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“I am empowered by this opportunity”: The role of abortion funds as an antidote to abortion stigma

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ABSTRACT

Beyond the many structural obstacles to obtaining abortion care in the United States, abortion stigma is a forceful impediment to accessing timely services and an injurious feature of the experience for some people who have abortions (Sorhaindo & Lavelanet, 2022). This study utilized a qualitative methodology to explore the experiences of 830 abortion fund applicants in the Rocky Mountain Region to better understand the unique barriers they face in accessing care, the role that stigma plays in influencing applications for abortion fund support, and inform strategies to expand support infrastructure for those facing isolation and hostility in their pursuit of care. For the applicants in this study, stigma was frequently cited as an impetus for seeking abortion fund support and a burdensome aspect of the experience itself. Stigma—whether internalized, perceived, enacted, or structural—prevented many applicants from seeking material or emotional support from their social networks and spurred the dissolution of interpersonal relationships—with far-reaching emotional and material consequences. The results suggest that abortion funds go far beyond merely providing material support, also acting as an antidote to the harms associated with abortion stigma by promoting feelings of interconnectedness and mutuality among applicants. While accounts of stigma were pervasive in the applications, so, too, were the myriad strategies of resistance that applicants called upon to challenge stigmatizing narratives and position their choice to have an abortion as both moral and necessary.

1. Background

In consequence of the Supreme Court’s decision in *Dobbs v. Jackson Women’s Health,* which eliminated federal constitutional protections for abortion, access to abortion care in many regions across the US has been—and continues to become—sharply limited (Damante & Jones, 2023). At present, 14 states have implemented total bans with narrow and poorly defined exceptions, with many states poised to follow suit (Damante & Jones, 2023). At least 61 clinics across the country have stopped providing abortion services, severing or dramatically curtailing access to abortion care for upwards of 25 million people of childbearing age who may need and desire it (McCann & Walker, 2023; Mulvihill et al., 2023).

The harms wrought by this tide of restrictive abortion laws are unevenly felt, sharply divided among lines of race, class, geography, disability, immigration status, and age (Gleason et al., 2021; Zernicke, 2023). As such, abortion bans serve to exacerbate existing social and economic inequalities and are but a continuation of historical practices of reproductive control and oppression that have been forced on people of color, poor people, and people with disabilities for decades (Kozhimannil et al., 2022). Consequentially, abortion bans tend to crop up in regions with the greatest proportions of people of color and people living in poverty, and regions with the most maternity care deserts, highest prevalence of maternal mortality and morbidity, and most staggering rates of child poverty (The Lancet, 2021).

Abortion funds play an indispensable role in enabling access to care for those who exist at the nexus of interlocking systems of oppression, and, resultingly, face significant barriers to accessing quality, affordable, and non-stigmatizing care (Rice et al., 2021). Largely owing to the Hyde Amendment—a 1977 law that prohibited the use of federal funding for abortion care unless the pregnancy endangers the life of the pregnant person or was the result of rape or incest—an estimated 87% of those living in states with restrictive abortion policies paid out of pocket for abortion care pre-*Dobbs* (Damante and Jones, 2023; Salganicoff et al., 2024). The burden imposed by federal policies limiting abortion financing disproportionately impact poor communities, Black, Latinx, and Indigenous populations and people with disabilities, 1 in 3 of whom are insured through Medicaid (Damante & Jones, 2023). Given that 75%

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of abortion patients are considered poor or low-income, abortion funds function as an indispensable resource for those who may otherwise be unable to obtain care and play a vital role in rectifying racial and economic disparities in reproductive healthcare utilization and reproductive health outcomes (Fletcher et al., 2023; Kimport & Rasidjan, 2023). But beyond providing essential material support, abortion funds also work to destigmatize abortion and provide emotional, social, and informational support to those they serve (White et al., 2023).

While exploring the financial and geographical barriers and legal restrictions are central to understanding impediments to obtaining abortion care, the discussion is incomplete without examining the role that stigmatization plays in restricting access to care. Abortion stigma can serve to sever people from social support, as well as lay the foundation for restrictive legislation. The stigmatization of abortion both underpins legal restrictions and contributes to an environment of hostility around abortion which can serve to delay decision making, compound financial burdens, and engender emotional distress and social isolation (Hanschmidt et al., 2016). Policies that position abortion as morally reprehensible and harmful are both *enabled by* and *responsible for* the stigmatization of abortion (Moore et al., 2021).

Stigma is a social process that privileges or penalizes individuals based on their achievement of normalcy. The process of stigmatization, then, reproduces power relations through the labeling, excluding, and punishing of those deemed deviant, and attaching to them all the indignities and social penalties of that designation (Kumar et al., 2009). Stigma both depends on and reproduces systems of inequality and power through strict enforcement of normal, resulting in the social marginalization and isolation of the stigmatized (Kumar et al., 2009). Abortion has been particularly targeted for stigmatization due to its perceived contradiction of expected norms for women about sexual purity and an innate disposition for nurturance (Kumar et al., 2009). Society views the desire to be a mother as one of the foundational pillars of being a good woman, and people who have abortions are said to be subverting their biological destiny (Kumar et al., 2009). Abortion stigma, then, attempts to mark those who have abortions as "inferior to the ideals of womanhood" (Kumar et al., 2009, p. 628). In this way, the stigmatization of abortion serves to perpetuate gender inequality and plays a significant role in the systemic control of female sexuality (Beynon-Jones, 2017).

Past scholarship has identified four kinds of distinct, though interlocking, manifestations of stigma: internalized, perceived, enacted, and structural (Biggs et al., 2020). Internalized stigma refers to the process of an individual adopting negative beliefs about a stigmatized behavior or attribute into their own self-concept (Biggs et al., 2020). In the case of abortion stigma, one may internalize negative cultural beliefs about abortion as harmful, immoral, or socially unacceptable. Perceived or felt stigma refers to the tendency of those with socially stigmatized actions or attributes to sense or anticipate condemnation if the stigmatized attribute were to be revealed (Biggs et al., 2020). Those who experience perceived stigma may go to great lengths to avoid revealing the stigmatized attribute to guard against discriminatory interactions and their ensuing social implications (Seewald et al., 2019). Enacted stigma refers to lived experiences of discrimination, condemnation, rejection, and discreditation when a stigmatized attribute is disclosed. Structural stigma refers to the manifold "societal conditions, sociocultural norms, and institutional policies" that constrain opportunities for, socially penalize, and threaten the well-being and social, emotional, and material livelihoods of those who are subject to stigmatization (Hatzenbuehler, 2016, p. 742). Structural stigma—such as criminal penalties for providers and restrictions on abortion financing—contributes to all other manifestations of stigma by diffusing implicit or explicit messaging about the inherent reprehensibility of having an abortion (Broussard, 2020).

To this end, in the later decades of the 20th century and continuing into the 21st century, the anti-abortion camp introduced a novel conceptualization of abortion as a destructive procedure that damages women and situates them as "objects of pity" (Norris et al., 2011, p. 52). The anti-abortion movement has used this framework to popularize the idea of 'post-abortion syndrome,' referring to the severe and adverse psychological effects of having an abortion, a baseless claim which further entrenches stigmatization and justifies restrictive abortion policies (Steinberg & Finer, 2011; Turan & Budhwani, 2021). These myths have pervaded legislation, with dozens of states in the U.S. mandating that abortion patients receive literature before their procedure that attests to enduring and severe psychological consequences of abortion—claims that have been repeatedly disproven in the literature (Guttmacher Institute, 2019). More than half of U.S. states require an abortion patient to wait a specified period after receiving an ultrasound to ensure that they are certain about their decision— a rationale grounded in the assumption that people who seek abortion care will inevitably experience regret (De Londras et al., 2022).

On the contrary, the literature on abortion stigma has shown that while the experience of having an abortion may elicit a kaleidoscope of emotional responses, the most salient emotion that many people who have abortions experience is relief (Rocca et al., 2020). One study demonstrated that the percentage of people reporting that the decision to have an abortion was the right decision began at 97% one week following the abortion and rose to 99% after a five year period—dispelling claims that abortion is inevitably regretted (Rocca et al., 2020). The anti-abortion movements' efforts to frame abortion as damaging, dangerous, and harmful are not only baseless, but they also function to solidify abortion stigma in our cultural consciousness and political, legal, and medical institutions (Norris et al., 2011).

While stigma has been identified as a formidable barrier to obtaining abortion care and a significant contributor to health inequities, it is neither "inevitable nor uncontested" (Hoggart, 2017, p. 200). One of the central premises of the modern anti-abortion movement is the idea that the experience of having an abortion is universally devastating and that those who have abortions will inevitably wrestle with regret, pain, and emotional distress (Rocca et al., 2020). Anti-abortion forces have framed the experience of having an abortion in such a way to essentialize these feelings—situating them as the natural, inevitable physiological responses to the procedure itself, instead of, for instance, the byproducts of a culture that punishes and pathologizes those who seek abortions (Kumar et al., 2009). These sorts of narratives about abortion decenter the social origins of stigma and reduce a systemic phenomenon to an individual experience. Assuming that abortion stigma is uniformly experienced reinforces the idea that abortion is inherently harmful and ignores the great diversity of experiences of those who have abortions that may differ from popularized narratives or social expectations. Those who do indeed experience stigmatization call upon a vast array of strategies to reject and resist it—negotiating their experiences in the face of an increasingly restrictive and hostile abortion landscape (Millar, 2020).

One such mechanism—social support—has been identified as an antidote to the isolation and indignities imposed by stigmatization (Li et al., 2020). Social support refers to the provision of emotional, material, or practical support amongst social networks to reduce psychological and material burdens and guard against the harms of stress and isolation (Li et al., 2020). When one's decision to have an abortion is validated, supported, assisted, or facilitated by social networks, professionals, organizations, or strangers, this support provides a buffer against the injuries wrought by stigmatization at all levels of social interaction (Hendrix et al., 2023). The results from the Turnaway Study attest to the importance of social support in providing a buffer against emotional harm. The Turnaway Study concluded that the participants who had abortions and were most susceptible to psychological and emotional distress were those who had low levels of social support and had perceived or experienced stigmatization (Seewald et al., 2019). Social support can defray the burdens of abortion stigmatization by contributing to social integration and feelings of interconnectedness and mutuality. Abortion funds are positioned at a critical juncture to normalize and destigmatize abortion—at the individual, interpersonal,

and structural level (Kimport, 2022). At the structural level, abortion funds serve to destigmatize abortion by reducing inequities in reproductive healthcare access for those who otherwise face significant barriers to accessing care.

2. The current study

In this study, we explore the complex and rich experiences of applicants to an abortion fund in the Rocky Mountain Region. While applicants for abortion funds tend to face the most significant structural and social barriers to accessing abortion care, there is, at present, a modest body of scholarship exploring their qualitative experiences in doing so (Leyser-Whalen et al., 2020; Liddell et al., 2024; Makleff et al., 2023; White et al., 2023). This study aims to build upon the extant literature and thicken our understanding of abortion stigma and stigma resistance among individuals applying to abortion funds. Owing to privacy and safety concerns, those who anticipate stigmatizing responses may be less likely to use their own funds to obtain care if their finances or insurance policies are entwined with disapproving parties—such as partners or parents (Leyser-Whalen et al., 2021) or to seek material support from their social networks who they perceive would be disparaging of their decision—making this sample pool of applicants very well suited to explore in depth experiences of stigma (Fletcher et al., 2023; Kimport & Rasidjan, 2023). This study was propelled and guided by the following research question: 1) What role does social, cultural, and structural stigma play in driving the decision to seek support from abortion funds?

3. Methods

To better understand the experiences of people applying to abortion funds, a secondary dataset was compiled and analyzed using administrative data collected from an abortion fund in the Rocky Mountain Region. Qualitative data was collected from 830 applications submitted between 2013 and June 2022. The research team acquired the deidentified data from the abortion fund. The information provided by applicants primarily centered around their reasons for seeking assistance from the fund; some descriptions were brief while others were more detailed and lengthier. Applicants were responding to the prompt “Why are you requesting support from the abortion fund?” Applicants were able to provide as much or as little information as they desired to the prompt. Deidentified demographic information often accompanied many qualitative responses, though not all, as this information was requested but not required. The study was determined to not be human subjects research since it was secondary analysis of a de-identified dataset by the [omitted for blind review]'s Institutional Review Board. The abortion fund board approved the use of the data in the study.

The research team utilized a thematic analysis approach to interpret the results, blending deductive and inductive methods of analysis (Braun & Clarke, 2006; Kiger & Varpio, 2020). This approach is flexible, and allows for an iterative process that includes both pre-determined codes (e.g. reason applicants needed financial support of the fund) and emergent themes, such as the description of experiencing stigma, and how this impacted abortion access, that emerged in our study. The research team consisted of a group of six cross-disciplinary researchers who utilized NVivo software to code and analyze the qualitative data. We purposefully created a research team with a broad range of disciplinary and research expertise. Team members included both academic faculty, PhD, masters, and undergraduate students, and non-academic abortion fund board members and people with lived experience of abortion. Mentorship of team members with limited qualitative coding experience was provided by the second and fourth author, who both have extensive experience with conducting and coding qualitative research. Our theoretical and personal orientations towards this research was discussed and we engaged in critical reflection throughout coding and manuscript development. The team began by creating a set of codes after an initial examination of the data. Following this initial review, the research team created additional codes and subthemes as the coding process progressed. The research team met regularly to discuss findings and emergent themes, and engaged individually in “memoing” during the entire coding process so that questions, emergent themes, and the overall coding process could be reviewed and documented by the research team. Of the 830 applications, 245 (30%) were dual-coded to assess reliability between research team member coding. This is above the recommend best practice amount of dual-coding 20% of findings when analyzing large qualitative datasets (Syed & Nelson, 2015). The concept of stigma was explicitly coded in 60 applicants responses to the open-ended question. Cohen's kappa coefficient was .5 or higher across all codes, indicating good agreement between coders (Burla et al., 2008). Previous articles exploring other themes that emerged from this study include (Author(s), 2023; Author (s), 2024; Author(s), Under Review).

4. Results

The following sections will address the themes that emerged from the abortion fund applications. Stigma exerted considerable influence over applicants' experiences accessing abortion care—oftentimes defining the contours of their emotional, psychological, and social experience. While stigma was pervasive in applications, so too were the strategies that applicants called upon to resist it. The themes are as follows: (1) Anticipated Rejection; (2)Relational Disruption; (3) Internalized Stigma; (4) Resistance, including two subthemes- Role of Parent and As an Individual; (5) Diffusing Stigma

4.1. Theme 1: “I have no one to turn to”: Anticipated Rejection

Many applicants anticipated disapproval, rejection, and ostracization from their social ties for seeking an abortion. This fear complicated their decision-making, compromised their safety and wellbeing, and contributed to their need for abortion fund support. Applicant 21 felt as though they would “be a disgrace to my mom and dad,” while applicant 20 felt “so ashamed that [they] haven't been able to talk to their family in fears of ridicule.” Many applicants anticipated estrangement if they sought support for their abortion—from family, friends, and society at large. Applicant 12 felt there was “no possible way to tell to tell him. I couldn't tell anyone as I felt judged and still to this day only have told one person.” This applicant's anticipation of disapproval deterred them from seeking wanted and needed emotional support.

The potential of rejection was particularly dire for those who were financially dependent on the disapproving party. For many, rejection meant the suspension of financial support or emotional support, and, in some cases, even disownment. The implications of disclosure thus posed a grave threat to applicants' well-being, stability, and livelihoods. Applicant 15 encapsulated this fear: “I don't really have any friends for emotional support and my parents are unaware, they would kick me out of the house if I turned to them for support.” Applicant 23, too, stated their parents “would disown me if they found out I got pregnant.” Yet another applicant explained that their reticence to seek support was based on anticipated disapproval that would potentially lead to dire consequences: “My mom wouldn't support me and that unfortunately would leave me homeless.”

Some applicants feared that disclosure could invite interpersonal pressure or coercion to carry their pregnancies to term. Applicant 1 explains: “So now I am over the halfway point with little to no funding, trying to plan an abortion with a small support system—I cannot tell my family as they will pressure me to keep it. I am honestly just terrified of the whole situation.” Applicant 22's awareness of their parent's position on abortion led them to fear the same outcome:

> As a single mom she always raised me to wait until marriage, when she found out I chose not to she almost kicked me out. She has made

it clear that she would make me have the baby if I ever were in this predicament.

4.2. Theme 2: "The hardest part has been losing the support of my mother": Relational Disruption

Experiences of discrimination and rejection were cited repeatedly as an impetus for seeking abortion fund relief and a painful fixture of many applicants' experiences. Enacted stigma was described as a devastating and destructive force in the lives of applicants. Many applicants experienced the rejection they had anticipated and became estranged from their families and partners, more often than not leading to financial insecurity or social isolation. Applicant 5 was "kicked out of my home due to becoming pregnant at 18." Applicant 10 detailed a devastating rejection from their loved ones, stating: "I found out I was pregnant, and my family pretty much told me they never wanted to speak to me again. My boyfriend left me as soon as he found out." The same rang true for applicant 19, who said that their "boyfriend wanted nothing to do with the baby after I announced I was pregnant and ran." Applicant 16 received no emotional or financial support from their partner, feeling his "absence as a shock" and feeling completely "on [their] own in this." Applicant 3 articulated their experience of "humiliation" at a faith-based pregnancy center, where they felt shamed and judged for their choice to have an abortion.

In some applicants' cases, disapproval forestalled decision making and jeopardized their ability to obtain care. For applicant 17, they "had no one to turn to for a loan" to assist in paying for their procedure, resulting in the need to delay care because "the clinics in Montana could no longer schedule an abortion." They felt as though they did not have "time to earn or plan any other way." Applicant 9 detailed a similar experience:

> I thought that I had help and support, but I do not. I have been used, abused, and want to terminate this pregnancy as soon as possible but I am all alone [...] I put it off because I could not afford it and now the only place I can go to now is Colorado and I have no way of getting there or no way to fund my stay once I get there.

For this applicant, the rejection and absence of emotional, material, or logistical support left them no choice but to delay seeking care for the abortion they knew they needed. This delay compromised their ability to obtain an abortion in their own state and forced them to seek care far from home, compounding financial and logistical hurdles and intensifying psychological distress.

Applicant 14 explained the rupture that their abortion disclosure caused in their relationship with their mother:

> I am 17, I thought my mother would help me, but it ruined our relationship, she does not support my decision in choosing abortion. She will not sign the consent papers in Utah so the closest place to me that does not require parents' consent is in Montana. My mom says if I have it, I can't live at home anymore. I really need help and it seems as though I have nobody right now.

The kind of rejection this applicant experienced exacerbated the already existing burdens of traveling out of state to obtain the abortion and resulted in emotional distress and feelings of isolation.

4.3. Theme 3: "I shouldn't have let it happen, so I had to pay for it": internalized stigma

The power of internalized stigma in shaping applicants' emotional appraisal of their decision to have an abortion was described by applicants. Applicants in this study spoke to experiencing feelings of guilt and shame about their pregnancies and subsequent decisions to seek abortion care. Some placed heavy judgements on the behaviors they had internalized as reckless, selfish, or irresponsible; these feelings led them to feel deserving of the emotional or physical pain associated with their abortions. Applicant 8 was forced to wrestle with narratives propagated by the anti-abortion movement that cast abortion as an immoral act that sullies one's character:

> I read [online] about how I am a monster and a murderer for this from numerous sites. That I could always put it up for adoption or go through with it and not give up and take the easy way out [...] I know I am going to feel guilt and sadness when I get this abortion, but I know deep down its better for me and the baby.

Applicant 18 perceived their behavior to be careless and irresponsible, rendering the physical and emotional pain they experienced during their pregnancies as self-imposed and, thus, acceptable and deserved: "I've read the longer you wait the less successful medication abortion can be and also that it is more painful when you take those pills. Although it seems like I deserve it along with puking every day. I'm not proud of myself." For this applicant, the negative cultural beliefs about abortion that they had internalized led them to feel as if their pain was a form of penance. Applicant 4 echoed this sentiment, declaring:

> "I take full responsibility for the situation I have put myself in. I am not looking for a handout, a do-over, or an easy path. In fact, I declined sedation during the upcoming procedure—primarily because I do not have a driver—but also, I need to face this challenge head on and in full force."

Applicant 12 felt undeserving of support because they felt responsible for their circumstances, which, in turn, led them to believe that they were not worthy of assistance: "So, I went to [the clinic] and took the pills and spent one very, very lonely evening in my bed letting it happen. I was ashamed. Guilty. Sad. And, also, relieved. I figured I would not ask for assistance because it was my fault. I should not have let it happen and that I had to pay for it."

Ultimately, some applicants felt that the physical and emotional pain wrought by their abortions was a form of retribution for the behaviors that they had been socialized to believe were somehow shameful, devaluing, or reckless.

4.4. Theme 4: "I am empowered by this opportunity": resistance

Applicants described their strategies of stigma resistance by positioning abortion as both a form of empowerment as well as a moral necessity. Alongside the applicants' experiences of stigmatization were powerful testaments to decisional certainty and rightness. For instance, many participants framed their abortion as a source of empowerment and an act of self-determination by resisting the forces that sought to constrain or condemn their decision. The two subthemes explore the ways in which participants asserted their moral agency in choosing abortion, firstly by framing their decision as originating out of care and concern for the potential and existing children, and, secondly, by acknowledging that they lack the kind of social, material, and emotional support to raise a child in the way they envisioned. As such, applicants drew upon these experiences to adjudicate their belief in the moral rightness of their decision despite existing in environments suffused with rejection, stigmatization, and hostility.

Some applicants framed their choice as a source of empowerment and as an act of self-determination. Applicant 24 framed her decision to have an abortion as a form of recognition of her inherent power to have control over her own life and decision making:

> My choice is my empowerment within this life. I do not feel ready for a baby as I have many things, I would like to progress prior to becoming a mother. I am currently trying to learn how to exist in a state of joy without expectancy, and this is something I believe is so powerful that I would like to have a greater grasp of it, so if the time comes that I decide to be a mom, I know I can walk in powerful example for the being that I will create.

This applicant characterized her abortion as a form of self-determination and a decision empowering her to construct her life the way that she sees fit, enabling her to be the kind of mother she wants to be if that is indeed what she decides.

Applicant 25 similarly framed the decision to seek abortion as grounded in certainty and as a source of empowerment, "I feel confident in my decision, empowered by this opportunity, and stronger as a woman guided by liberation." Applicant 28 echoed this sentiment and sought help to pay for the abortion as they did not want their lack of finances to come between the "decision I know is what's best for me, my health, my sobriety and my ability to care for my daughter." In this way, these applicants framed their decision as an act of self-determination, enabling them to seek the kind of lives, health, career, wellness that they knew was best for themselves, and as, applicant 29 expressed, they were extremely "thankful to have a choice."

Feelings of certainty and resoluteness were present in many of the applicants' accounts. Applicant 30 reported feeling "100% confident in my decision." Applicant 60 framed their decision as one of absolute certainty:

> All emotions and fear of being judged aside, I am, without a doubt, 110% sure that terminating this pregnancy is the best option for all involved, and that scrambling to come up with the cost for an abortion will be significantly easier than scrambling the rest of my life to raise a child that I'm just not prepared to have.

Applicant 53 spoke to a week of "hard deliberation, debate, and soul searching" to conclude that "abortion is the best option" as it is "simply not the right time to bring a little one into my world." Applicant 43 knew that any decision would be a difficult one and bring about some sort of "trauma" whether it be parenting, adoption, or abortion" but felt with certainty that "abortion would be the one that would ensure there would be less of it."

Another factor that solidified applicants' resolve in having an abortion was the absence of the kind of social support and material support necessary to raise a child. Applicant 49 felt as though they had "zero support or family to lean on" while applicant 38 spoke to not having a "good enough support system to be able to raise a child on my own." Applicant 32's decision to have an abortion was informed by her own upbringing and the knowledge of how integral a support system is in raising a child, and how she felt she did not have access to the same networks of support: "I was raised by a single mother who did have a great family support system. I don't want to do that myself without a support system."

4.4.1. *Subtheme 1: "It deserves to live a perfect life I could never give it": role of parent*

Some applicants described their decision to have an abortion as being borne out of care and concern for the potential child and their existing children. Other applicants based their desire to obtain an abortion on the wellbeing of the potential child and the knowledge that they were not in a position to give them the type of life they deserved. Applicant 59 felt that as a single mom working two jobs and trying to make ends meet, the "situation I am in right now is just not best for another baby." Applicant 34 based the decision on the knowledge that they were sparing the potential child from pain by having an abortion. They reasoned:

> I know deep down it is better for me and the baby. I cannot give the baby the life it needs, and I feel my depression and anxiety will come back and I never want to put my body with a growing child inside through that. Giving up a baby or keeping it would make me sadder than aborting it because it deserves to live a perfect life that I cannot give it.

Applicant 20 echoed these sentiments:

> I know that carrying through with this pregnancy would be more irresponsible than anything, as I am still struggling to learn how to fend for myself in this world and am nowhere near ready to support another and I do not want to put another little one through anything I was growing up.

Applicant 58 similarly based the decision on a desire to give the potential child a better upbringing than she had, which she felt unable to do at the time: "I would love to have kids one day, but I am not prepared to bring a child into this world. My relationship could not handle it and it would kill me to see my kids raised without both parents like me. I want the best for my kids, and I know I would not be able to provide that." Applicant 45 sought an abortion because they "knew it was the best option for me, but more importantly for the life growing inside me." These applicants saw their decision to have an abortion as being based on the care of and concern for a potential child and a desire to give them a life they did not feel capable of providing at that moment in time.

Another frequently cited reason for applicants' decision to seek abortion care was for the sake of their existing children. Applicant 33 knew that she needed an abortion because she "can't afford another baby and this pregnancy has me feeling so depressed and stressed I feel like I'm not being the best mother I can be to my son who I love more than anything." Applicant 52 echoed this applicants' experience, "I am a single mother struggling every day to keep my baby and I above water [...] I am in no financial place to raise another child at this time. I have goals for my daughter, and I do not always want to be struggling."

4.4.2. *Subtheme 2: "I don't want to bring a baby into the world when I am having a hard time feeding myself": as an individual*

Many applicants described their decision to have an abortion as driven by a lack of material, emotional, practical support. Many applicants reasoned that they were not in a solid enough financial position to support a child or give the child the life that they believed they were deserving of. Applicant 51, speaking to this very feeling, "I don't have a home, I started a new job, but I don't want to bring a baby into the world when I am having a hard time feeding myself." Applicant 46 spoke to "barely making ends meet month to month, without family support or many friends in the area." Applicant 50 felt that because they had no financial support, that they "could not handle doing this alone and struggling the way I do now, to add child into the equation would not be fair to anyone."

For many applicants, it was the joining of financial and emotional instability that solidified their resolve to obtain abortion care. Applicant 54 reasoned that, "I cannot afford to raise a child as I am unstable financially and mentally as well as emotionally [...] I am struggling to take care of myself let alone a child." For this applicant, the combination of emotional insecurity and limited financial resources made continuing the pregnancy untenable. Applicant 39 spoke to similar feelings: "I am not emotionally nor financially stable enough for a child. I know I'm not capable of taking care of a baby right now and I know I need more time and experience."

4.5. *Theme 5: "Thank you for hearing my story": Diffusing Stigma*

Applicants described the role of abortion funds in destigmatizing abortion care and acting as a vital source of social, emotional, and logistical support for those seeking assistance. One significant thread through many of the applicant's narratives was the framing of the abortion fund as an essential source of emotional, social, or material support in the midst of an experience in which participants otherwise felt entirely alone. Applicant 40 spoke to feeling as though they had "nowhere to turn." Applicant 7 sought assistance from the fund as they "did not have any family or friends who can help, and I need to keep it a secret." Applicant 17 felt as though they had "no one else to turn to." Applicant 44 articulated feeling in "desperate need of help and scared walking through this alone." Applicant 41 expressed feeling in need of

emotional support as she "sincerely could use someone to talk to about this. I'm scared and I do not know what to do." These responses indicate that the abortion fund acted not just as a financial resource, but also a crucial source of emotional and social support.

Many applicants' appreciation for the fund was so great that they made a commitment to pay the fund back or volunteer their time to help those in parallel circumstances in their future. In this way, support from the abortion fund became bidirectional, with those who had been supported committing to support others in turn—creating an interlocking network of support and mutuality. Many applicants characterized their future actions as "paying it forward" to support other applicants, with applicant 33 feeling "really excited about the idea of helping others in [the same] position." For instance, applicant 55 noted:

> If you can help me through this time, I would like to be able to give back in any way I can, such as volunteering. I am only putting this in because even though I am going through a time in life that I may not be able to give financially I would like to give back in any way I can so other girls in my current situation can get the help they need as well.

Applicant 61 expressed a similar sentiment:

> I promised myself that I would donate to clinics and Planned Parenthood from now on, even if it is only small amounts, because I would hate to see another girl be stuck in a situation like mine and NOT have resources to turn to.

These applicants considered their decision to apply for abortion fund support as being reflective of a "unique time of need," and felt strongly that they should lend future support to the fund, and those in need of its resources, when they were ready and able.

Many applicants identified the fund as providing a key form of emotional and social support, as their interactions with the fund led them to feel heard, understood, and less alone. Multiple applicants thanked the fund for "hearing their story" and extending "kindness and understanding." Applicant 43 offered "blessings [to the fund] for understanding that people make mistakes and still deserve help," while applicant 66 attested that "I greatly appreciate your organization & will donate & speak highly of your program to anyone that I feel could benefit from hearing my words. I am forever grateful to your agency. Thank you for hearing my story." Applicant 63 expressed gratitude for the support the fund offered that went beyond material support:

> Every single person I've talked to these past couple of weeks has been great, and I can't wait to be able to support these programs so that someone else like me can get the help they need and feel heard and understood like I am feeling!

Applicant 47 underscored the importance of support from the fund in a particularly fraught time:

> I am so grateful for any assistance that your foundation may be able to give. Thank you for being there for women such as myself in times of darkness and need. I hope that in the future when I am working again that I will be able to return the assistance given to me so that another woman may be helped.

Many applicants characterized the fund as an indispensable, community-driven resource defending people's rights. Applicant 57 noted that "[she] is extremely grateful for a fund that supports women's rights and decisions," while applicant 27 expressed being "forever appreciative" to the fund, articulating that she considered it to be a "beautiful thing that you guys have started here, and I will be willing to donate any money I can to help girls that are also in this situation." These applicants framed the fund as going beyond mere material support by working to ensure that the human right of reproductive autonomy is universally felt, and not determined by one's social or financial position. Applicant 42 summarized this sentiment succinctly:

> It's amazing to see that this fund is available for women and girls across the state, and I will be honored to donate in the future when I regain my stability. Thank you so much for your consideration and for all that you do in standing for women's rights.

Many applicants sought support from the fund because they had anticipated or experienced rejection for their decision to have an abortion. Being met with kindness, understanding, and the practical support necessary to obtain the abortion during the application process offset some of the emotional and financial burdens they were facing and strengthened feelings of interconnectedness and solidarity with the organization and others who utilize its resources. The fund was positioned at a crucial juncture to ease the reverberating harms of stigmatization by providing emotional and social support, empathy, and understanding during a time in which many applicants felt incredibly alone. Further, applicants felt the process of receiving support in turn activated their own feelings of generosity, empathy, and mutuality, and contributed their feeling honored by the opportunity to pay it forward to others wrestling with difficult circumstances in the future.

5. Discussion

The data compiled from applications to the abortion fund revealed five major themes centering around applicants' experiences with and resistance to abortion stigma. Importantly, applicants experienced varying types and degrees of stigmatization both internally and externally focused. The three types of stigma applicants spoke about included internalized, perceived, and enacted stigma—all of which worked in concert to delay decision making and care, magnify the pressure to conceal their intent to have an abortion, and sever folks from social networks and support. This rendered the process of accessing care more cumbersome and endangered their safety and wellbeing. Despite abortion stigma being a destructive force in the lives of many applicants, they still found avenues to challenge stigma and find support for their decision from the abortion fund.

Consistent with existing literature, perceived stigma surfaced frequently in applicants' accounts as a significant impediment to accessing care, a distressing feature of the experience itself, and, oftentimes, as a central force driving the need to seek support from the abortion fund (Biggs et al., 2020; Hanschmidt et al., 2016; Shellenberg & Tsui, 2012; Sorhaindo & Lavelanet, 2022). Many of the applicants were deterred from seeking financial and emotional support from disapproving social networks, which prolonged the overall process of accessing care and jeopardized some applicants' ability to obtain an abortion in their home state (Gelman et al., 2017). Many applicants were tied to their parents' or partners' insurance policies and were unable to use the coverage out of fear they would not be able to conceal the abortion (Leyser-Whalen et al., 2021). Further, in accordance with findings from previous studies, perceived stigma fostered an environment of fear and uncertainty for applicants and, and, at times, contributed to feelings of emotional distress (Moore et al., 2021; Moseson et al., 2019; Shellenberg et al., 2011; Shellenberg & Tsui, 2012).

In keeping with prior scholarship exploring the consequences of abortion stigma, enacted stigma was a devastating and destructive feature of many of the applicants' experiences in accessing abortion care (Cockrill & Nack, 2013; Cowan, 2017; Frohwirth et al., 2018; Gelman et al., 2017). Many applicants experienced harsh condemnation—typically from parents and partners—which left them feeling isolated and disposable. The consequences of enacted stigma were numerous, including emotional and psychological distress, social isolation, and deepening financial instability owing to the discontinuation of material support from disapproving parties (Astbury-Ward et al., 2012; Biggs et al., 2023; Coleman-Minahan et al., 2020). For many applicants, it was not the abortion itself that led to emotional distress or turmoil, but the social circumstances surrounding the abortion—including whether their decision was vilified by their loved ones or those closest to them—which

produced the most emotional difficulty (Kimport et al., 2011).

Some applicants in this study identified internalized stigma as a consequential feature of their abortion experience (Hanschmidt et al., 2016). These applicants attributed their need for an abortion as being a result of behaviors they deemed irresponsible; other applicants singularly shouldered responsibility for their pregnancies, and, in some instances, felt undeserving of support because of it. Other applicants characterized their behavior as reckless and chided themselves for losing the types of control they had otherwise maintained in their life. Consistent with previous literature, internalized stigma was often accompanied by feelings of shame and guilt and statements of self-condemnation, oftentimes leading applicants to feel undeserving of support and isolating them from their loved ones as a result (Hoggart, 2017; A. T. O'Donnell et al., 2018; Shellenberg & Tsui, 2012).

Another notable aspect of applicants' narratives was their emphasis on how stigma delayed access to care, increasing logistical and financial challenges and emotional distress. This is in keeping with prior scholarship which has linked abortion stigma with significant delays in accessing care—primarily by deterring individuals from seeking support (Gelman et al., 2017). Those who anticipate rejection or stigmatization often go it alone, which can lead to delays in care and increase the likelihood that they will have to have an abortion later in their pregnancy when it is more expensive and difficult to access (Jones et al., 2013). Such delays subject patients to higher financial costs, can increase the risk of complications, and magnify privacy concerns (Gelman et al., 2017). In the most severe of cases, delays in care may be so significant that the pregnancy has advanced past the sanctioned gestational limits. In these cases, patients may be denied abortion services altogether. Many applicants noted that, because they could not put forward the funding to cover their abortion in their home state, they were left with no choice but to travel across state lines to procure care, demonstrating how stigma stymies timely access to abortion care and compounds the already formidable burdens individuals face in their pursuit of care (Boonstra, 2016; Ely et al., 2017; Jones et al., 2013).

In keeping with prior research demonstrating high levels of decisional certainty among people who have abortions, another major theme that emerged from applicants' accounts was consistent expressions of certainty and an enduring belief in the necessity and rightness of their decision to seek an abortion (Jovel et al., 2021; Rowland et al., 2021). While many applicants spoke about stigmatizing experiences in their applications, they also explored a litany of avenues to contest and challenge stigma. Applicants repeatedly framed their decision to have an abortion as a moral one—calling upon their beliefs about what kind of life a child deserves and framing their decision as arising out of care and concern for their existing children (Cockrill & Nack, 2013). Similarly, applicants frequently spoke of their decision with clarity, certainty, and resoluteness, arguing that despite the relative difficulty of the decision, that they stood firm in its necessity for themselves, their families, and the potential child (Rowland et al., 2021). These framings represent strategies of stigma resistance that applicants had adopted to contest the dominant framings of abortion as always representing a source of turmoil, suffering, and regret (Cockrill & Nack, 2013). These declarations of certainty on behalf of applicants build upon extant literature which demonstrates that despite abortion being a pervasively stigmatized phenomena, people who have abortions still find ways to contest stigmatizing narratives and assert their own moral agency in their decision (Baird & Millar, 2019; Cockrill & Biggs, 2018; Cockrill & Nack, 2013; Hoggart, 2017; Millar, 2020; J. O'Donnell et al., 2011).

Our findings are consistent with and offer greater depth to the limited scholarship examining the outsized role that abortion funds play in destigmatizing abortion and acting as an emotional refuge and lifeline for those seeking care (Makleff et al., 2023; White et al., 2023). In light of the increasingly complex, fragmented, and hostile legal and political landscape surrounding abortion, social support plays a pivotal role in enabling access to abortion care (Dickey et al., 2022). Because the presence of social support has been shown to counteract the pernicious and isolating effects of stigma, abortion funds play an important role in not only deconstructing structural barriers to abortion care, but also destigmatizing abortion itself, by way of offering compassionate counsel and care to those who have faced or anticipated condemnation for their decision (Hendrix et al., 2023; Norris et al., 2011; White et al., 2023). Our findings suggest that the role of abortion funds far surpasses that of merely providing financial support—in many ways acting as an antidote to stigma and a refuge from hostility. Unique to our study, applicants noted that the process of receiving support from the fund—both material and emotional—prompted feelings of genorsoity and collective responsibility. As a result, applicants were moved to provide tangible support for others in their position when they were equipped to do so and experienced greater empathy and compassion for themselves and others.

6. Limitations

The current study presents various limitations. First, the applicants' accounts only offer insight into a small window of their whole abortion experience, thereby precluding any longitudinal analysis into the shifting dynamics of stigma over time. Understanding if the intensity of stigma waxes and wanes over time would provide us with a clearer picture of the long-term costs of abortion stigma. Next, experiences of stigma may have been more pervasive—and thus overly represented—in this study. It is known that abortion stigma can prevent people from seeking financial support from their social networks or deter them from using their own funds or insurance coverage to guard against disclosure to disapproving parties. As such, people who might experience the costs of abortion stigma more dramatically—such as young people or low-income people—may be overrepresented in applications to abortion funds (Leyser-Whalen et al., 2021). Further, not all applicants opted to provide demographic data along with their descriptions, meaning that a deep analysis of stigma based on social context and identity was not possible. Future studies should aim to capture the longitudinal experiences of people applying for abortion fund support accompanied by comprehensive demographic data to better understand how the experience of stigmatization differs based on social context. In addition, these findings emerged from application data, and participants were not specifically asked about their experience or perception of stigma. Future studies may seek to specifically explore the experience of stigma by abortion fund clients to better understand this topic. Lastly, these data were collected over a period of ten years—beginning in 2013 and concluding in June of 2022—and thus do not include the experiences of those who sought abortion fund support after the *Dobbs* decision. This study therefore cannot attend to the seismic changes in abortion access and availability in the US and the steeper obstacles that individuals are currently grappling with in their pursuit of abortion care.

7. Implications

This study has important implications shedding light as it does on the crucial role abortion funds in not only reducing structural barriers to abortion care, but also providing emotional and social support to ease the harms of stigmatization.This finding suggests the need for more research on how to expand the tools abortion funds have at their disposal to provide emotional and social support for applicants. Moreover, many applicants expressed empathy for others in their position and committed to provide support—either financial or volunteer—in the future, in order to alleviate the strain faced by those in similarly difficult circumstances. These committments indicate that there could be some value in developing an avenue for applicants to connect with one another confidentially—perhaps to share resources, stories, or support. Applicants repeatedly spoke to the importance of the fund in attenuating their feelings of isolation, and stirring feelings of genority, empathy, and mutual responsibility. More research is needed on how abortion funds can expand these built-in networks of support to support previous,

current, and future applicants contending with the consequences of stigma.

8. Conclusion

The results of this study illustrate that stigma—internalized, perceived, enacted, and structural—was a powerful impetus for applications for abortion fund support and a challenging and burdensome feature of the experience. For many applicants, experiences of stigmatization were oftentimes accompanied by heightened social isolation—effectively compounding the already formidable financial, logistical, and emotional burdens involved in procuring abortion care. However, despite the centrality of stigma in the experiences among applicants to this abortion fund, many applicants resisted stigmatizing narratives by framing their decision as both morally necessary and empowering. Importantly, the abortion fund played a role that far surpassed mere financial support—acting as an emotional lifeline to those wrestling with hostility, rejection, and judgement. The act of applying for and receiving assistance from the abortion fund heightened applicants' feelings of generosity, mutual responsibility, and compassion for themselves and others in parallel circumstances—underscoring the function of abortion funds as not merely enabling access, but working to destigmatize abortion itself.

CRediT authorship contribution statement

Al Garnsey: Writing – review & editing, Writing – original draft, Formal analysis, Data curation, Conceptualization. **Jessica L. Liddell:** Writing – review & editing, Writing – original draft, Supervision, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Annie Glover:** Writing – review & editing, Writing – original draft, Supervision. **Celina M. Doria:** Writing – review & editing, Formal analysis, Conceptualization. **Alex Buscaglia:** Writing – review & editing, Formal analysis. **Lauren Buxbaum:** Writing – review & editing, Formal analysis.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

References

Astbury-Ward, E., Parry, O., & Carnwell, R. (2012). Stigma, abortion, and disclosure—findings from a qualitative study. *The Journal of Sexual Medicine, 9*(12), 3137–3147. https://doi.org/10.1111/j.1743-6109.2011.02604.x

Baird, B., & Millar, E. (2019). More than stigma: Interrogating counter narratives of abortion. *Sexualities, 22*(7–8), 1110–1126. https://doi.org/10.1177/1363460718782966

Beynon-Jones, S. M. (2017). Untroubling abortion: A discourse analysis of women's accounts. *Feminism & Psychology, 27*(2), 225–242. https://doi.org/10.1177/0959353517696515

Biggs, M. A., Brown, K., & Foster, D. G. (2020). Perceived abortion stigma and psychological well-being over five years after receiving or being denied an abortion. *PLoS One, 15*(1), Article e0226417. https://doi.org/10.1371/journal.pone.0226417

Biggs, M. A., Driver, M., Kaller, S., & Ralph, L. J. (2023). Unwanted abortion disclosure and social support in the abortion decision and mental health symptoms: A cross-sectional survey. *Contraception, 119*, Article 109905. https://doi.org/10.1016/j.contraception.2022.10.007

Boonstra, H. (2016). *Abortion in the lives of women struggling financially: Why insurance coverage matters*. Guttmacher Institute.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101.

Broussard, K. (2020). The changing landscape of abortion care: Embodied experiences of structural stigma in the Republic of Ireland and Northern Ireland. *Social Science & Medicine, 245*, Article 112686. https://doi.org/10.1016/j.socscimed.2019.112686

Burla, L., Knierim, B., Barth, J., Liewald, K., Duetz, M., & Abel, T. (2008). From text to codings: Intercoder reliability assessment in qualitative content analysis. *Nursing Research, 57*(2), 113–117.

Cockrill, K., & Biggs, A. (2018). Can stories reduce abortion stigma? Findings from a longitudinal cohort study. *Culture, Health and Sexuality, 20*(3), 335–350. https://doi.org/10.1080/13691058.2017.1346202

Cockrill, K., & Nack, A. (2013). "I'm not that type of person": Managing the stigma of having an abortion. *Deviant Behavior, 34*(12), 973–990. https://doi.org/10.1080/01639625.2013.800423

Coleman-Minahan, K., Jean Stevenson, A., Obront, E., & Hays, S. (2020). Adolescents obtaining abortion without parental consent: Their reasons and experiences of social support. *Perspectives on Sexual and Reproductive Health, 52*(1), 15–22. https://doi.org/10.1363/psrh.12132

Cowan, S. K. (2017). Enacted abortion stigma in the United States. *Social Science & Medicine, 177*, 259–268. https://doi.org/10.1016/j.socscimed.2017.01.011

Damante, B., & Jones, K. (2023). A year after the Supreme Court overturned roe v. Wade. *Trends in state abortion laws have emerged*. The Center for American Progress.

De Londras, F., Cleeve, A., Rodriguez, M. I., Farrell, A., Furgalska, M., & Lavelanet, A. (2022). The impact of mandatory waiting periods on abortion-related outcomes: A synthesis of legal and health evidence. *BMC Public Health, 22*(1), 1232. https://doi.org/10.1186/s12889-022-13620-z

Dickey, M. S., Mosley, E. A., Clark, E. A., Cordes, S., Lathrop, E., & Haddad, L. B. (2022). "They're forcing people to have children that they can't afford": A qualitative study of social support and capital among individuals receiving an abortion in Georgia. *Social Science & Medicine, 315*, Article 115547. https://doi.org/10.1016/j.socscimed.2022.115547

Ely, G. E., Hales, T. W., Jackson, D. L., Maguin, E., & Hamilton, G. (2017). Where are they from and how far must they go? Examining location and travel distance in U.S. Abortion fund patients. *International Journal of Sexual Health, 29*(4), 313–324. https://doi.org/10.1080/19317611.2017.1316809

Fletcher, J., Yee, H., Ong, B., & Roden, R. C. (2023). Centering disability visibility in reproductive health care: Dismantling barriers to achieve reproductive equity. *Women's Health, 19*, Article 17455057231197166. https://doi.org/10.1177/17455057231197166

Frohwirth, L., Coleman, M., & Moore, A. M. (2018). Managing religion and morality within the abortion experience: Qualitative interviews with women obtaining abortions in the U.S. *World Medical & Health Policy, 10*(4), 381–400. https://doi.org/10.1002/wmh3.289

Gelman, A., Rosenfeld, E. A., Nikolajski, C., Freedman, L. R., Steinberg, J. R., & Borrero, S. (2017). Abortion stigma among low-income women obtaining abortions in western Pennsylvania: A qualitative assessment. *Perspectives on Sexual and Reproductive Health, 49*(1), 29–36. https://doi.org/10.1363/psrh.12014

Gleason, J. L., Grewal, J., Chen, Z., Cernich, A. N., & Grantz, K. L. (2021). Risk of adverse maternal outcomes in pregnant women with disabilities. *JAMA Network Open, 4*(12), Article e2138414. https://doi.org/10.1001/jamanetworkopen.2021.38414

Hanschmidt, F., Linde, K., Hilbert, A., Riedel- Heller, S. G., & Kersting, A. (2016). Abortion stigma: A systematic review. *Perspectives on Sexual and Reproductive Health, 48*(4), 169–177. https://doi.org/10.1363/48e8516

Hatzenbuehler, M. L. (2016). Structural stigma: Research evidence and implications for psychological science. *American Psychologist, 71*(8), 742–751. https://doi.org/10.1037/amp0000068

Hendrix, T., Roncoroni, J., Magdamo, B., Whitaker, S., Zareba, K., & Grieco, N. (2023). Stigma, social support, and decision satisfaction in terminations of pregnancy for medical reasons. *Women's Health Reports, 4*(1), 271–279. https://doi.org/10.1089/whr.2022.0092

Hoggart, L. (2017). Internalised abortion stigma: Young women's strategies of resistance and rejection. *Feminism & Psychology, 27*(2), 186–202. https://doi.org/10.1177/0959353517698997

Jones, R. K., Upadhyay, U. D., & Weitz, T. A. (2013). At what cost? Payment for abortion care by U.S. Women. *Women's Health Issues, 23*(3), e173–e178. https://doi.org/10.1016/j.whi.2013.03.001

Jovel, I., Cartwright, A. F., Ralph, L., & Upadhyay, U. D. (2021). Abortion waiting periods and decision certainty among people searching online for abortion care. *Obstetrics & Gynecology, 137*(4), 597–605. https://doi.org/10.1097/AOG.0000000000004313

Kiger, M. E., & Varpio, L. (2020). Thematic analysis of qualitative data: AMEE Guide No. 131. *Medical Teacher, 42*(8), 846–854.

Kimport, K. (2022). Reducing the burdens of forced abortion travel: Referrals, financial and emotional support, and opportunities for positive experiences in traveling for third-trimester abortion care. *Social Science & Medicine, 293*, Article 114667. https://doi.org/10.1016/j.socscimed.2021.114667

Kimport, K., Foster, K., & Weitz, T. A. (2011). Social sources of women's emotional difficulty after abortion: Lessons from women's abortion narratives. *Perspectives on Sexual and Reproductive Health, 43*(2), 103–109. https://doi.org/10.1363/4310311

Kimport, K., & Rasidjan, M. P. (2023). Exploring the emotional costs of abortion travel in the United States due to legal restriction. *Contraception, 120*, Article 109956. https://doi.org/10.1016/j.contraception.2023.109956

Kozhimannil, K. B., Hassan, A., & Hardeman, R. R. (2022). Abortion access as a racial justice issue. *New England Journal of Medicine, 387*(17), 1537–1539. https://doi.org/10.1056/NEJMp2209737

Kumar, A., Hessini, L., & Mitchell, E. M. H. (2009). Conceptualising abortion stigma. *Culture, Health and Sexuality, 11*(6), 625–639. https://doi.org/10.1080/13691050902842741

Leyser-Whalen, O., Torres, L., & Gonzales, B. (2021). Revealing economic and racial injustices: Demographics of abortion fund callers on the U.S.–Mexico border. *Women's Reproductive Health, 8*(3), 188–202. https://doi.org/10.1080/23293691.2021.1973845

Leyser-Whalen, O., Zareei Chaleshtori, S., & Monteblanco, A. (2020). Another disaster: Access to abortion after hurricane harvey. *Health Care for Women International, 41*(10), 1111–1127. https://doi.org/10.1080/07399332.2020.1833883

Li, J., Liang, W., Yuan, B., & Zeng, G. (2020). Internalized stigmatization, social support, and individual mental health problems in the public health crisis. *International Journal of Environmental Research and Public Health, 17*(12), 4507. https://doi.org/10.3390/ijerph17124507

Liddell, J. L., Buscaglia, A., Doria, C. M., Weekley, A., & Mascarena, L. (2024). "I need help with the abortion, so I won't have to ever see or hear from him again": Relationship barriers faced by abortion fund applicants in the Rocky Mountain west. *Violence Against Women.* , Article 10778012241236671. https://doi.org/10.1177/10778012241236671

Makleff, S., Blaylock, R., Ruggiero, S., Key, K., Chandrasekaran, S., & Gerdts, C. (2023). Travel for later abortion in the USA: Lived experiences, structural contributors and abortion fund support. *Culture, Health and Sexuality*, 1–17. https://doi.org/10.1080/13691058.2023.2179666

McCann, A., & Walker, A. (2023). *One year, 61 clinics: How Dobbs changed the abortion landscape.* The New York Times.

Millar, E. (2020). Abortion stigma as a social process. *Women's Studies International Forum, 78*, Article 102328. https://doi.org/10.1016/j.wsif.2019.102328

Moore, B., Poss, C., Coast, E., Lattof, S. R., & Van Der Meulen Rodgers, Y. (2021). The economics of abortion and its links with stigma: A secondary analysis from a scoping review on the economics of abortion. *PLoS One, 16*(2), Article e0246238. https://doi.org/10.1371/journal.pone.0246238

Moseson, H., Mahanaimy, M., Dehlendorf, C., & Gerdts, C. (2019). Society is, at the end of the day, still going to stigmatize you no matter which way": A qualitative study of the impact of stigma on social support during unintended pregnancy in early adulthood. *PLoS One, 14*(5), Article e0217308. https://doi.org/10.1371/journal.pone.0217308

Mulvihill, G., Kruesi, K., & Savage, C. (2023). *A year after fall of Roe, 25 million women live in states with abortion bans or tighter restrictions.* Associated Press.

Norris, A., Bessett, D., Steinberg, J. R., Kavanaugh, M. L., De Zordo, S., & Becker, D. (2011). Abortion stigma: A reconceptualization of constituents, causes, and consequences. *Women's Health Issues, 21*(3), S49–S54. https://doi.org/10.1016/j.whi.2011.02.010

O'Donnell, A. T., O'Carroll, T., & Toole, N. (2018). Internalized stigma and stigma-related isolation predict women's psychological distress and physical health symptoms post-abortion. *Psychology of Women Quarterly, 42*(2), 220–234. https://doi.org/10.1177/0361684317748937

O'Donnell, J., Weitz, T. A., & Freedman, L. R. (2011). Resistance and vulnerability to stigmatization in abortion work. *Social Science & Medicine, 73*(9), 1357–1364. https://doi.org/10.1016/j.socscimed.2011.08.019

Rice, W. S., Labgold, K., Peterson, Q. T., Higdon, M., & Njoku, O. (2021). Sociodemographic and service use characteristics of abortion fund cases from six states in the U.S. Southeast. *International Journal of Environmental Research and Public Health, 18*(7), 3813. https://doi.org/10.3390/ijerph18073813

Rocca, C. H., Samari, G., Foster, D. G., Gould, H., & Kimport, K. (2020). Emotions and decision rightness over five years following an abortion: An examination of decision difficulty and abortion stigma. *Social Science & Medicine, 248*, Article 112704. https://doi.org/10.1016/j.socscimed.2019.112704

Rowland, B. B., Rocca, C. H., & Ralph, L. J. (2021). Certainty and intention in pregnancy decision-making: An exploratory study. *Contraception, 103*(2), 80–85. https://doi.org/10.1016/j.contraception.2020.11.003

Salganicoff, A., Sobel, L., Gomez, I., & Ramaswamy, A. (2024). *The Hyde Amendment and Coverage for abortion services under Medicaid in the post-roe era (womens health policy)*. KFF.

Seewald, M., Martin, L. A., Echeverri, L., Njunguru, J., Hassinger, J. A., & Harris, L. H. (2019). Stigma and abortion complications: Stories from three continents. *Sexual and Reproductive Health Matters, 27*(3), 75–85. https://doi.org/10.1080/26410397.2019.1688917

Shellenberg, K. M., Moore, A. M., Bankole, A., Juarez, F., Omideyi, A. K., Palomino, N., Sathar, Z., Singh, S., & Tsui, A. O. (2011). Social stigma and disclosure about induced abortion: Results from an exploratory study. *Global Public Health, 6*(sup1), S111–S125. https://doi.org/10.1080/17441692.2011.594072

Shellenberg, K. M., & Tsui, A. O. (2012). Correlates of perceived and internalized stigma among abortion patients in the USA: An exploration by race and Hispanic ethnicity. *International Journal of Gynecology & Obstetrics, 118*(S2). https://doi.org/10.1016/S0020-7292(12)60015-0

Sorhaindo, A. M., & Lavelanet, A. F. (2022). Why does abortion stigma matter? A scoping review and hybrid analysis of qualitative evidence illustrating the role of stigma in the quality of abortion care. *Social Science & Medicine, 311*, Article 115271. https://doi.org/10.1016/j.socscimed.2022.115271

Steinberg, J. R., & Finer, L. B. (2011). Examining the association of abortion history and current mental health: A reanalysis of the national comorbidity survey using a common-risk-factors model. *Social Science & Medicine, 72*(1), 72–82. https://doi.org/10.1016/j.socscimed.2010.10.006

Syed, M., & Nelson, S. C. (2015). Guidelines for establishing reliability when coding narrative data. *Emerging Adulthood, 3*(6), 375–387.

The Lancet. (2021). Abortion bans in the USA harm health equity. *The Lancet, 398*(10310), 1461. https://doi.org/10.1016/S0140-6736(21)02307-2

Turan, J. M., & Budhwani, H. (2021). Restrictive abortion laws exacerbate stigma, resulting in harm to patients and providers. *American Journal of Public Health, 111*(1), 37–39. https://doi.org/10.2105/AJPH.2020.305998

White, K., Leyser-Whalen, O., Whitfield, B., Dane'el, A., Andrea, A., Rupani, A., Kumar, B., & Moayedi, G. (2023). Abortion assistance fund staff and volunteers as patient navigators following an abortion ban in Texas. *Perspectives on Sexual and Reproductive Health, psrh.12240*. https://doi.org/10.1363/psrh.12240

Zernicke, K. (2023). Five women sue Texas over the state's abortion ban. *The New York Times*.