper Bound	Tolerance	VIF
1	(Constant)	1.676	.014		121.096	.000	1.649	1.703		
	Age USE	-.004	.000	-.123	-33.421	<.001	-.004	-.004	.894	1.118
	Religious Attendance (4L) - Weekly or more	-.097	.007	-.078	-13.625	<.001	-.111	-.083	.369	2.709
	Religious Attendance (4L) - Semi-regularly	-.036	.007	-.020	-5.446	<.001	-.049	-.023	.856	1.168
	Religious Attendance (4L) - Rarely/never	-.008	.006	-.005	-1.386	.166	-.020	.004	.906	1.104
	USE_PoliticsNatLibTogether=Greens	.072	.007	.039	9.602	<.001	.057	.087	.715	1.399
	USE_PoliticsNatLibTogether=Labor	.017	.005	.016	3.329	<.001	.007	.028	.553	1.809
	USE_PoliticsNatLibTogether=Other	-.007	.009	-.003	-.810	.418	-.025	.010	.910	1.099
	USE_PoliticsNatLibTogether=None	-.003	.006	-.002	-.425	.671	-.015	.009	.726	1.378
	Someone told you about their abortion experience	-.027	.004	-.023	-6.457	<.001	-.035	-.019	.952	1.051
	Knowledge - Safety - Subscale mean score	-.170	.008	-.111	-21.883	<.001	-.185	-.155	.469	2.132
	Sexism Commposite (MEAN)	.057	.005	.056	11.172	<.001	.047	.067	.482	2.076
	Attitudes Subscale Mean - After Factor Analysis - GOOD	.350	.005	.540	77.465	.000	.341	.359	.247	4.042

a. Dependent Variable: Community Attitudes Subscale Mean (Good, over3answers)

AL.4 Tests of Homoscedasticity

Figure L19. Scatterplot of Residuals, Anticipated Stigma model

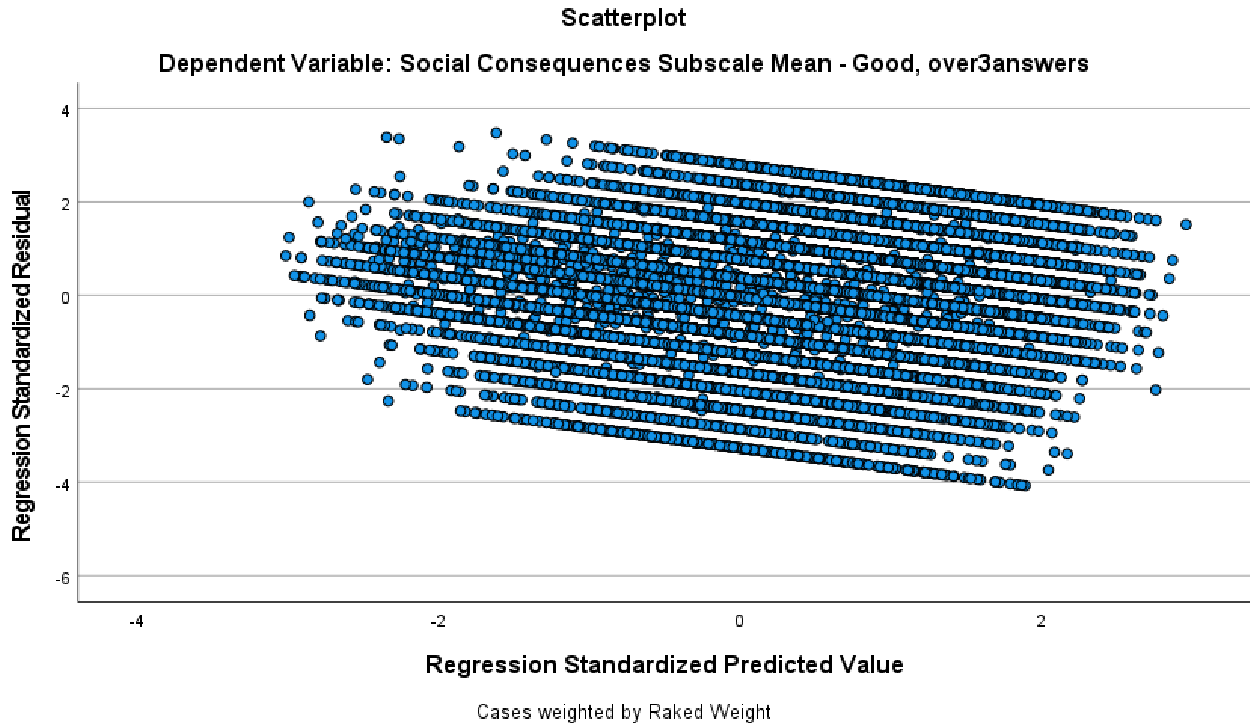
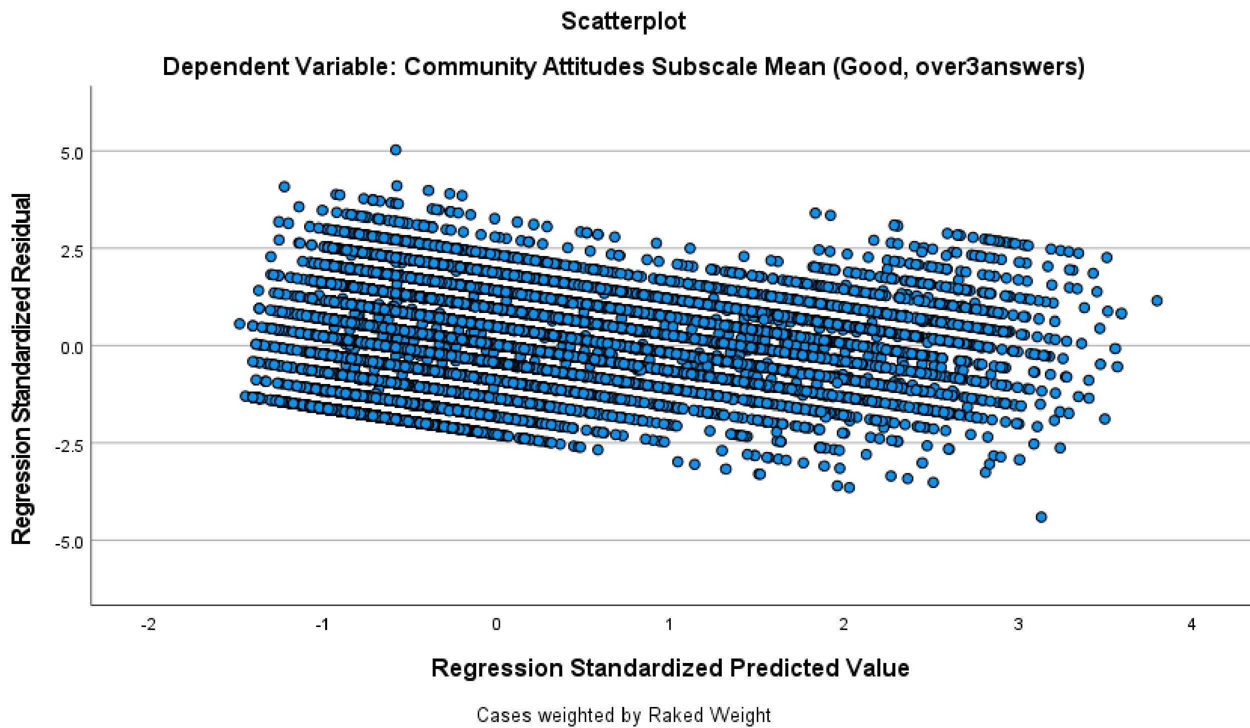


Figure L20. Scatterplot of Residuals - Perceived Community Stigma model



Appendix M: Interview guides

AM.1 Interview guide – No abortion experience

Purpose	Item no.*	Topic/Question example	Probes, variations
Formalities	1	Welcome, thanks, consent, distress protocol	
Rapport	2	How are you feeling about doing interview? Questions before we begin?	
Rapport, background information	3	A bit about your life: Where live, background, work study, family.	Work, study, children, partner, where live/grew up, religion Note intersections If religious: Attendance, friends and family same religion? How does it influence your life and values?
	4	Key values. Things you hold dear.	Feminist? What does feminism mean to you?
Drivers abortion attitudes, knowledge, stigma	6	Can you think back to/ tell me about the first time you can remember hearing, thinking or talking about abortion?	Context? Content? How did that make you feel? What did you think? Why do you think now about… *If Anti-abortion, religious: additional probes:* Where did beliefs come from?

			Heard anything about abortion during religious services?
	7	Has anyone ever told you about their abortion experience?	Relationships effected? Reactions? Other impacts on life? Impact on own beliefs re. abortion
	8	Other influences on your beliefs around abortion.	Family, friends, school, media, doctor, religion
CHECK IN – consent, happy to continue?			
Social norms, community, social context, perceived community views & stigma	9	Friends and family views: similar to yours?	
	10	Disclosure – hypothetical pregnancy.	Anyone you *would not* want to find out? Why?
	11	Aware of social issues abortion seekers face?	Abortion seeker, partner Multiple abortions Anticipated reactions *If anti-abortion/ religious*: do you think the responses from people involved in your church/religion would be different to reactions of others? *If male:* male partners of abortion seekers - Social impacts? Anticipated reactions? Disclosure choices – hypothetical.
	12	What do you think Australians generally think about abortion?	Thoughts on what drives these beliefs?

	13	Do you think abortion is stigmatised?	Church/ school/ uni/ community/ Australia? Why/why not? What does ‘stigma’ mean to you? Drivers? Aware of anti-abortion protestors? Anticipated impact?
	14	Do you think people are generally comfortable talking about abortion?	
CHECK IN – consent, happy to continue?			
Beliefs and knowledge	15	Do you believe abortion should be legal and easily accessible to all people in Australia?	Why/why not? Could you tell me more about…?
	16	Think abortion responsible choice?	Conditionality, circumstances Unplanned pregnancy same? *If anti-abortion:* Mentioned you support abortion in limited circumstances. Could you describe to me when you do feel you could support abortion? How would you feel if you had to support someone in such an experience?
	17	Awareness of Aus abortion laws?	Decrim processes
Non-directed dialogue	18	Anything else you’d like to share?	Beliefs Experiences
Check in	19	How has the interview process been?	
	20	Any questions for me; Transcript copy?	Interview process, abortion, other

AM.2 Interview guide – Abortion experience

Purpose	Item no.*	Topic/Question example	Probes
Formalities	1	Welcome, thanks, consent, distress protocol	
Rapport	2	How are you feeling about doing interview? Questions before we begin?	
Rapport, background information	3	A bit about your life: Where live, background, work study, family.	Work, study, children, partner, where live/grew up, religion Note intersections If religious: Attendance, friends and family same religion? How does it influence your life and values?
	4	Key values. Things you hold dear.	Feminist? What does feminism mean to you?
Drivers	5	First time you remember hearing, thinking or talking about abortion.	How did that make you feel? What did you think? Why do you think…
Perceived/ community	5	Friends and family views on abortion	Is that how you feel?
Confirm abortion history	6	Confirm abortion history	How are you feeling about talking about abortion today?

Abortion experience	7	Pregnancy, abortion decision, story	How were you feeling when you found out pregnant? Who did you talk to first? What did you do – ring doc, helpline?
CHECK IN – consent, happy to continue?			
Decision rightness	8	Was there anything you heard, were told, or read that made you feel uncertain?	How did that make you feel? Decision rightness since abortion
barriers, enablers (structural, interpersonal)	9	Did you feel supported? Was there anything that made it hard?	Did anyone go with you? Money, transport, work, children, partner, family, health, location
Disclosure	10	Who told – pre and post	Worried people would find out? Why them/ Why not?
Healthcare experience	11	How was your experience with the referring doc/helpline? How was experience in the clinic/hospital?	Friendly/encouraging? Anything that made you question or feel bad? Protesters?
Impacts	12	How do you feel about the experience now?	
	CHECK IN – consent, happy to continue?		
	13	Have your thoughts on abortion changed because of your experience?	Thought on abortion seekers? Abortion itself?

	14	Has having an abortion had any ongoing impacts on your life?	Discrimination or harassment? You said you experienced XX. Do you think other people who have abortions would experience something similar? Is your case exceptional? Why/why not? What would you think 'most women' experience instead?
Media – interaction with stigma	15	Do you recall seeing anything about abortion in the media, before or after experience?	How did it make you feel?
Anticipated consequences	16	Do you think there are any other social issues that women face from having an abortion?	What if they have more than one?
Beliefs	17	Do you think having an abortion is a responsible choice for most women? Was it for you?	Can you talk a bit more about… Why do you think most people choose abortion?
Social discussion about abortion	18	Have you and your friends or family spoken about abortion before?	What was the conversation about? Language, positive negative? How did it make you feel?
CHECK IN – consent, happy to continue?			
	19	Has anyone else you know had an abortion?	Can you tell me what you know about experience? What did you think when found out?

	19	Do you think people are comfortable talking about abortion?	Why do you think people are worried about telling others about abortion or talking about it?
	20	What do you think Australians generally think about abortion?	Thoughts on what drives these beliefs?
	21	Do you think abortion is stigmatised?	Church/ school/ uni/ community/ Australia? Why/why not? What does ‘stigma’ mean to you? Drivers?
Non-directed dialogue	22	Anything else you’d like to share?	Beliefs Experiences Feel free to get in touch.
Check in	23	How has the interview process been?	
	24	Any questions for me	Interview process, abortion, other
End	25	Copy of transcript? Follow up email	Process if yes.

*Item numbers for admin/examination purposes only. Interviews followed interviewee storylines and train of thoughts. Not all questions were asked, and the order of topics was flexible

Appendix N: TAASS sample characteristics & descriptive statistics – whole sample, unweighted data

Table N1: Additional participant characteristics

Characteristics	Categories (excluding 'missing' data)	Frequency	(Valid) % of sample
State/Territory of residence	NSW	14301	24.8%
	Vic	17803	30.8%
	QLD	9610	16.6%
	WA	5374	9.3%
	SA	5638	9.8%
	Tas	1973	3.4%
	NT	489	.8%
	ACT	2564	4.4%
Highest education attained	No schooling	15	.0%
	Completed Primary	85	.1%
	Completed year 10	2400	4.1%
	Completed high school	7499	12.8%
	Trade/cert/apprenticeship	9295	15.9%
	Bachelor degree	21974	37.6%
	Post-graduate degree	17224	29.4%
Religion	None	42212	72.3%
	Catholic	5072	8.7%
	Anglican	2580	4.4%
	Uniting Church	939	1.6%
	Presbyterian	729	1.2%
	Baptist	1322	2.3%
	Budhism	336	.6%
	Greek Orthodox	253	.4%
	Hindu	129	.2%
	Muslim	149	.3%
	Other	4684	8.0%

Religious Attendance	Weekly (once or more p/wk)	6061	10.3% (37% ‘yes – religion’)
	Monthly	4555	7.8% (27.82% ‘yes – religion’)
	Rarely/never	5758	9.8% (35.17% ‘yes – religion’)
	Never – Non-religious	42212	
Religion impacts abortion beliefs	Yes, Significantly	4451	27.6% (of ‘yes – religion’)
	Yes, Somewhat	2319	14.4%
	No, Not much	2081	12.9%
	No, Not at all	7276	45.1%

Table N2: Parenting, pregnancy, birth, and abortion experiences

Characteristics	Categories	Frequency	% sample
Ever given birth	No	35556	60.5%
	Yes	23170	39.5%
Ever (biologically) fathered a child	No/ Not applicable	52942	90.2%
	Yes	5748	9.8%
Ever parented non-biological children	No	49674	84.8%
	Yes	8879	15.2%
Ever had (or partner had) an abortion	No	41319	70.4%
	Yes, once	11165	19.0%
	Yes, more than once	4805	8.2%
	NA/ Prefer not to say	1437	2.4%
Ever experienced (or partner experienced) unplanned pregnancy	No	34964	59.4%
	Yes	22462	38.2%
	Prefer not to say/ missing	1300	2.2%
Someone has told you about their abortion experience (excluding intimate partner)	No/ Don’t know	14399	24.6%
	Yes	44235	75.4%

Table N3: Abortion experience by participant sub-group

Participant group	Abortion - No	Abortion – Yes
Urban	33614 (73.1%)	12401 (26.9%)

Rural	7623 (68.3%)	3544 (31.7%)
Religion – No	29014 (70.0%)	12418 (30%)
Religion – Yes	12114 (77.7%)	3486 (22.3%)
Aboriginal and/or Torres Strait Islander	583 (62.9%)	344 (37.1%)
Not Aboriginal or Torres Strait Islander	39224 (72.5%)	14885 (27.5%)

Table N4: Results - Knowledge questions

Questions	**Response categories (valid %)**					
	Strongly agree	**Agree**	**Disagree**	**Strongly disagree**	**Unsure**	**Missing %**
Having an abortion increases risk of breast cancer (Breast cancer)	1%	2.3%	27.8%	52.2%	16.6%	.2%
The public health system provides abortions in most towns & cities in Australia (Public provision)	4.8%	32%	34%	13%	16%	.4%
Teenagers are more likely to have abortions than other women (Teens)	1.6%	14.3%	49.3%	20.6%	14.1%	.3%
Women experiencing domestic violence are more likely to experience an unplanned pregnancy (Violence)	12.4%	40.7%	16.2%	4%	26.7%	.3%
How many women do you think will have an abortion in their lifetime? (Abortion proportion)	1 in 3	1 in 6	1 in 10	1 in 15	1 in 20	
	22.7%	40.2%	22.3%	7.1%	7.7%	.6%
What % of pregnancies in Australia do you think are unplanned? (Proportion UPP)	5%	10%	30%	50%	70%	
	2.2%	13.6%	49.6%	27.6%	6.6%	.5%
	Very safe	Quite safe	Not very safe	Very unsafe	Unsure	
How physically safe is medication abortion? (Safety – medication)	45.8%	40.3%	4.2%	2.5%	7.1%	.9%
How physically safe is surgical abortion? (Safety – surgical)	38.5%	50%	4.9%	2.9%	3.7%	1.1%

Table N5: Results - Beliefs (abortion rights and morality)

Question	Response categories			
	Always	In most circumstances	Sometimes	Never
Abortion should be legal & available	82.5%	6.2%	5.8%	5.6%
Women have the right to make decisions about their bodies	88.6%	6.3%	3.6%	1.5%
The public health system should provide abortion services	82%	6.5%	5.5%	6%
Medicare should cover the cost of abortion services	74.1%	12.3%	6.9%	6.7%
Abortion is the same as murder	6.6%	3.2%	7.2%	83%

Table N6: Results – Attitudes

Questions	Response categories				
	Strongly agree	Agree	Disagree	Strongly disagree	(Missing = n)
I would feel ashamed if a member of my family experienced an unplanned pregnancy	.4%	1.8%	15.4%	82.4%	1.3%
I would feel ashamed if a member of my family had an abortion	1.9%	3.3%	9.4%	85.5%	2.2%
It is okay for a woman to feel relieved after an abortion	74.7%	17.6%	5.3%	2.4%	2.4%
Women who have an abortion have done something wrong	3.8%	5.9%	9.1%	81.2%	2.2%
Women who have an abortion usually have good reasons	70.2%	21.1%	6.1%	2.5%	2.2%
Women who have an abortion do not deserve to have a family of their own	.5%	.5%	6.9%	92.1%	2.2%
I would think negatively about a woman who has had multiple abortions	3.4%	10.7%	26.4%	59.5%	2.1%
Women who have an abortion because they don't feel ready to have children are making a responsible choice	65.9%	20.7%	6.2%	7.1%	2.1%
I would defend someone who had an abortion in a social setting	82.7%	13.5%	3.0%	.8%	2.4%
A woman who has more than one abortion is irresponsible	3.3%	8.5%	28%	60.2%	2.4%

Abortion providers are bad people	1.6%	2.6%	8.1%	85.1%	2.6%
I respect a health professional who helps women have a safe abortion	82.7%	6.4%	4.9%	3.5%	2.6%
Health professionals who provide abortions make a positive contribution to society	75.5%	11.5%	4.2%	6.3%	2.6%

Appendix O: Knowledge sub-scale scores

Table O1: Knowledge mean scores (& standard deviation) by key participant characteristics

Variable	Category	Knowledge – Safety	Knowledge – Commonality	Knowledge – Public Provision	Knowledge – Violence
Age	16-24	.819 (.267)	.728 (.208)	.375 (.413)	.512 (.401)
	25-34	.858 (.244)	.717 (.220)	.414 (.418)	.482 (.209)
	35-44	.847 (.252)	.693 (.238)	.411 (.418)	.428 (.411)
	45-54	.823 (.276)	.664 (.259)	.377 (.416)	.368 (.406)
	55-64	.771 (.319)	.641 (.271)	.344 (.412)	.314 (.393)
	65-74	.693 (.366)	.614 (.281)	.300 (.400)	.314 (.390)
	75+	.547 (.405)	.586 (.304)	.228 (.372)	.351 (.398)
	TOTAL	**.825 (.275)**	**.690 (.241)**	**.388 (.416)**	**.428 (.411)**
Sex	Male	.756 (.321)	.633 (.704)	.311 (.400)	.375 (.403)
	Female	.840 (.262)	.704 (.232)	.404 (.418)	.440 (.411)
	Other/ Non-binary	.873 (.219)	.734 (.211)	.473 (.421)	.547 (.410)
Biological parent	No	.857 (.240)	.711 (.225)	.403 (.416)	.465 (.410)
	Yes	.792 (.305)	.670 (.255)	.372 (.415)	.372 (.415)
Rurality	Urban	.833 (.268)	.689 (.241)	.375 (.414)	.433 (.411)
	Rural/remote	.792 (.302)	.696 (.239)	.4390 (.423)	.412 (.409)
Religion	No	.881 (.201)	.700 (.233)	.417 (.418)	.441 (.411)
	Yes	.679 (.371)	.666 (.258)	.311 (.402)	.397 (.409)
Religious Attendance	Weekly	.431 (.391)	.646 (.237)	.196 (.347)	.347 (.399)
	Monthly	.812 (.280)	.675 (.250)	.373 (414)	.431 (.411)
	Rarely/Never	.838 (.251)	.680 (.247)	.388 (.418)	.424 (.412)
	Never (non-religious)	.881 (.201)	.700 (.233)	.417 (.418)	.441 (.411)
Abortion experience	No	.810 (.291)	.676 (.245)	.372 (.413)	.448 (.409)
	Yes	.869 (.214)	.731(.224)	.430 (.423)	.383 (.410)

Appendix P: Multivariable linear regression - SPSS outputs

AP.1 Anticipated Stigma model

Model Summary[c]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics					Durbin-Watson
					R Square Change	F Change	df1	df2	Sig. F Change	
1	.394[a]	.155	.155	.49546	.155	713.896	14	54352	.000	.[b]

a. Predictors: (Constant), Beliefs Subscale - mean Score (good), Religious Attendance (4L) -Semi-regularly, USE_PoliticsNatLibTogether=Other, Knowledge - Violence and abortion (Value assigned), USE_PoliticsNatLibTogether=None, Religious Attendance (4L) -Rarely/never, Biological Parent BIN _ New, USE_PoliticsNatLibTogether=Greens, Knowledge - Public Health provides abortions most towns (Value assigned), Age USE, USE_PoliticsNatLibTogether=Labor, Sexism Commposite (MEAN), Knowledge - Safety - Subscale mean score, Religious Attendance (4L) - Weekly or more

b. Not computed because fractional case weights have been found for the variable specified on the WEIGHT command.

c. Dependent Variable: Social Consequences Subscale Mean - Good, over3answers

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	2453.504	14	175.250	713.896	.000[b]
	Residual	13342.583	54352	.245		
	Total	15796.086	54366			

a. Dependent Variable: Social Consequences Subscale Mean - Good, over3answers

b. Predictors: (Constant), Beliefs Subscale - mean Score (good), Religious Attendance (4L) -Semi-regularly, USE_PoliticsNatLibTogether=Other, Knowledge - Violence and abortion (Value assigned), USE_PoliticsNatLibTogether=None, Religious Attendance (4L) -Rarely/never, Biological Parent BIN _ New, USE_PoliticsNatLibTogether=Greens, Knowledge - Public Health provides abortions most towns (Value assigned), Age USE, USE_PoliticsNatLibTogether=Labor, Sexism Commposite (MEAN), Knowledge - Safety - Subscale mean score, Religious Attendance (4L) - Weekly or more

Coefficients[a]

Model		Unstandardized Coefficients B	Unstandardized Coefficients Std. Error	Standardized Coefficients Beta	t	Sig.	95.0% Confidence Interval for B Lower Bound	95.0% Confidence Interval for B Upper Bound	Collinearity Statistics Tolerance	Collinearity Statistics VIF
1	(Constant)	3.076	.016		193.371	.000	3.045	3.107		
	Age USE	-.008	.000	-.225	-47.581	.000	-.008	-.008	.693	1.443
	Religious Attendance (4L) - Weekly or more	-.066	.009	-.052	-7.473	<.001	-.084	-.049	.323	3.094
	Religious Attendance (4L) - Semi-regularly	-.009	.008	-.005	-1.149	.250	-.024	.006	.855	1.170
	Religious Attendance (4L) - Rarely/never	.007	.007	.004	.998	.318	-.007	.021	.909	1.100
	USE_PoliticsNatLibTogether=Greens	.050	.009	.027	5.775	<.001	.033	.068	.709	1.409
	USE_PoliticsNatLibTogether=Labor	.029	.006	.025	4.745	<.001	.017	.041	.544	1.837
	USE_PoliticsNatLibTogether=Other	.016	.010	.006	1.567	.117	-.004	.037	.908	1.101
	USE_PoliticsNatLibTogether=None	.013	.007	.008	1.764	.078	-.001	.026	.723	1.383
	Biological Parent BIN _ New	-.055	.005	-.050	-10.941	<.001	-.065	-.046	.732	1.366
	Knowledge - Safety - Subscale mean score	-.175	.009	-.112	-19.016	<.001	-.193	-.157	.451	2.215
	Knowledge - Public Health provides abortions most towns (Value assigned)	.131	.006	.099	23.849	<.001	.121	.142	.898	1.114
	Knowledge - Violence and abortion (Value assigned)	.195	.005	.147	36.443	<.001	.184	.205	.958	1.044
	Sexism Commposite (MEAN)	.046	.006	.044	7.953	<.001	.034	.057	.514	1.944
	Beliefs Subscale - mean Score (good)	-.086	.005	-.162	-19.064	<.001	-.095	-.077	.216	4.624

a. Dependent Variable: Social Consequences Subscale Mean - Good, over3answers

Residuals Statistics[a]

	Minimum	Maximum	Mean	Std. Deviation	N
Predicted Value	1.9765	3.2454	2.6155	.21257	54617
Residual	-2.01830	1.72690	.00024	.49539	54617
Std. Predicted Value	-3.010	2.963	-.002	1.001	54617
Std. Residual	-4.074	3.485	.000	1.000	54617

a. Dependent Variable: Social Consequences Subscale Mean - Good, over3answers

AP.2 Perceived Community Stigma model

Model Summary[c]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics R Square Change	Change Statistics F Change	Change Statistics df1	Change Statistics df2	Change Statistics Sig. F Change	Durbin-Watson
1	.560[a]	.314	.314	.43356	.314	1578.525	13	44842	.000	.[b]

a. Predictors: (Constant), Attitudes Subscale Mean - After Factor Analysis - GOOD, Religious Attendance (4L) -Semi-regularly, USE_PoliticsNatLibTogether=Other, USE_PoliticsNatLibTogether=None, Religious Attendance (4L) -Rarely/never, Someone told you about their abortion experience, Abortion Experience - Binary, USE_PoliticsNatLibTogether=Greens, Teenagers have more abortions (BIN), USE_PoliticsNatLibTogether=Labor, Sexism Commposite (MEAN), Knowledge - Safety - Subscale mean score, Religious Attendance (4L) - Weekly or more

b. Not computed because fractional case weights have been found for the variable specified on the WEIGHT command.

c. Dependent Variable: Community Attitudes Subscale Mean (Good, over3answers)

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	3857.305	13	296.716	1578.525	.000[b]
	Residual	8429.016	44842	.188		
	Total	12286.322	44855			

a. Dependent Variable: Community Attitudes Subscale Mean (Good, over3answers)

b. Predictors: (Constant), Attitudes Subscale Mean - After Factor Analysis - GOOD, Religious Attendance (4L) -Semi-regularly, USE_PoliticsNatLibTogether=Other, USE_PoliticsNatLibTogether=None, Religious Attendance (4L) -Rarely/never, Someone told you about their abortion experience, Abortion Experience - Binary, USE_PoliticsNatLibTogether=Greens, Teenagers have more abortions (BIN), USE_PoliticsNatLibTogether=Labor, Sexism Commposite (MEAN), Knowledge - Safety - Subscale mean score, Religious Attendance (4L) - Weekly or more

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B		Collinearity Statistics	
		B	Std. Error	Beta	t	Sig.	Lower Bound	Upper Bound	Tolerance	VIF
1	(Constant)	1.585	.016		100.081	.000	1.554	1.616		
	Religious Attendance (4L) - Weekly or more	-.122	.008	-.096	-14.975	<.001	-.138	-.106	.376	2.663
	Religious Attendance (4L) - Semi-regularly	-.031	.007	-.018	-4.264	<.001	-.046	-.017	.869	1.151
	Religious Attendance (4L) - Rarely/never	-.015	.007	-.009	-2.199	.028	-.029	-.002	.917	1.091
	USE_PoliticsNatLibTogether=Greens	.081	.008	.045	9.786	<.001	.065	.097	.710	1.409
	USE_PoliticsNatLibTogether=Labor	.006	.006	.005	.951	.342	-.006	.017	.553	1.807
	USE_PoliticsNatLibTogether=Other	-.022	.010	-.009	-2.184	.029	-.042	-.002	.909	1.100
	USE_PoliticsNatLibTogether=None	.011	.007	.007	1.596	.110	-.002	.024	.723	1.383
	Abortion Experience - Binary	-.039	.005	-.033	-8.073	<.001	-.048	-.029	.924	1.083
	Someone told you about their abortion experience	-.040	.005	-.034	-8.363	<.001	-.050	-.031	.938	1.066
	Knowledge - Safety - Subscale mean score	-.165	.009	-.103	-18.011	<.001	-.183	-.147	.465	2.150
	Teenagers have more abortions (BIN)	-.017	.005	-.014	-3.353	<.001	-.027	-.007	.844	1.185
	Sexism Commposite (MEAN)	.040	.006	.038	6.874	<.001	.028	.051	.493	2.027
	Attitudes Subscale Mean - After Factor Analysis - GOOD	.337	.005	.510	64.250	.000	.327	.348	.243	4.112

a. Dependent Variable: Community Attitudes Subscale Mean (Good, over3answers)

Residuals Statistics[a]

	Minimum	Maximum	Mean	Std. Deviation	N
Predicted Value	1.5564	3.1037	1.9909	.29325	45057
Residual	-1.90844	2.17991	-.00015	.43328	45057
Std. Predicted Value	-1.481	3.795	.001	1.000	45057
Std. Residual	-4.402	5.028	.000	.999	45057

a. Dependent Variable: Community Attitudes Subscale Mean (Good, over3answers)

Appendix Q: Findings of the sensitivity analysis

Table Q1: Characteristics of participants from the 3 recruitment waves

Characteristic – number, proportion	Wave 1 - *Facebook** (n=2705)	Wave 2 - *ACL** (n= 3741)	Wave 3 – *Viral** (n=52280)	Whole Sample – unweighted (n=52769)	Whole sample – weighted (n=52769)
Age – <24 years	1418, 52.5%	286, 7.7%	6911, 13.2%	8615, 14.7%	6617, 11.4%
Sex - % Female	2498, 92.3%	2448, 65.5%	42051, 80.5%	46997, 80.1%	44732, 76.8%
Urban residing	2086, 77.3%	2631, 70.8%	42409, 81.35%	47126, 80.4%	41962, 72%
Aboriginal &/or Torres Strait Islander	54, 2.1%	49, 1.4%	864, 1.7%	967, 1.7%	722, 1.3%
Born in Australia	2357, 87.1%	2978, 80%	44437, 85.2%	49772, 85%	40797, 70%
Religion - Yes	787, 29.1%	3012, 81.6%	12394, 23.8%	16193, 27.7%	26162, 44.9%
Education - Degree	1151, 42.7%	2215, 59.8%	35832, 68.8%	39198, 67%	38230, 65.9%
Political left (Greens, Labor)	1382, 51.4%	234, 6.3%	20307, 38.9%	21426, 36.6%	5187, 8.9%
Abortion experience Yes	418, 15.9%	510, 14.3%	15042, 29.5%	15970, 27.9%	15074, 26.5%
Biological Parent Yes	747, 27.6%	2846, 76.1%	25232, 48.3%	28825, 49.1%	35148, 60.3%
Unplanned pregnancy experience Yes	633, 24.1%	1538, 43.1%	20291, 38.8%	22462, 39.1%	23750, 41.8%
Teens More Abortions - Agree	877, 38.3%	1250, 44.5%	7219, 13.8%	9346, 18.6%	12453, 25.5%
Support Marriage Equality Yes	2228, 82.4%	651, 20%	46885, 95.7%	49764, 91%	39897, 75.6%
	Mean scores (SD)				
Knowledge – Safety (Low=0, High=1)	.763 (.305)	.38 (.38)	.86 (.234)	.825 (.276)	.731 (.347)
Knowledge – Commonality (Low=0,High=1)	.701 (.220)	.635 (.28)	.694 (.238)	.691 (.241)	.666 (.255)
Public Provision (Low=0,High=1)	.373 (.414)	.172 (.33)	.404 (.418)	.387 (.416)	.327 (.406)
Beliefs (1=abortion supportive, 4=anti-abortion)	1.427 (.770)	2.987 (.935)	1.218 (.545)	1.339 (.729)	1.72 (1.025)
Attitudes (1=abortion supportive, 4=anti-abortion)	1.470 (.619)	2.661 (.763)	1.279 (.472)	1.374 (.603)	1.682 (.816)

Table Q2: Multivariable linear regression - comparisons between 3 recruitment waves & full weighted sample

	Recruitment Wave 1*		**Recruitment Wave 2***		**Recruitment Wave 3***		**Weighted, whole sample**	
Variables	R^2	**Standardised coefficient, significance**	R^2	**Standardised coefficient, significance**	R^2	**Standardised coefficient, significance**	R^2	**Standardised coefficient, significance**
***Anticipated Stigma* Model**								
Age	.247	-.328, P<.001	.102	-.127, P<.001	.140	-.260, P<.001	.155	-.225, P<.001
Religious Attendance:								
Weekly		.008, P =.756		-.005, P =.856		-.028, P<.001		-.052, P<.001
Monthly		.020, P =.253		.009, P =.679		-.003, P=.531		-.005, P=.250
Rarely/Never		.047, P =.008		.020, P =.305		.011, P=.011		.004, P=.318
Never -not religious) ^								^
Politics:								
Greens		-.044, P =.180		.044, P=.046		.042, P<.001		.027, P<.001
Labor		.006, P =.824		.024, P=.224		.027, P<.001		.025, P<.001
Other		.002, P =.924		-.002, P=.917		.009, P=.081		.006, P=.117
None		.000, P =.990		-.016, P=.380		.008, P=.352		.008, P=.078
Liberal/National^								
Biological parent		.003, P =.907		-.074, P<.001		-.032, P<.001		-.049, P<.001
Knowledge - Safety		-.016, P =.484		-.067, P=.002		-.088, P<.001		-.112, P<.001
Knowledge – Public Health		.109, P <.001		.034, P =.047		.101, P<.001		.099, P<.001

Knowledge – Violence	.131, *P* <.001	.117, *P* <.001	.152, *P*<.001	.147, *P*<.001
Sexism	-.067, *P* <.001	.031, *P* =.123	.025, *P*<.001	.044, *P*<.001
Beliefs	-.219, *P*<.001	-.207, *P* <.001	-.086, *P*<.001	-.162, *P*<.001
***Perceived Community Stigma* Model**				
Religious Attendance:	.095	.268	.149	.314
Weekly	-.049, *P* =.067	-.070, *P*=.020	-.058, *P*<.001	-.096, *P*<.001
Monthly	-.025, *P* =.225	.005, *P*=.838	-.017, *P*<.001	-.018, *P*<.001
Rarely/Never	.002, *P* =.942	-.020, *P*=.320	-.011, *P*=.014	-.009, *P*=.028
Never – non-religious^				^
Politics:				
Greens	.036, *P*=.355	.056, *P* =.015	.104, *P*<.001	.045, *P*<.001
Labor	-.017, *P*=.623	.002, *P* =.926	.021, *P*=.019	.005, *P*=.342
Other	.021, *P*=.361	-.008, *P* =.674	-.005, *P*=.352	-.009, *P*=.029
None	.010, *P*=.795	.023, *P* =.241	.012, *P*=.176	.007, *P*=.110
Liberal/National				^
Abortion experience	-.071, *P* <.001	.008, *P* =.651	-.045, *P*<.001	-.033, *P*<.001
Someone told you about their abortion	-.052, *P* =.013	.005, *P* =.787	-.043, *P*<.001	-.034, *P*<.001
Knowledge - safety	-.054, *P* =.035	-.124, *P* <.001	-.077, *P*<.001	-.103, *P*<.001
Knowledge - teens	-.020, *P*=.354	.009, *P*=.623	-.006, *P*=.237	-.014, *P*<.001

Sexism	-.055, $P=.025$	.018, $P=.410$	.033, $P<.001$	.038, $P<.001$
Attitudes	.301, $P<.001$	.491, $P<.001$	.347, $P<.001$	.510, $P<.001$

** Unweighted data: ^ Reference category where dummy variables were used*

Appendix R: “Going Viral: Researching safely on social media”

Viewpoint

Journal of Medical Internet Research

Going Viral: Researching Safely on Social Media

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Abstract

Safety issues for researchers conducting and disseminating research on social media have been inadequately addressed in institutional policies and practice globally, despite posing significant challenges to research staff and student well-being. In the context of the COVID-19 pandemic and given the myriad of advantages that web-based platforms offer researchers over traditional recruitment, data collection, and research dissemination methods, developing a comprehensive understanding of and guidance on the safe and effective conduct of research in web-based spaces has never been more pertinent. In this paper, we share our experience of using social media to recruit participants for a study on abortion stigma in Australia, which brought into focus the personal, professional, and institutional risks associated with conducting web-based research that goes viral. The lead researcher (KV), a postgraduate student, experienced a barrage of harassment on and beyond social media. The supportive yet uncoordinated institutional response highlighted gaps in practice, guidance, and policy relating to social media research ethics, researcher safety and well-being, planning for and managing web-based and offline risk, and coordinated organizational responses to adverse events. We call for and provide suggestions to inform the development of training, guidelines, and policies that address practical and ethical aspects of using social media for research, mental and physical health and safety risks and management, and the development of coordinated and evidence-based institutional- and individual-level responses to cyberbullying and harassment. Furthermore, we argue the case for the urgent development of this comprehensive guidance around researcher safety on the web, which would help to ensure that universities have the capacity to maximize the potential of social media for research while better supporting the well-being of their staff and students.

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KEYWORDS

cyber bullying; online bullying; research activities; occupational safety; research ethics; students; bullying; social media

Introduction

Social media is rapidly becoming a mainstream tool for the conduct and dissemination of research, health interventions, and evaluations [1]. Researchers and research students are increasingly expected to conduct and communicate their research on the web [2], including using a range of social media platforms to conduct and promote their work. Such spaces present new opportunities and risks for research. Rapid and potentially targeted recruitment and (perceived) anonymity provide access to historically hard-to-reach populations. At the same time, the boundaries between researchers' professional and personal identities have become increasingly blurred as images, information, and work are shared and searchable across platforms. As such, communication with and harassment of researchers on the web can move rapidly from public to private spaces, with a suite of personal and professional consequences that are in line with those of web-based bullying and trolling more broadly.

In this context of new risks and opportunities, research ethics processes, the literature, and guidelines are beginning to address the specific concerns associated with research participant safety and well-being in web-based and social media research. However, robust and constructive cross-institutional and interdisciplinary conversations and guidance addressing the management of and support for researcher safety and well-being continue to be largely missing. In this paper, we argue that there is an urgent need for robust guidance on the use of social media for research, paying particular attention to the need for institutional and ethical frameworks and researcher training that address web-based safety and mental well-being. By outlining our extraordinary and challenging experience of *going viral*, along with the limited published experiences of other researchers, this paper calls for institutional and industry-wide practices that aim to keep researchers and their work safe in increasingly unavoidable web-based workspaces.

New Norms, New Risks

Under consistent pressure to meet research performance expectations in the context of time constraints, in the COVID-19 pandemic environment of limited travel and face-to-face engagement opportunities, and given the benefits of engaging with technological innovations to improve research processes, researchers increasingly occupy web-based networks and social media platforms for the communication and conduct of research. In this context, social media–enabled recruitment has never been more relevant. The reach, speed, affordability, flexibility, and potential for multidirectional communication and *sharing features* afforded by social media make it a favorable alternative to traditional research processes and their limitations [3-6]. In particular, social media has been found to be an effective tool in health research and promotion. Social media has been used to successfully recruit hard-to-reach populations and may be particularly "well-suited to research and practice on 'taboo' public health topics" [4], such as sexual health. This is partly because of the potential for anonymity on social media, along with the high number of young people present on these platforms [4,6-10]. Engaging research participants via social media can help to minimize research fatigue, facilitate engagement and retention of research participants, and contribute a richer data set than traditional methods can achieve on their own [5].

Along with these benefits, the limited (albeit growing) body of literature on using social media for research also describes challenges, including self-selection bias, engagement, and underrecruitment, along with a lack of control over the framing and sharing of content shared on the web [8,11,12]. Social media platforms have been described as *echo chambers*; users are constantly and progressively exposed to content aligned to their pre-existing belief systems, confirmation bias thus being a feature of social media use [13]. This allows for the specific targeting of messaging and advertisements beneficial to the conduct of science and health promotion; it also means politically charged or emotionally arousing content is most likely to spur engagement and *go viral* [13,14].

There are additional potential challenges associated with the use of social media in research. The absence of facial and social cues and gestures on the web that would otherwise be present in face-to-face interactions and the real or perceived anonymity that web-based interactions can afford increase the potential for interpersonal conflicts and escalation of arguments [15-17]. "Language truncation, the use of images and hashtags, results in inappropriate, inaccurate or mis-judged commentary in 140 characters" [18], which can affect the narrative that surrounds research shared on the web and limit the ability of researchers to control it [8]. Misinformation, misinterpretation, and misappropriation of research or research activities on the web could be described as somewhat of an inevitability, as is highlighted in the discussion of our own experience. Users' perceived anonymity and strength in numbers also means that communication and harassment among users can escalate rapidly, shifting from public to private and professional to personal web-based spaces [17,19,20]. Harassment on the web is not new; however, cultural and technological changes are likely to increase the risks of experiencing harassment and the speed at which *cyber mobs* rally, posing evolving challenges to researcher privacy, safety, and well-being.

Despite the myriad of challenges it poses, social media will be increasingly used by researchers who will become fluent in navigating and imagining its potential. Concurrently, these researchers will inevitably face evolving and fluent forms of harassment. As such, there is an onus on higher education and research industries and institutions to assume greater responsibility for the well-being of staff and students on the web, supporting and equipping them with the tools needed to safely navigate and effectively use these platforms and appropriately responding when harassment occurs.

Going Viral: Triumphs and Troubles

As part of the primary author's (KV) PhD research on abortion stigma in Australia, Facebook was used to recruit members of the Australian public to a web-based survey.

A number of professional, academic, and ethical challenges were faced by our research team during this process, which we share here in the hope that they will inform conversation and debate around the role of universities in better understanding, mitigating, and addressing researcher and student safety on the web.

Over 2 years, the authors developed a quantitative survey measuring abortion attitudes, knowledge, and perceived abortion stigma, which is the first of its kind to be developed and implemented in

Australia. The survey tool was informed by extensive literature searching and qualitative and quantitative testing. It included, among others, a combination of items that endorsed and rejected stigmatizing abortion-related statements. The study received approval from the Flinders University ethics committee, including approval to omit all researcher names from the study documents.

Participants were recruited to the study using Facebook advertisements, which were targeted broadly at anyone living in Australia aged ≥16 years. Our ability to alter and retarget advertisements over time to ensure that the self-selected sample was as representative of the population as possible, the team's familiarity with using paid Facebook advertising and the relative speed at which recruitment could occur made recruitment via Facebook an appealing and logical choice. It may be relevant to consider that the survey was released during the height of the first round of the COVID-19 pandemic restrictions in Australia in April 2020 when other methods of recruitment were likely to be more challenging than usual.

In just 2 weeks of Facebook advertising, 3500 participants completed the survey. At this time, the advertisements were retargeted to facilitate the recruitment of participants aged >40 years and male participants, underrepresented among the respondents. During the process of releasing these more targeted advertisements, the survey attracted the attention of a prominent antiabortion (prolife) lobby group who shared it with their membership via email and on their Facebook page. Within 48 hours, >5000 survey responses and close to 100 emails were received by the lead researcher (KV). At this time, the paid Facebook advertisements were halted, although the survey link remained live.

Comments undermining and debating the survey method and style, along with common antichoice sentiments around the "irresponsibility of women seeking abortion" and "abortion as murder" were noted as relevant social media posts. Emails to the research team and the university ethics committee contained *concerned queries* and *recommendations* for improvements, along with explicit hostility and requests to have the study ceased. McPherson et al [21] found that users who are the first to share a study (on social media) are likely to affect the composition of the resulting sample, reflecting the power and influence of individuals to amplify and influence messaging and information accuracy on the web. Our experience supports their finding, as the vast majority of the 5000 responses received in the days following the lobby group's sharing of the study reflected their otherwise minority (in Australia) strong antiabortion views.

Coordinated attempts by this lobby group to undermine rights or evidence-based laws, policies, or programs, such as those pertaining to abortion, contraception, and lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA+) rights, including marriage equality, are common in Australia [22,23]. Along with the use of more formal lobbying channels, direct communication (often abusive) with staff involved in projects or organizations that the group does not agree with have been reported [24,25]. The potential for such a response to our research was likely amplified by the growing (at least in prominence) public mistrust in science more broadly. This was facilitated by social media and exemplified by apparent global shifts towards conservatism over recent years [18], along with the abortion decriminalization process that fueled antiabortion activism in South Australia at the time our research was taking place.

Although it has been difficult to formally track *shares* and *reposts* of the study, 3 days after the survey was shared by the antiabortion group, a prominent feminist politician, feminist author and public figure, and a number of women's health and women's rights organizations became aware of the study. To counter the perceived attempts by antiabortionists to sway the findings, these individuals and groups began sharing the survey in their networks. The survey was subsequently shared at least several thousand times across Twitter and Facebook and emailed to multiple women's health, women's rights (feminist), health provider, and lobby group mailing lists across a 4-day period. Much of the narrative around these *shares* sought to encourage people to complete the survey to balance the nature of responses received. However, in a number of social media posts, the survey purpose was misconstrued as being a tool for promoting an antichoice agenda, causing anger from proponents of abortion rights. Items asking participants to select their level of agreement or disagreement with statements reflecting common abortion-related stereotypes and antiabortion sentiments were construed as evidence that the survey was inherently antichoice, which further fueled this narrative. As such, hostility from both proponents and opponents of abortion rights was directed at the research team and the university.

Going viral resulted in 67,000 responses in 6 days, with a total of 70,051 responses received over the 3-week recruitment period. Ultimately, the final sample broadly represented the Australian public regarding support for or opposition to abortion accessibility and legality, with approximately 89% (9/10) supporting legal abortion always or mostly [26,27]. The survey link was made inactive after a week of *going viral*, 3 weeks after it was first published, as the responses received represented a mix of views and were deemed more than sufficient to facilitate a detailed and meaningful analysis. Within days of ending the recruitment, the antichoice lobby group *claimed victory* in their email newsletter, suggesting it was their campaign against the study that resulted in it being closed.

A month later, a freedom of information request was submitted to the university to seek documents related to the study, including documents that indicated the reasons for the survey being closed and the survey responses themselves. As the lead researcher (KV) was a student, their name and most of the information requested were redacted. Details regarding other members of the research team and the content of several personal emails between the lead researcher and her supervisors were provided; some of them were later published on the web by the antiabortion lobby group.

Despite such a successful recruitment process, our unpreparedness for the speed with which the survey would be shared on the web led to a number of challenges for the research team. For example, we were initially unprepared to manage (practically and emotionally) the hundreds of hostile emails, which appeared to be a coordinated attempt to shut down the project and were received in a span of a few days. Although the researchers' names were not in the public sphere, staying anonymous was a short-term solution, with the need to publish the work and findings, along with the freedom of information request, making disclosure inevitable.

A number of safety concerns arose, including concerns and uncertainty around the following: best practices for keeping safe on the web and preventing disclosure of personal details and location (of residence, in particular), the safety precautions that ought to be considered or implemented offline, and a lack of institutional capacity to provide such knowledge and support, the research team awareness of other strategies (with associated risks) that lobby or activist groups were likely to engage in, ways to balance the potential professional benefits of media interest with researcher and student well-being, and an understanding of risks and managing them to protect the university and individual reputations.

Phone and web-based meetings with the research team (because of the COVID-19 pandemic restrictions), on-campus phone-based mental health support, and the university media team and ethics committee were all available to support and respond to the lead researcher's (KV) questions throughout the process of *going viral*. Although the responses received from individuals within the university were unanimously supportive, they were also ad hoc and sometimes conflicting. A coordinated response across departments, from media to ethics and student support, would have been beneficial in bolstering a sense of safety and clarity around how to respond and manage risks in relation to social media commentary, media requests and email communications, and threats.

Although it was deemed unlikely that web-based harassment would translate into offline risks of violence, a history of hostile activism and violence against abortion providers and supporters by antiabortion individuals and groups, both locally and abroad [28-30], contributed to heightened anxiety and fear throughout the experience. Recently, Glenza [31] described the antiabortion movement in the United States as *radicalized* and posing an *increased threat* [31]. Similarly, the decriminalization process and surrounding antiabortion campaign that occurred in South Australia, where the research team was located during the time of the research, heightened perceived risks. Overexposure to unpleasant social media commentaries and emails and comments on social media calling on people to *inundate* the research team with *concerned emails* resulted in the lead researcher (KV) experiencing both short- and long-term mental health consequences.

Researcher Harassment on the Web: An Anomaly?

There is a dearth of literature documenting research *going viral* and its impact on research outcomes and researcher well-being. Kosinski et al [6] described a project that, owing to web-based snowball sampling, successfully recruited 6 million participants over 4 years, with safety concerns not reported. Cuevas [19], a social scientist in the United States, described his experience of a large-scale, coordinated harassment campaign. It began in response to a comment Cuevas [19] had made on a social media post regarding the 2016 US presidential campaign, which rapidly moved into private and personal messages, threats, racist slurs, and false reviews, resulting in coordinated

attempts to undermine his employment and family well-being. Cuevas [19] filed police charges, and the harassment was treated as a hate crime; however, he continued to experience harassment and threats to his job security. Cuevas [19] published about his experiences in the hope of giving a "voice to others who have been similarly harassed," stating in a media interview that he later received "emails from more than 60 professors from all over the world telling stories of their own" [32]. An Australian academic and antiracism activist, Dr Stephen Hagan, has also reported receiving hate mail and death threats in response to fake news reports about his work in advocating for the renaming of consumable products with racist connotations. Similar to that experienced by Cuevas [19], this hate campaign was fueled by right-wing political campaigns with racist dynamics [33]. Although neither of these harassment campaigns was initially in direct response to research activities, they were in response to web-based communication regarding their areas of expertise; in the Cuevas [19] case, the harassment rapidly became about his role as an academic and threatened it. As Viney [34] described, "academics have privileged knowledge that should be put to use in the community in a form of 'ethical academia'." As such, activism and academia are often fundamentally intertwined. As social media becomes a vital stage for the performance and communication of science and research, the relevant social media posts made by academics may be necessarily considered to be part of their work.

Other researchers have reported harassing experiences in response to Facebook advertising, including in response to advertisements for LGBTQIA+ research participants [20,35]. Mitchell and Jones [20] reported cyberbullying in the form of Facebook comments, private messages, and voicemails to their research team, demonstrating the way harassment moves effortlessly from public to private spaces. Researchers working with marginalized communities or on marginalized social issues are most likely to face web-based harassment (usually not originating from the marginalized communities in which they are working). Research has also found that "harassment often arises in spaces known for their freedom, lack of censure, and experimental nature" [36]. This suggests that there is a particular risk for academics who are inherently working in *experimental* spaces (ie, conducting research) and who may be conducting research with or are members of marginalized communities themselves.

Trolling, defined as web-based behavior deliberately intended to antagonize or offend someone [37,38], is often intended as a silencing strategy, as was much of the response to our abortion stigma work. However, trolling is not the only method used to silence victims of web-based harassment and abuse. The advice offered to victims to help them cope with trolling is often to *not engage* with or *further provoke* abusers. However, such advice further silences the voices of victims and their stories and is situated within a victim-blaming narrative, whereby conducting work on the web is in itself deemed a *provocation* and harassment a normal response [36].

Among the Australian public, negative web-based experiences are common. In 2019, 14% of adults in Australia were estimated to have been the target of hate speech [39], and 67% had negative experiences on the web [40]. Studies with university students internationally report varied rates of cyberbullying, in part likely because of definitional and measurement variations; however, it is common for such studies in the United States, Canada, and Australia to find that between 20% and 40% of participants have experienced cyberbullying [41].

Cyberbullying and harassment result in social, mental, physical, financial, and academic consequences for victims, and these impacts are more commonly experienced by minority or marginalized individuals and communities [16,17,39,42]. *Secondary traumatic stress* may be of particular concern for researchers witnessing harassment of their target populations or for those who have experienced personal trauma themselves [35]. Studies that have addressed cyberbullying in universities (investigating contexts of web-based learning and web-based bullying of staff by students or colleagues) have found that it can lead to significant psychological harm (in terms of mental health, productivity, and engagement), occupational impacts (including risks to job security, satisfaction, and employment opportunities), and physical consequences (including the risk of violence) [17,19,41].

Ethical Considerations: Something Is Missing

The literature describing the ethical challenges associated with social media use in research are

rooted in traditional ethical frameworks, with a focus on participant safety and protection. Ethical dilemmas regarding the appropriateness of the use of social media users' web-based data as *research data* and the automatic sharing of social media users' web-based behavior (including engagement with research-related content) with data companies are being increasingly addressed as they pertain to issues of consent, anonymity, and privacy [8,12]. Privacy and confidentiality risks to consenting research *participants* and nonparticipatory bystanders and the implications for participant *aftercare* (ie, the need for researchers to remain available to participants post data collection) have also been described [8,12,43]. Issues of inclusion and accessibility have also been raised, with the *digital divide* continuing to signal and exclude already-disadvantaged communities [5].

Ethics committees routinely request, as they must, detailed information about potential risks to participant safety and strategies to manage these risks. However, what is often neglected in ethics processes, the published literature on social media–based research, and institutional policies is researcher safety and well-being on the web. We acknowledge that this gap exists within a broader gap regarding researcher safety issues, described most frequently as relating to fieldwork and sensitive research, which are not new but remain inadequately addressed [5,44].

A Call for Guidance and Integrated Management of Researcher Safety on the Web

Health and social scientists and research students can face considerable risks and consequences associated with conducting research on politically contested or otherwise sensitive topics, which are characteristic of many areas of health research [45,46]. However, such risks, particularly their relevance in web-based settings, have been insufficiently acknowledged in the literature, policy, or practice. Researcher safety and work health and safety in research are most often defined in terms of risks of physical violence in field and laboratory work [47-49]. Cyberbullying policies and the literature focus largely on peer-to-peer or peer-to-staff (or vice versa) interactions.

There appears to be a dearth of comprehensive and integrated frameworks, training, and guidance for preparing research staff and students to implement and manage their work and safety on the web, both at the institutional and research levels [50]. There is limited evidence-based or regulatory guidance on the use of social media for research broadly [3,6,8,12]. This contributes to ambiguity around relevant ethical considerations and best practices, including how to interpret and apply existing ethics principles [51]. Guidelines published by The British Psychological Society note that exposure to distressing content, unsolicited attention or messages, or *derogatory attacks* may cause emotional distress and threaten researcher and institutional reputations as a result of web-based research [20]. However, descriptions of risks and implications of ethical considerations regarding public–private distinctions, confidentiality, and anonymity (among others) for researchers are not provided, nor is guidance on mitigating or managing risk and adverse events.

The under- or overestimation of risks resulting from a lack of ethical and practical guidance for web-based research and inconsistent approval outcomes from ethics boards affects researchers' ability to conduct ethical web-based research and may discourage social media use in research, resulting in lost opportunities [5,6].

Research from North American universities has found that over half of their faculty members are unsure whether there are resources available to support them if they experience web-based bullying; however, they believe universities should be responsible for preventing and stopping web-based bullying [17]. Although Cuevas [19] reported a *uniformly supportive* response from the faculty to the harassment campaign against him, he also noted that he would have preferred a more assertive organizational response that would call out his attackers and deter future harassment campaigns rooted in the use of *collective power* against a public minority figure. Our own experience mirrors that of Cuevas [19] as responses to our experience were *uniformly* and personally supportive; however, there was no sense that a broader institutional response or positioning against the harassment was considered. This leads us to consider whether a desire to appear *objective* (and, likely, to appease diverse funders) mutes what should be confident, evidence-based, inclusive responses by academic and scientific institutions toward homophobic, antichoice, or other hate-fueled harassment of their staff and students.

Research institutions have a duty of care toward staff and students and, as such, an obligation to develop and implement strategies to protect

researchers in the diversity of their modern workspaces. Although universities in Australia are legally mandated to hold policies addressing cyberbullying of staff, similar policies are not legally required for students [41]. A study found that although approximately 70% of Australian universities have policies relating to *bullying via computers*, less than half indicate *support for victims of bullying*, and only 20% provide *advice for students about bullying* [41]. An analysis of 465 policies at Canadian universities conducted in 2015 found that only one-third referenced cyber behaviors, and few addressed the prevention of web-based harassment [52]. Furthermore, such policies tend to focus on cyberbullying among peers or colleagues and often fail to address web-based safety management more broadly.

Failing to remain current with and address web-based safety concerns is not unique to universities. The *Guide for Preventing and Responding to Workplace Bullying* by Safework Australia [53] acknowledges the health and safety risks of bullying but fails to mention web-based harassment or bullying at all. However, as thought leaders and public institutions, it is questionable whether these gaps in universities—organizations that are designed to lead in knowledge generation and translation—are acceptable any longer.

Recommendations

In 2019, Russomanno et al [35] published what they described as "the first formal, safety and monitoring guidelines for researchers using social media" for recruitment, particularly of marginalized population group members. These guidelines recommend protection for both participants and researchers, with a focus on minimizing, managing, and addressing negative comments and cyberbullying. Recommendations include assigning research team members to regularly administrate and monitor recruitment posts; posting advertisements for at most a 1-week period (at a time) to minimize researcher burnout; using inclusion *and* exclusion terms to minimize negative responses; restricting who can respond to or comment on public pages; frequent reviewing of Facebook policies around privacy, profanity, and reporting before recruitment to reduce the burden on research staff and decrease users' experiences of negative comments and bullying; screenshotting and reporting all negative interactions to internal review boards; organizing regular staff debriefs and team meetings to minimize compassion fatigue (secondary traumatic stress); and making a relevant referral to mental health services or resources for staff as needed [35]. Evidence also suggests that the use of both inclusion and exclusion terms when targeting Facebook advertisements could help to minimize the likelihood of cyberbullying toward both the study population and, presumably, web-based researchers [20,35]. It is the specifics of managing safety, such as those that we believe should be shared and understood widely across research institutions and ethics boards.

On the basis of our experiences, relevant guidance addressing researcher safety on the web could also speak to the following:

1. The need for the routine provision of evidence-based training in ethical issues in web-based research for both researchers and ethics committees; this could support increased confidence of institutional review boards and individual researchers in using social media research strategies effectively, along with encouraging the teaching of techniques to minimize the risk of exposure to potentially harmful content and responses
2. Information on and strategies addressing the blurring of private and professional boundaries on the web and changing notions of privacy, including the implications for researcher safety and security, and guidance on the responsibilities of institutions in cases where harassment occurs and may move through public and private spaces
3. Emphasis on the legal, practical, and ethical implications of working across various social media platforms
4. The need to understand, support, and strengthen the digital fluency and mental health risks and capacity of researchers to prevent, manage, and respond to potential harassment and bullying, including clear protocols for individual and institutional support and response when harassment does occur
5. Strategies for engaging with media, both in the more traditional sense of media training and in regard to responding and communicating on the web, ensuring such strategies are not centered around avoidance of social media or on a victim-blaming mentality
6. Understanding language use, inclusion and exclusion terms, and other platform-specific

features that can help researchers to minimize risks associated with social media–based recruitment

Universities may also benefit from institution-wide efforts toward understanding and planning for the ways in which various departments and roles across the organization need to contribute to and work together toward coordinated and effective responses to adverse events.

There appears to be a consensus in the literature that guidance pertaining to web-based research ethics should be based on traditional ethical and well-being frameworks, partially to aid ethics bodies in their transition to assessing risks in these *new* web-based workspaces, particularly as overarching ethical concerns remain the same across the various locations of research [5,8,50,54]. However, the evolving risks, expectations around privacy, personal and professional boundaries, and ethical norms will necessarily generate new understandings and definitions of safety and require new applications and imaginations of existing ethical frameworks [50].

Instead of fearing the unknowns and risks of web-based research, the development of comprehensive guidance around web-based safety will help to ensure that universities and research groups have the capacity to maximize the potential of social media for research while better supporting the well-being of research staff and students. As such, we propose that the higher education sector, research institutions, and ethics bodies need to engage more fully with the emerging risks social media presents. When the potential benefits for the quality of research outcomes and for staff and student well-being are weighed against the risks of not better engaging with these issues, the urgency and importance of this work become clear.

Conflicts of Interest

BB is the coconvenor of the South Australian Abortion Action Coalition. KV holds a position as a Research Assistant with Children by Choice.

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Abbreviations

LGBTQIA+: lesbian, gay, bisexual, transgender, queer, intersex, and asexual

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