



Original Research Article

Exploring providers' experience of stigma following the introduction of more liberal abortion care in the Republic of Ireland

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ARTICLE INFO

Article history:

Received 15 January 2021

Received in revised form 1 April 2021

Accepted 7 April 2021

Keywords:

Republic of Ireland

Abortion

Abortion providers

Stigma

Dirty work

Health workers

ABSTRACT

Objective: To explore if abortion care providers in the Republic of Ireland experience abortion-related stigma.

Study Design: The survey was distributed to abortion care providers working in community and hospital units nationwide. We measured stigma using the 35-item version of the *Abortion Providers Stigma Scale* (APSS). We also collected data on demography, professional involvement in providing abortion care, and risk of burnout (measured by the *Maslach Burnout Inventory*).

Results: Of the 309 providers invited to take part, 156 (50.5%) completed the survey between January to May 2020. The sample reported a mean score of 70.9 on the total scale of the APSS. This was comparable with the scores of providers in a Massachusetts-based study but was lower than a sample of providers from across the USA. Linear regression analyses found that the Irish hospital-based obstetricians ($b = 10.51$, 95% CI 3.16–17.86) and midwives/nurses ($b = 10.88$, 95% CI 2.3–19.47) reported higher stigma than their colleagues working in general practice.

Conclusions: Comparing the scores of the current sample to published studies highlight the factors that may drive stigma in the Irish context. The Irish providers reported fewer issues in disclosing their abortion work than providers in the USA, which may be explained as they also reported fewer experiences of judgment and discrimination. They did, however, report higher levels of social isolation. Additionally, the findings suggest that providing surgical and/or later-gestation abortion care and providing within the hospital environment may present additional challenges for staff which increase level of stigma.

Implications: Despite widespread support for the expansion of the abortion care services, providers in Ireland still experience stigma related to this work. Our findings suggest that Irish providers, particularly those working in hospitals, may benefit from supports to reduce abortion-related isolation and challenges posed by collegial interactions or later-gestation care.

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1. Introduction

In May 2018, the Republic of Ireland voted to expand its abortion care legislation [1, 2]. The Health (Regulation of Termination of Pregnancy) Act 2018 allowed Irish residents, for the first time, to legally end a pregnancy under 12 weeks gestation “without specific indication” [3]. Past 12 weeks, the act clarified that abortion is only permitted when there is a serious risk to the health of the pregnant person, in cases of medical emergency, or when a medical

condition means the fetus is unlikely to live more than 28 days after birth. The expanded abortion services have been available since January 1st, 2019. General practitioners (GPs, equivalent of Family Medicine) can provide early medical abortion to individuals below 9⁺⁶ weeks gestation. Between 10 and 12⁺⁰ weeks, care can be managed either medically or surgically (electrical or manual vacuum aspiration) in one of 10 providing hospitals. Care after 12 weeks is medically provided in hospital. More than 6,600 people accessed the expanded services in 2019 [4]. Recent publications outline the history of Irish abortion legislation [5] and the provision of abortion care in Ireland at the time of data collection [6, 7].

Abortion care, however, can be described as “dirty work” [8–10]. Over the past decade, a growing body of evidence has explored

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and documented the sources and impacts of abortion stigma for those involved in providing the service [11–17]. Included in this is the creation of the *Abortion Providers Stigma Scale* (APSS) [18, 19], which quantitatively measures providers' experience of stigma. The APSS has also allowed researchers to uncover the impacts of stigma, such as its positive relation to occupational burnout [19, 20].

The aim of the current study was to explore health care workers' experience of abortion stigma in the Republic of Ireland. This study also compared level of stigma for Irish-based abortion care providers to published samples and explored if there were demographic patterns in level of stigma within the sample. Finally, the current study investigated the relationship between stigma and burnout.

2. Materials and methods

2.1. Recruitment

The population of interest was health care workers who were directly involved in caring for patients undergoing an abortion in the Republic of Ireland, hereafter referred to as “providers”. This exploratory observational study required providers to complete an online or paper survey at one time-point. Data were collected between January and May 2020.

The *START Doctors* and *Hospital Providers* aided the research team in recruiting providers. Both organizations were created by providers in Ireland in response to the public support and later liberalization of abortion care. They offer clinical advice and training to new and practicing providers. The *Start* group shared a link to the online survey in a closed *WhatsApp* group containing 239 GP providers. The *Hospital Providers* group shared study information and a link to the online survey with senior staff at the providing hospitals and snowball sampling was used to recruit staff. We shared the paper survey in the National Maternity and Rotunda Hospitals, 2 large tertiary level maternity units (>9,000 births and >10,000 gynecology visits per year). We left paper surveys in clinical areas where abortion care is provided (i.e. operative theater and the gynecology and antenatal wards) and invited staff to place completed forms in a locked box to ensure confidentiality. The *Hospital Providers* group determined that there were 70 providers working in Irish hospitals.

2.2. Materials

We measured stigma using the 35-item APSS [19]. Each item describes either a stigmatizing or a positive experience that the provider may have encountered related to their work in abortion care. Providers were asked to respond on a 5-point Likert scale identifying how often, if at all, they have faced each experience (1 = *Never*, 5 = *All of the time*). The APSS measures total level of abortion-related stigma using 5 subscales: “*disclosure management*” (10 items), “*internalized states*” (10 items), “*judgment*” (7 items), “*social isolation*” (4 items), and “*discrimination*” (4 items). Higher scores on the APSS indicate higher levels of stigma.

We measured burnout using the “*Human Services Survey for Medical Personnel*” version of the Maslach Burnout Inventory (MBI) [21]. This version measures risk of burnout among workers in helping professions along 3 dimensions: “*emotional exhaustion*”, “*depersonalization*”, and “*personal accomplishment*”. Higher scores on the emotional exhaustion and depersonalization subscales and lower scores on the personal accomplishment subscale indicate greater risk of burnout.

2.3. Procedure

The survey began with the demographic questions, was followed by the APSS, and ended with the MBI. We made the MBI questions optional; we hoped that more providers would take part if given the choice to complete a shorter survey. We removed the MBI questions in March 2020 as increased work-related stress placed on health care workers during the COVID-19 pandemic may have impacted levels of staff burnout, potentially confounding the results.

We made the online survey using *Qualtrics* (Provo, UT) and we designed the paper survey in a similar format. Once collected, we uploaded paper surveys to Qualtrics. Ethical approval for this study was granted by the National Maternity Hospital Research Ethics Committee. We followed the STROBE guidelines for observational studies in writing this paper [22].

2.4. Analysis

We conducted independent t-tests to compare the APSS scores of the Irish and published samples. To test for demographic differences in stigma, we developed exploratory linear regression models. We included information on the providers' job title (GP, obstetrician/gynecologist, or midwife/nurse), geographical region (Dublin, Rest of Leinster, Munster, or Connacht/Ulster), gender (female or male), proportion of clinical time dedicated to abortion care (<5% or >5%) and reported involvement in providing emergency abortion care (involved or not involved). First, we conducted a simple linear regression for each variable and then we developed a multivariable linear regression model with the 5. Given previous research on abortion stigma, we hypothesized that providers may differentially experience stigma because of their job title [15] or region [17]. We also hypothesized that gender may be associated with stigma as abortion is often framed as a women's issue and that stigma may differ between those who occasionally vs regularly provided care. We included reported involvement in providing emergency abortion care during analyses as we believe it may have been related to stigma. We had also intended to include involvement in surgical abortion care, however we did not due to high collinearity with job title ($r = .79$). We excluded 2 service administrators and one anesthesiologist from the regression analyses as small groups meant that reliable claims about others in those professions could not be made. We used Spearman's rank-order correlations to test the relationship between scores on the MBI scales and the APSS. We used GraphPad, a web-based tool, to compare the Irish and published samples' APSS mean scores and we used IBM SPSS version 26.0 to complete all other analyses. No method of missing data imputation was used.

3. Results

3.1. Sample characteristics

Of the 309 providers with whom study information was shared, 156 (50.5%) completed the survey. This included 104 of 239 GPs (43.5%) and 49 of 70 hospital-based staff (70%). [Table 1](#) presents the demography of the sample. Ireland is geographically divided into 4 provinces (Connacht, Leinster, Munster, and Ulster) and 26 counties. For the purposes of the study, we separated Dublin and Leinster to represent the large concentration of respondents from the capital and we amalgamated Connacht and Ulster as there were only 2 responses from Ulster. Fifteen counties were represented. The proportion of clinical time dedicated to abortion care was similar for the community and hospital-based providers ($p = 0.35$). In line with Irish legislation, the community providers

Table 1
Demographic information for the sample of abortion care providers from the Republic of Ireland (n = 156)

Worker demographics	n (%)		
Job title *			
GP	104 (66.7%)		
Obstetrician/Gynecologist	28 (18%)		
Midwife	17 (10.9%)		
Nurse	3 (1.9%)		
Service administrator	2 (1.3%)		
Anesthesiologist	1 (.6%)		
Gender *			
Female	131 (84%)		
Male	23 (14.7%)		
Geographical region **			
Dublin	70 (44.9%)		
Rest of Leinster	11 (7%)		
Munster	58 (37.2%)		
Connacht/Ulster	15 (9.6%)		
Age group*			
20's	5 (3.2%)		
30's	43 (27.6%)		
40's	66 (42.3%)		
50's	29 (18.6%)		
60's	11 (7.1%)		
70's	1 (.6%)		
Worksite *			
Community-based practice	106 (68%)		
Hospital-based practice	49 (31.4%)		
Involvement in providing abortion care	Total sample	CBP^a	HBP^b
Legal circumstances^c			
Pregnancy under 12 weeks	142 (91%)	97	42
Medical emergency	69 (44.2%)	37	32
Fatal fetal anomaly	34 (21.8%)	1	33
Risk to the health of the mother	33 (21.2%)	3	30
Abortion procedures			
Medical (mifepristone and misoprostol)	117 (75%)	106	11
Surgical (manual vacuum aspiration)	9 (5.8%)	-	8
Involved in providing both	29 (18.6%)	-	28
Neither	1 (.6%)	-	-
Clinical time spent providing **			
Less than 5%	105 (67.3%)	76	29
Between 5% and 25%	43 (27.6%)	27	15
Between 25% and 50%	5 (3.2%)	3	1
Between 50% and 75%	1 (.6%)	-	1
International experience in abortion care *			
Yes	25 (16%)	11	14
No	130 (83.4%)	95	32

^a Community-based provider, n = 106 (GPs, n = 104; Midwives, n = 2).

^b Hospital-based provider includes clinical staff only, n = 47 (Obstetricians, n = 28; Midwives, n = 15; Nurses, n = 3; and Anesthesiologist, n = 1).

^c Some providers reported providing in multiple legal circumstances.

* Missing data for one respondent.

** Missing data for 2 respondents.

only offered medical abortion care whereas most of the hospital staff (77%) were involved in providing surgical abortion.

3.2. Irish providers' experience of stigma

Table 2 reports the Irish samples' scores on the APSS total scale and subscales. Scores on the total scale and 4 of the 5 subscales were normally distributed. The sample scored an average of 70.9 (SD 15.35) on the APSS total scale. Responses to each item of the APSS are included in the Appendix.

3.3. Comparing stigma in Ireland to published studies

Table 3 displays the APSS scores for the current sample and the 2 published studies. The Irish providers mean score on the APSS total scale was lower than that of the nationwide USA sample [19]. Looking to the subscales, the Irish sample scored lower on disclosure management and judgment but higher on social isolation. We could not statistically compare discrimination scores as

the Irish scores were not normally distributed. The Irish and Massachusetts samples scored similarly on the APSS total scale [15]. Subscale scores were not reported so further exploration was not possible.

3.4. Demographic patterns in stigma

The regression analyses included a subsample of 138 providers who had fully completed the APSS and reported all the demographic variables included in the model. Chi-square tests found that the demographic distribution of this subsample did not differ from the excluded providers, except for job title as 2 professions were removed from the regression models. We found that obstetricians and midwives/nurses scored higher on the APSS total scale than GPs (see Table 4). Differences in gender, region, proportion of clinical time, and involvement in emergency care did not produce unique contributions in predicting variations in stigma.

We also noted 2 variables that may have influenced the hospital providers' experience of stigma but could not be included in the regression models (see Table 5). First, we compared APSS total score by abortion procedure provided (medical only, surgical only, or both) using a one-way ANOVA. The "surgical only" group scored higher on the APSS compared to the other 2 groups; they did not statistically differ most likely due to the small number within the "surgical only" group. We then conducted an independent t-test on APSS total score using survey format (online or paper survey) as the independent variable. We found that both groups had similar scores.

3.5. Relationship between stigma and burnout

This analysis was completed with a subsample of providers who had completed the MBI scales before they were removed from the survey at the onset of the COVID-19 pandemic. Chi-square tests revealed there was no difference in APSS scores and the distribution of demographic information between those who did (n = 45) and did not (n = 111) complete the MBI. Table 6 shows the results of the Spearman's correlations between scores on the MBI and APSS. APSS total score was not correlated with any of the MBI scales. Analysis of the APSS subscales, however, revealed that emotional exhaustion was positively correlated with scores on judgment and disclosure management, while personal accomplishment was negatively correlated with internalized states.

4. Discussion

We found that Irish providers encounter stigma related to their abortion work, which is consistent with the international literature [10–16, 18–20]. The Irish providers reported lower levels of overall stigma than the nationwide USA sample [19], which included providers from both liberal and conservative states. Looking to the subscales, the Irish providers reported fewer issues in disclosing their abortion work. Research in the USA has highlighted that some providers conceal their abortion work to avoid becoming the target of harassment and violence [10, 23]. This need to conceal abortion work to preserve safety does not appear to be as prominent for the Irish providers as they also reported fewer experiences of judgment compared to the USA sample. Discrimination also appeared to be lower for the Irish sample, for example, 15% in Ireland had experienced a verbal threat or attack related to their abortion work compared to 51% in the USA. Fewer experiences of judgment and discrimination among the Irish providers may be related to the public support for the service, as evidenced by the strength of vote for expanded abortion care [1].

The Irish sample, however, reported greater social isolation than their USA counterparts. Despite widespread support, a third of

Table 2

A summary of the Irish abortion care providers scores on the total scale and subscales of the *Abortion Providers Stigma Scale* (n = 156)

	Average ^a	SD	n	Min score	Max score	Possible range ^b	Cronbach's alpha
APSS total score	70.90	15.35	144	37	134	35–175	.91
Disclosure management	21.43	6.74	152	10	43	10–50	.88
Internalized states	21.91	5.31	151	12	39	10–50	.76
Judgment	13.44	4.09	153	7	28	7–35	.77
Social isolation	10.36	3.47	154	4	19	4–20	.82
Discrimination	(4)	(4, 4)	155	4	9	4–20	.48

^a Scores on the Discrimination subscale were not normally distributed, hence median and inter-quartile range are presented. The total scale and the other subscales were normally distributed, so mean and SD are given.

^b Higher scores on the APSS indicate higher levels of abortion stigma.

Table 3

A summary of the Irish and USA abortion care providers scores on the total scale and subscales of the *Abortion Providers Stigma Scale*

	Irish sample			USA nationwide sample (19)			Massachusetts, USA sample (15)			Possible range ^b
	Average ^a	SD	n	Average	SD	n	Average	SD	n	
APSS Total Score	70.9	15.35	144	76.1**	17.4	253	69	15.2	137	35–175
Disclosure Management	21.43	6.74	152	24**	8.5	291	-	-	-	10–50
Internalized States	21.91	5.31	151	22	4.2	291	-	-	-	10–50
Judgment	13.44	4.09	153	15.1***	4.8	287	-	-	-	7–35
Social isolation	10.36	3.47	154	9.4**	3.6	296	-	-	-	4–20
Discrimination	(4)	(4, 4)	155	5.4	1.9	290	-	-	-	4–20

Significantly differed from the Irish sample:

** p < 0.01

*** p < 0.001.

^a Irish scores on the Discrimination subscale were not normally distributed, hence median and inter-quartile range are presented. These scores could not be statistically compared to the USA nationwide sample.

^b Higher scores on the APSS indicate higher levels of abortion stigma.

Table 4

Linear regression analyses of the Irish abortion care providers' scores on the total scale of the *Abortion Providers Stigma Scale* ^a (n = 138)

	Simple linear regressions		Multivariable linear regression ^b		n
	b coefficient	95% CI	b coefficient	95% CI	
Job title					
GP	Ref		Ref		95
Obstetrician/Gynecologist	9.08	(2.57, 15.59)	10.51	(3.16, 17.86)	25
Midwife and nurses	10.72	(3.44, 18.01)	10.88	(2.3, 19.47)	18
Gender					
Female	Ref		Ref		117
Male	-5.96	(-13.06, 1.14)	-6.18	(-13.45, 1.1)	21
Geographical region					
Dublin	Ref		Ref		62
Rest of Leinster	-3.12	(-13.05, 6.82)	2.2	(-8.08, 12.49)	11
Munster	-3.74	(-9.47, 1.99)	-.03	(-6.29, 6.23)	51
Connacht/Ulster	-4.15	(-13.13, 4.83)	-.87	(-9.94, 8.19)	14
Clinical time spent providing abortion					
Under 5% of clinical time	Ref		Ref		92
Over 5% of clinical time	.29	(-5.19, 5.77)	-2.25	(-7.94, 3.49)	46
Reported providing emergency abortion care					
Did not provide	Ref		Ref		76
Did provide	1.61	(-3.53, 6.74)	-1.36	(-6.78, 4.06)	62

^a Possible scores on the APSS range from 35 to 175, with higher scores indicating higher levels of abortion stigma. The scores of this sample ranged from 37 to 134.

^b All variables were included in the multivariable linear regression model.

the Irish public voted against expanded abortion care [1]. Irish providers may experience stigma-related isolation if family and friends are opposed to the liberalization of abortion care. The Irish providers reported a similar level of stigma to the providers in the Massachusetts sample [15], a typically liberal state. The scores on the APSS subscales were not reported, however, so we could not conduct a nuanced comparison of stigma between these territories. In addition, the Irish abortion care services were relatively new at the time of data collection, between 13 and 17 months old. The abortion services in the USA have been in place for much longer so many providers have had more time to experience stigma. Level

of stigma in Ireland may change over time as providers continue to gain experience within the services.

As for differences in stigma based on provider demographics, the Massachusetts study found no difference in level of total stigma between providers working in hospitals or free-standing women's health care clinics [15]. This contrasts with our finding, where the hospital-based obstetricians and midwives/nurses reported higher levels of stigma compared to community-based GPs. Janiak et al. [15] theorized that the comparable level of stigma between providers working in hospitals and freestanding clinics may have been observed as the hospital staff likely encountered stigma within the workplace while the clinic staff faced regular antiabortion

Table 5

A summary of the Irish hospital-based providers^a scores on the total scale of the *Abortion Providers Stigma Scale*^b by procedures provided and survey format

	Mean	SD	n	p
Abortion procedure ^c				
Medical abortion only	76.89	24.44	9	.45
Surgical abortion only	85.29	20.51	7	
Provided both	76.16	12.29	25	
Survey format ^d				
Online survey	77.18	17.11	28	.7
Paper survey	79.38	16.92	13	

^a This table includes data from obstetricians, midwives, and nurses only (n = 41).

^b Possible scores on the APSS range from 35 to 175, with higher scores indicating higher levels of abortion stigma. The scores of this subsample ranged from 51 to 134.

^c We explored group differences using a one-way ANOVA.

^d We explored group differences using an independent t-test.

tion protests at their practices. Applying this to Ireland, obstetricians and midwives/nurses may also experience higher levels of stigma in hospitals while many GPs may be protected as they do not face regular protests. This may be further supported as the hospital staff in this sample was all involved in providing surgical and/or later-gestation abortion care, meaning they must work in a team to provide care and may be exposed to stigma. Difficulties in providing abortion care as part of a team were discussed by fetal medicine specialists' in Ireland, where feelings of disapproval and disrespect from colleagues, as well as resistance and conflict were noted [24]. By contrast, the GPs work in much smaller practices and can provide care without the assistance of others, shielding them from stigmatizing interactions.

Additionally, hospital staff may be attributed direct responsibility for ending the pregnancy and must encounter the fetal remains. This increases the moral and physical taint ascribed to abortion work [9], which in turn may increase stigma. The GPs only provide early medical abortion which is less morally and physically tainted as the abortion is instigated by the patient and is completed at home. Additionally, vacuum aspiration care has previously been highlighted as more difficult to provide than medical methods due to increased physical taint [25, 26]. While we found that stigma did not statistically differ by procedure provided, we do note that the hospital-based providers who were only involved in surgical abortion care did score notably higher on the APSS compared to providers who were only involved in medical care or pro-

vided both medical and surgical care. This indicates that involvement in surgical methods of abortion care may also drive stigma in the Irish context. Dilation and evacuation has also been suggested to be highly stigmatizing [16], though this procedure is not offered in Ireland. Senior trainees are undergoing international training with a view to offering the procedure in the future in select cases where it will be morally, ethically, and clinically the most appropriate way to end the pregnancy.

We also note one unexpected finding in the survey. Sixty-nine providers (37 community, 32 hospital) indicated that they provide abortion care in cases of medical emergencies, yet only 3 abortions occurred for this reason in 2019 [4]. We believe that some Irish providers may have felt the need to reframe their involvement as providing “emergency” care to alleviate stigma associated with “elective” abortion procedures. This may be particularly true for the 37 community providers as abortion care in cases of medical emergencies should only be provided in hospitals per Irish guidance. Additionally, 9 community-based providers indicated that they only provide abortion care in cases of medical emergency. In our sample, however, level of stigma did not differ between those who did and did not report involvement in providing emergency abortion care.

Concerning burnout, our finding that total level of stigma was not related to the MBI scales deviates from previous literature [19, 20]. While greater experience of stigma will likely have negative impacts, we believe it is reasonable that Irish providers who experience greater stigma are not at increased risk of burnout given that the majority dedicate very little time to providing abortion care. As with stigma, however, risk of burnout may also change over time. The Irish providers may have felt a renewed sense of purpose in the wake of the referendum which may have protected against burnout. This sense of purpose may diminish as we move further away from the support of the referendum and as providers continue to gain experience. Analysis of the subscales, however, found that certain aspects of stigma did influence risk of burnout for the Irish providers. Greater experience of judgment and feeling unable to disclose one’s abortion work were associated with greater risk of burnout, while having positive thoughts about involvement in abortion care appeared to negate it.

Our findings must be considered within some limitations. We calculated the response rate by using the number of providers who received an invitation to complete the survey as the denominator. Our sample, however, may not be representative of the true population of providers in Ireland, particularly among GPs as some may provide but not engage with the *Start* group. We were unable to assess the representativeness of our sample as there was no official source on the demography of providers in Ireland. Additionally, we

Table 6

The relationship between scores on the *Maslach Burnout Inventory*^a and on the total scale and subscales of the *Abortion Providers Stigma Scale*^b in a subsample of the Irish abortion care providers^c (n = 45)

	Emotional exhaustion		Depersonalization		Personal accomplishment	
	r _s	n	r _s	n	r _s	n
APSS total scale	.14	42	.15	42	-.05	42
Disclosure management	.27*	45	.18	45	-.04	45
Internalized states	-.09	44	.08	44	-.28*	44
Judgment	.32*	44	.16	44	.02	44
Social isolation	.03	45	-.08	45	-.12	45
Discrimination	.15	44	.12	44	.17	44

Significant relationship between MBI and APSS scores: p < .05.

^a Higher scores on emotional exhaustion and depersonalization and lower scores on personal accomplishment indicate greater risk of burnout.

^b Higher scores on the APSS total scale and subscales indicate higher levels of abortion-related stigma.

^c This analysis was conducted with a subsample of 45 responses. The burnout questions were removed from the survey at the onset of the COVID-19 pandemic, due to concern that increased workload would confound burnout.

* p < .05.

used paper surveys to collect more data from hospital-based staff, however, providers may have responded differently depending on whether they had completed the paper or online survey. The impacts appear minimal as stigma did not differ for hospital staff based on survey format. As previously mentioned, we removed the MBI questions from the survey due to the COVID-19 pandemic. Having more data may have revealed further or affected the observed associations between stigma and burnout. Finally, it would have been satisfying to compare the Irish scores with providers from a country that has a similar model of care or social context to Ireland; however, to our knowledge these studies do not exist.

While this exploratory study offers valuable insights on the prevalence of abortion-related stigma for providers in Ireland, some larger studies, particularly in the USA, have also sought to aid staff by offering support against the challenges of providing abortion care [10, 27]. We believe that providers in Ireland, particularly those in Irish hospitals, may also benefit from supports to negate the stigma surrounding abortion care. Quantitative research in this area should also be conducted throughout Europe to document and compare providers' experience of stigma and to explore if designated supports for providers may be beneficial. Finally, stigma is only one facet of the challenges related to providing abortion care [28]. Further research in Ireland will add to our understanding of these challenges and will inform the design of possible supports.

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.

Funding

This work was supported by the National Maternity Hospital, Dublin, Ireland in fulfilment of an academic qualification to be completed by Mr. Brendan Dempsey. The funding organization was not involved in designing the study, in collecting, analyzing, or interpreting the data, in deciding to submit the article for publication, or in writing this report.

Acknowledgments

We thank the *Start Doctors* and the *Hospital Providers* group for distributing the survey and promoting this research with their members. We also thank Dr Lisa Martin for sharing information about the Abortion Provider's Stigma Scale and Athina Kranidi of CStar UCD for her advice during data analysis.

Supplementary materials

Supplementary material associated with this article can be found, in the online version, at [doi:10.1016/j.contraception.2021.04.007](https://doi.org/10.1016/j.contraception.2021.04.007).

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