Title: “Stigma R Us”: Stigma Management at the Intersection of Abortion Care and Transgender Care in Family Planning Clinics

Key Words (up to 8): stigma management, abortion care, transgender care, abortion stigma, qualitative

Highlights (3-5 statements, 85 characters):

- Abortion care work is highly stigmatized; as are transgender people in medical settings.
- Abortion providers utilize stigma management experiences from abortion care work to provide transgender care.
- Abortion providers leverage transgender care in stigma management of abortion care work.

Abstract:

Rationale: The intersection of LGBTQ health and reproductive health represents several stigmatized social locations in health care work. Although we know that transgender people also face stigma in healthcare settings, we know less about the possible stigma related to provision of transgender and transition-related care. Abortion providers have extensive experience navigating stigmatized healthcare work, but less is known about if or how stigma of transgender care may impact providers’ experience of their work in these clinics.

Methods: Using theories of stigma management and “dangertalk” discourse, we examined qualitative data from 25 in-depth interviews with family planning clinic staff members in the United States.

Results: The majority of staff members who disclosed utilizing stigma management strategies worked at independent abortion-providing clinics. Previous experiences with abortion provider stigma equip staff to navigate the structural stigmas built into providing transgender healthcare. Offering transgender care also presents an avenue for abortion providers to practice stigma management during interpersonal interactions about their jobs. Providers can publicly celebrate providing transgender care in ways they cannot with abortion care.

Conclusions: Family planning care providers are able to tap into dominant discourses of pride and activism related to the provision of transgender health care. However, providers’ hesitation in sharing their abortion care work remains. This can lead to burnout or even internal dissonance when a transgender patient also needs an abortion. This study highlights the need for more research on the intersection of transgender healthcare and abortion care at a variety of health facilities.

Introduction
A foundational report from the Institute of Medicine, combined with engagement from community stakeholders, challenged researchers to pay increased attention to the health of lesbian, gay, bisexual, transgender, and queer (LGBTQ) groups (Institute of Medicine (U.S.). Committee on Lesbian 2011). In response, researchers increased focus on the intersection between LGBTQ health and reproductive health and how family planning clinics can provide transition-related care to transgender and non-binary people (Abern and Maguire 2018; Porsch, Dayananda, and Dean 2016). Family planning clinics are defined as clinics offering comprehensive reproductive health services, which can, but does not always, include abortion care.

A portion of family planning care providers across the United States have expanded their services in the last ten years to offer transgender health care in addition to contraceptive and reproductive health care. As of 2018, approximately 20% of family planning providers publicized that they offered transition-related care (Ingraham and Rodriguez 2021). While more clinics have implemented transgender-focused healthcare in their overall services, the experiences of clinic staff who have had to implement these new services are understudied. Since clinic staff have a direct impact on the experiences of transgender patients seeking care (White Hughto, Reisner, and Pachankis 2015), it is important to understand how they navigate the addition of transition-related healthcare to traditional family planning duties. To address this gap, we qualitatively explored clinic staff experiences with adding transgender care in family planning clinics from 2017-2019. While most clinics in our sample also provided abortion care not, not every clinic did. Another paper from the same data highlights the barriers and facilitators to transgender care integration for family planning clinics (Ingraham and Rodriguez, 2021). This article focuses on how clinic staff shift, transform, and avoid stigma at the intersection of transgender care and abortion care in their work.

We used theories of stigma management to examine how abortion clinic staff navigate structural and interpersonal stigma when providing both abortion care and transgender care. This exploration also led us to the conceptual framework of “dangertalk” (Martin et al. 2017) to understand the boundaries of how and when abortion providers are able to talk about their work in public spaces, with a particular eye on the self-disclosure differences between abortion care work and transgender care work. We sought to compare this to how they did or did not discuss their transgender care work publicly and if there were any areas of “dangertalk” related to transgender care. We know that individual transgender people are stigmatized in healthcare settings, and we know that abortion care work is stigmatized, but we know less about if and how transition-related care could be considered stigmatized care work. We argue that previous experiences with abortion stigma equip staff to navigate the structural stigmas built into
providing transgender healthcare, and that transgender care also offers these staff members a potential escape from abortion provider stigma during interpersonal interactions about their jobs.

**Background**

*Accessing transgender health care*

Recommendations for standards in transgender healthcare, primarily transition-related hormone therapy, have been set by multi-disciplinary professional organizations like the World Professional Association for Transgender Health (The World Professional Association for Transgender Health (WPATH 2011), university-based centers such as the University of California, San Francisco’s Center for Excellence for Transgender Health (2016), and LGBTQ health centers such as the Fenway Institute (Reisner et al. 2015). Several studies regarding barriers to transgender health access indicate that transgender and gender non-conforming individuals face discrimination in healthcare settings and most social settings (Bauer et al. 2009; Cobos and Jones 2009; Cruz 2014; Puckett et al. 2018; White Hughto et al. 2015). This discrimination can lead to worsening health outcomes, including delays in seeking care (Jaffee, Shires, and Stroumsa 2016). This may be especially true in Southern US states that may not have LGBTQ health centers in major metropolitan areas, where patients rely on smaller primary care clinics or other specialty providers for access to transition-related care (Marshall et al. 2018).

*Transgender Care in Family Planning Clinics*

Family planning and abortion-providing clinics have long integrated a variety of healthcare services, beyond traditional contraceptive and abortion care, as a means of increasing their organizations’ financial sustainability (Church and Mayhew 2009). Research shows that incorporating other sexual and reproductive health services, such as sexually transmitted infection testing and pap smears, positively impacts client satisfaction, improves access to services, and is cost-effective (Das et al. 2007). This cost effectiveness may strengthen financial sustainability of a clinic by increasing patient load and service reimbursement when abortion services are not reimbursed by private or public insurance, as is often the case in the US (Das et al. 2007; Dennis, Blanchard, and Córdova 2011). Previous research on the intersection of LGBTQ sexual and reproductive health has generally focused on sexual minority women seeking contraception or abortion services (Agénor et al. 2017; De Sutter et al. 2008; Robinson et al. 2017). However, little research has examined the rise of transition-related care, including hormone therapy and gender affirming reproductive healthcare, within clinics that previously focused mostly on
reproductive healthcare, including abortion. Our larger study (Ingraham & Rodriguez 2021) found that clinics became invested in offering transition-related care through existing patient and community requests rather than as a financial sustainability strategy. We found that clinics also felt a moral imperative to offer services to transgender and non-binary patients after becoming aware of immense access needs for this marginalized population.

**Stigmatized Transgender Care**

Cruz (2014) describes the patient-provider relationship as a potential site of social stigma for transgender people; one where they experience significant barriers when attempting to access hormones, surgeries, or other transition-related treatments (Drescher, Cohen-Kettenis, and Winter 2012). Qualitative work on transgender people’s pregnancy experiences and transgender individuals’ navigation of primary healthcare settings indicate that large gaps in transgender care knowledge and cultural humility remain (Light et al. 2014; Roller, Sedlak, and Draucker 2015). A recent review of the literature on transgender care access confirms these findings through a modified gender affirmation framework, noting how care provision supports four aspects of gender affirmation: social, medical, legal, and psychological (Cicero et al. 2019). Most research on healthcare stigma experienced by transgender people is based in primary care or LGBTQ clinic settings while relatively little research has examined the intersection of transgender care-seeking in a reproductive health context such as family planning clinics. It is important to explore how the addition of transgender care in new clinical settings may impact the stigma experiences of those seeking and providing care.

**Stigmatized Abortion Care**

As one of the most contested social issues in the United States, abortion faces a variety of access limitations for individual patients based on legislation that requires extensive waiting periods, increased regulation of abortion facilities, and other factors like geographic scarcity that decrease abortion access (Munson 2018; Weitz 2009; Berglas et al. 2017; Karasek, Roberts, and Weitz 2016; Upadhyay et al. 2017). Abortion is also a highly stigmatized healthcare procedure that can result in delay or avoidance of the procedure from patients who perceive negative social consequences, thus delaying access to care (Kumar, Hessini, and Mitchell 2009; Cowan 2017). Abortion providers often bear this brunt of abortion stigma both in and outside of work.

**Abortion Provider Stigma, Stigma Management, & DangerTalk**
Abortion care work in the US has long been considered stigmatized “dirty work” that does not yield the same prestige, social capital, and respect as other healthcare work (Harris et al. 2011; Joffe 2009). Those who work in abortion care, including physicians, nurses, counselors, laboratory technicians, administrators, and others—hereby called “abortion providers”—have reported being both proud of their work and shunned by others for it (Harris et al, 2011). Outside of the clinic, abortion providers are subject to online and in-person harassment, a constant barrage of antiabortion legislation, and exclusion from institutions like schools, churches, and organizations aimed at healthcare providers (Harris et al. 2011; Joffe, Carole E. 2018; Shane and Wilson 2013). Abortion stigma is still present when providers go home; many report family members and close friends outright vilifying the work they do, refusing to talk with them about their jobs, or avoiding the topic altogether (Debbink et al. 2016; Hann and Becker 2020; Harris et al. 2011; O’Donnell, Weitz, and Freedman 2011). “Dangertalk” describes the routinely silenced stories of abortion providers, including self-censorship of discourse that may seem at odds with approved messages of the greater prochoice movement (Martin et al. 2017). Providers report that abortion stigma impacts their personal and professional relations, and studies have found that higher levels of stigma can lead to provider burnout, while higher levels of pride in one’s work can counterbalance the negative impacts of stigma (Harris et al. 2011; Martin et al. 2014).

Stigma management can occur publicly or privately when people with stigmatized social identities attempt to minimize the social costs of their identities through techniques such as passing (hiding the identity), disclosure (sharing the identity), or disavowal (where both people ignore the stigma altogether) (Ashforth et al. 2007; O’Brien 2011). In particular, private stigma management work can occur among ingroups, or individuals who share the same stigma, where members share strategies for managing the stigma in more public settings (Herman-Kinney 2003; Schneider and Conrad 1980). Abortion providers use many techniques to navigate stigma in their personal and professional lives. Perceived and experienced stigma influences many abortion providers to either decline talking about their work in personal settings, or to exercise extreme caution before sharing their profession with others via a disclosure management process (Martin et al. 2014; O’Donnell et al. 2011). However, stigma management may be limited by when and how providers are able to discuss their work or how their work is discussed in larger discourse.

The “dangertalk” conceptual model (Martin et al. 2017) highlights the many barriers that abortion care providers face in United States prochoice discourse, including the juxtaposition of “acceptable” stories against self-censored ones about their lived experiences working in abortion care. The dangertalk conceptual model proposes expanding abortion discourse through understanding dangertalk and providing
more spaces to have tough conversations where new meaning can be made among a variety of professionals (Martin et al. 2017). Then, this shared meaning can be used to craft new messages that reach a variety of audiences, while continuing to challenge abortion stigma.

Current Study

The concept of care work stigma was not originally a part of our larger study regarding how and why family planning clinics integrated transition-related healthcare into their clinic’s services. Discussions of care work stigma emerged during interviews when staff compared their experiences with providing transgender care to the stigma of abortion care. This led us to revisit the larger study data to ask if provision of transition-related care is stigmatized for family planning clinic staff members and if there are similar dangertalk boundaries for transition-related care as there are for abortion care work. We argue that family planning clinic staff members are uniquely positioned to provide transition-related care services because of their experience managing abortion care stigma, and that dangertalk provides a lens through which to understand this stigma management.

Methodology

The study team used inductive thematic analysis (Guest, Namey, and Mitchell 2013) with constant comparative analysis of data during and after data collection. The study received approval from the CSU East Bay IRB before recruitment began.

Recruitment

Recruitment occurred through two primary means. As described in Ingraham & Rodriguez (2020), all websites for a national network of family planning clinics and clinic websites for all members of the Abortion Care Network (a national network of independent abortion clinics) were reviewed to determine if they provided transition-related hormone therapy (TRHT). The first author contacted all clinics whose websites indicated they provided TRHT by email or phone. The first author also recruited participants using convenience sampling from her own professional networks (including clinics from the website list) and via snowball sampling from staff who already participated in the study. Participants were eligible if they currently or had previously worked in a family planning clinic in the last year and priority was given to participants who worked directly with existing transgender healthcare programs. However, not all clinics included in our sample also provided abortions at the same location as transgender health services, as some networked clinics had multiple locations providing transition-related care, but only one providing
abortion care. Recruitment targeted approximately 50 clinics and participants represented 17 different clinics across the United States.

Procedures

Twenty-five staff members participated in this study between March and August 2018. After confirming eligibility and reviewing study information, participants set up a time and location for the interview. At the time of the interview, participants reviewed consent documents and approved by verbal consent, per the IRB. Verbal consent was used to avoid having staff member signatures on file for privacy and security reasons, and due to the use of video and phone interviews for the majority of data collection. Interviews were recorded and transcribed using a transcription service. Participant interviews lasted from 30 to 75 minutes. Participants were asked about the process of integrating transgender care into their clinics, what training they participated in related to transgender care, staff and community response to transgender care integration, and motivations for integration transgender care into their clinics. Participants were not directly asked about abortion stigma or stigma related to provision of transgender care. Most participants did not receive any incentive for participation since the study was not funded. One clinic required staff time reimbursement, so these participants (n=3) were paid by the first author in $20 gift cards out of pocket. All participants were given pseudonyms to protect their identities. Demographic data was not collected from participants due to privacy and safety concerns and the small sample size of the study. However, many participants self-disclosed demographic elements during their interviews. These are highlighted when relevant to the theme, e.g., when two participants disclosed their transgender identity in relation to their role in the clinic.

Analysis

Analysis was completed by the first author and an undergraduate research assistant using Dedoose, an online mixed methods software that allows for collaborative work. We began initial coding with a short list of themes based on key words from the literature review that formed the interview guide, such as “stigma,” “barriers to care,” “facilitators for care,” and “health insurance.” During initial coding, we also added in vivo codes (Charmaz 2006) drawn from participant interviews directly, including codes related to stigma that shaped the results of this paper. We added background information about clinics (region of the US and geographic descriptor) and participants (type of position, e.g., administrative, provider, front desk staff and length of time worked at the clinic) into Dedoose as “descriptors,” which were helpful in seeing coding patterns across clinic location or type of staff position. Clinic locations were divided using
Census categories (West, Northeast, South, and Midwest) (Geography Division ND) and geographic size of the clinic location (urban, suburban, or rural). While the first author had previously worked in the field of reproductive health research and thus knew a few of the participants professionally from conferences, the undergraduate research assistant was unfamiliar with all participants and the topic, which aided in coding data without preconceived notions of its contents.

The first author and research assistant first independently coded the same interview in Dedoose with settings that allowed temporarily blinding another person’s codes, then continued coding check-ins throughout the development of the codebook. In developing this paper, the first author returned to the data to reexamine transcripts for all mention of stigma and possible areas of dangertalk related to transition-related care. The second author for this paper reviewed all participant interview summaries as well as the published manuscript of main findings for the main paper from the study (Ingraham & Rodriguez 2021) to add analysis related to the dangertalk framework.

Findings

Twenty-five staff members participated by reflecting on the process of integrating and providing transgender health care in abortion-providing family planning facilities (Table 1). Participants served primarily in administrative roles (n=15) either as executive directors of smaller clinics in suburban or rural areas, or mid-tier administrative roles at larger clinic networks in urban settings. Several medical providers (n=10), including medical directors who also provide part-time patient care, also participated. Clinics (n=17) were in the West (n=9), Northeast (n=5), South (n=2), and Midwest (n=1) of the United States in suburban (n=7), urban (n=5) and rural (n=5) areas.

The length of time clinics had been providing transgender health care ranged widely, from just a few months to more than 10 years. For more details on clinic background, see Ingraham and Rodriguez (2021). The following sections detail the way stigma impacts staff experiences of providing transgender healthcare in abortion clinics, including how abortion work stigma builds resilience and knowledge of structural barriers, while transgender care may offer an escape from the abortion work stigma in interpersonal interactions.

Connecting Abortion/Family Planning Care & Transition-Related Care

Our previous analysis from the larger study of transgender care integration found that clinics were motivated to provide transition-related care based on existing care relationships with transgender and non-binary patients or by community request (Ingraham & Rodriguez 2021). We found that staff members
recognized a clear community need via lack of access to transition-related care, especially for clinics in suburban or rural locations far from large urban centers that may have transition-related care connected to LGBTQ health centers or university medical centers. Participants also described provision of transgender care as clearly aligned with their clinic’s mission to provide compassionate, evidence-based care to those who need it most. Several linked these missions to their independent clinic histories as feminist health centers, noting no conflict between these histories and caring for transgender and non-binary patients. Some participants did mention concerns related to gendered clinic names, e.g., women’s health center, in relation to patient comfort, but did not report any major issues with patient complaints in this area.

In analysis for this paper, we found that many staff members discussed stigma as part of their history of abortion care work, though most did not generally connect transgender care work and abortion care work through stigma directly. In one of the more memorable exceptions, a provider from a Southern urban clinic reflected on how the high saturation of religiously affiliated medical centers in their area increased the chance that transgender patients might experience mistreatment there. This provided an opportunity for abortion providers to incorporate transgender health care and reach more patients. Rachel, an administrator from a Southern clinic, summarized experiences of providing stigmatized care:

A lot of our public health stuff, providers and stuff for federally qualified health centers ... they're faith based. Their [transgender] community just isn't gonna feel very welcomed or particularly sought out there. I think we say sometimes, "Stigma R Us," you know. Bring it on. We're already dealing with that as an issue and are working with those kinds of populations. So we seemed a natural fit for some of those services.

Rachel describes the stigmatized healthcare environments of religious medical centers for transgender patients as an opportunity for her clinic to help patients by offering a more compassionate, welcoming environment. She describes how expertise of one type of stigma (abortion care work) can translate into provision of care across stigmatized patient populations.

Building on Experiences of Providing Stigmatized Care

Many participants had worked in abortion care for at least five years and sought out their current positions precisely to provide abortion care. We asked participants if they had struggled with any additional community or patient pushback in integrating transgender care. Most reported very little or no pushback from existing patients or community members. None of the participants reported increased threats or protests from outside sources because of adding transgender care. A few said that abortion care still took the “brunt” of the protests and stigma for the clinic. One staff member said that protestors “can’t
hate us any more than they already do,” and that transgender care felt like an afterthought for groups that already disliked or protested the clinics. Penny, a provider from a Western clinic, said that the primary stigma they face is due to abortion care work and so abortion stigma “takes the heat off, for whatever heat there is, of the LGBT stuff... I'm sure there are people who it is a big deal, but the same people who have issue with [transgender care], are people who care way more about the fact that we do abortions.” Participants said that the people who hate them think of abortion as the “worst” thing they can do, so transgender care gets to “fly under the radar” in many ways.

However, participants still recognized the “sensitive” nature of the care they provided to transgender patients—many of whom are not “out” beyond the provider’s office—especially in rural areas. Staff members said that providing abortion prepared them to provide transgender care due to several overlaps in service provision. They reported that transgender and non-binary patients, like abortion patients, often traveled from far away with limited access to these specific services. Patients from both groups, according to providers, tended to be lower income and face multiple marginalizations that prevented them from accessing care regularly. Providers reported witnessing patients who faced shame and stigma for seeking this type of healthcare.

Stigma Management Strategies in Staffing

The recognition of stigmatized work in these clinics also extended to screening employees and volunteers for their attitudes toward abortion and LGBTQ people. Rachel described a process on the employment application that assessed the potential worker’s comfort level with abortion but realized after they added transgender care that they had not similarly assessed their staff about transgender care. She reported that in her Southern urban clinic, staff were comfortable with providing abortion care, but some were unsure about their comfort level with transgender care. Kelli, a provider from a Northeastern suburban clinic, also described a screening process for employees and volunteers that assessed for “values” around abortion, LGBTQ people, and feminism, noting that “if they don’t answer [the questions] correctly, then we don’t have them” in the clinic. Felicity, a provider from a Western suburban clinic, noted that their volunteer training included anti-choice screening questions and that this has been expanded to also include screening for anti-LGBTQ values. The staff members’ experiences with screening potential volunteers and employees for safety and comfort around abortion allowed for increased awareness of the need to screen for LGBTQ cultural competency and comfort as well. This ensured that newly hired staff would have a baseline level of knowledge about and comfort with providing otherwise stigmatized care.
Stigma Management Work of Abortion Care vs. Transgender Care

The stigma of providing abortion care impacted how and when staff members disclosed their work, but transgender care did not present the same challenge. Staff members described stigma management work when disclosing the details of their job outside of their workplace. Several expressed excitement and relief at being able to discuss the addition of transgender care as a part of their work experiences, reporting they were not always able to share their abortion care work with others. Sierra, a suburban Northeastern clinic staff member, said that her clinic got “hit so hard” with anti-abortion protestors that she was afraid to tell people where she worked. She opted to talk about the transgender care the clinic provided instead:

When you go to a new hairdresser, like, "What do you do?" And I'm like, "Oh, gosh." And I don't know what to say. I always feel so much more comfortable saying, "Oh, well we work with ... We do transgender healthcare, and gynecological healthcare," and I feel like it would be less stigmatized for me to say that than “abortion.” So, to me, it's kinda like, "Ooh. Ooh, it's cool and I could say this, and I don't even have to say the abortion piece." Because to me, who's probably a little naïve, I feel like [transgender care is] more acceptable than abortion.

Disclosing the transgender care work of her position provided Sierra a form of passing, allowing her to hide the more stigmatized aspect of her job (abortion care) in favor of a type of health care work she assumed would be more acceptable by acquaintances (transgender care) in her suburban clinic. Providing transgender care meant less stigma management work for staff and it allowed them to feel proud of their work without added concerns for their safety. Many staff members were also proud of providing abortion care, but they reported they could not be as open about it. Some participants attributed this to wider social acceptance of transgender people in social media, the news, and in entertainment. Elliot, another staff member from the same suburban Northeastern clinic commented, “You're not hearing this actress or actor talking about their abortion or abortion care. It's just not talked about. So, I think it's a lot more stigmatized if I say abortion care than trans health care.” This administrative staff member, whose role focused on transgender care specifically, continued, describing how he pushes back against friends and family who do not want to discuss all the aspects of his work:

I think the hardest is ... when I talk to people about what I do. I've gotten so much flak from family members mostly, but sometimes even friends. They're like, "Why can't you just say that you work at a women's clinic?" I'm like, "No, it's very important that I specifically say what I do." I do trans health care, I do abortion care, and I do GYN [gynecological] care. If you only want to accept the
GYN care but not the abortion and trans care then I'm sorry, but I'm not going to shut up about it. I'm an advocate. That is my job title.

Elliot tended to disclose his work in transgender care in his stigma management work, though this is perhaps less surprising given that his job is specifically focused on case management and resource connections for transgender patients, rather than routinely interacting with cisgender abortion or family planning patients.

This desire for more widespread stigma reduction around abortion was not discussed in all interviews, as the interview guide did not ask about it specifically. Yet at least a third of staff members interviewed described joy in being able to be “loud and proud” about getting to offer transgender services. Katrina, a staff member from an urban Northeastern clinic, remarked that offering transgender care felt “more excit[ing] and respected” than abortion care.

It is worth noting that all but one of the participants who discussed stigma management work were from independent family planning clinics that provided abortions. Only one of the participants from a national network of family planning clinics mentioned this type of stigma management work directly. This could be because the interview protocol did not initially include questions about stigmatization, as it came up spontaneously in the middle of data collection. However, another explanation is that while the national network of clinics is perhaps most targeted for abortion work, they have also worked to distance themselves from the idea that abortion is the only type of care they provide, in favor of describing their work more holistically as women’s health and preventive care (Sundstrom 2012). Additionally, independent clinics are often freestanding and may not have the same name brand recognition for services that they provide beyond abortions, and thus may need to publicize transgender healthcare services more specifically.

**Dangertalk: Areas of Stigma in Transition-Related Care**

Several participants discussed aspects of providing transgender care that are still considered too risky or too stigmatizing for providers to take on. The main concern discussed by participants was the prescription of hormone blockers to young trans or non-binary children before puberty. Several clinics did not mention provision of care to minors, while others said they had considered it, but lacked the medical expertise or had liability concerns about treating minors. This represents an area of transgender care “dangertalk” similar to the “dangertalk” framework of abortion care stigma: an area of care with enough social stigma that providers remain hesitant to discuss or perhaps even consider. In this case, providers
feared that offering transition services to minors might compromise the positive social capital gains they received from being LGBTQ friendly and providing transition-related care.

Two participants mentioned prescribing hormone blockers after requiring parental consent, but their respective clinics did not publicly advertise this service. This lack of advertisement for these services could be considered evidence of stigmatization of one type of transition-related care. A few other participants mentioned some interest in prescribing hormone blockers for children in the future, but were unsure because they did not treat minors, or did not think that their clinic would support adding this type of care since they did not currently treat minors. While several participants did see patients ages 16-18 for reproductive healthcare, they assumed that this may be too late for hormone blockers to be useful for minor patients. Only 4 of our 25 participants mentioned puberty blockers at all, so this is an area that future research should consider further.

**Discussion**

This analysis demonstrates how family planning clinic staff experience and utilize stigma in the provision of care for transgender and non-binary patients. Staff members described how previous work in abortion care prepared them to deal with possible stigma associated with transgender care services, even though they did not report experiencing stigma in relation to their transgender care work. We argue that this expertise in managing one type of stigma, abortion stigma, bolsters providers’ ability to manage other potential stigmas that arise when caring for transgender people. Our data reveal that, for family planning clinic staff, transition care was not stigmatized like their abortion care work. In fact, transition-related care work felt safe enough to discuss with friends, family, or casual acquaintances, unlike their abortion care work. Staff could be outwardly proud of the addition of transition-related care in their clinics in a way they could not be with abortion care.

Our findings echo previous research indicating that abortion providers face stigma around their work and are hesitant to disclose their job to acquaintances outside of the clinic (Debbink et al. 2016; Hann and Becker 2020; Harris et al. 2011; O’Donnell et al. 2011). We did not find any reports of increased stigma in the provision of transgender care from abortion providers. Providers described challenges with structural stigma of transgender care built into electronic medical records or insurance systems (Ingraham and Rodriguez 2021), but not increased interpersonal stigma in disclosing this aspects of their jobs. They describe disclosure of transgender care as a stigma management strategy for abortion care stigma (O’Brien 2011). Our findings also contribute to the larger sociological discussion of stigma.
management strategies in occupational settings, including Ashforth and colleagues’ empirical data on dirty work and occupational taint (2007) and Meisenbach’s model of stigma management communication (2010).

We also support the application of the dangertalk framework (Martin et al, 2017) that calls on the prochoice movement to have tough conversations about the realities about abortion care so that new shared meaning can be made. Our findings show that some abortion providers do not feel comfortable talking about their abortion work in public spaces, and that they feel more pride and comfort in discussing their transgender care work than their abortion care work. This can be considered dangertalk, as it complicates the dominant prochoice discourse where abortion providers are expected to openly take pride in their abortion care roles and commitment to women. Opting to talk about transgender care instead of abortion care, as opposed to talking about transgender and abortion care, highlights the impact abortion stigma has on the lived and professional experiences of abortion providers. If left unaddressed, this could have unanticipated impacts for abortion care providers and their patients, by unintentionally exacerbating abortion stigma in the clinic.

A potential new form of dangertalk arose within the small number of participants who already provided, or who were interested in providing, transition-related care to minors via puberty blocking medications. These providers were more hesitant to discuss this work as compared to their work with transgender and non-binary adults, potentially due to stigma related to transition care before puberty. Data for this study was collected in 2018 and 2019 when some state and national legislation restricted puberty blockers. Since then, there has been a rapid rise in the number of legislative decisions aimed at reducing access to care for transgender youth (Hughes et al. 2021). As such, it will be important to assess if and how family planning providers navigate stigma toward age-based transition care as they add transgender service options to their clinics.

Limitations

This study is limited by its smaller sample size. The available number of staff members who provider transgender care across the country is difficult to estimate given the lack of standardized data on these services when compared to large data sets on contraception and abortion provision (Jones, Witwer, and Jerman 2019). While we had diversity in staff member type and clinic location, we also had clusters of staff members from two specific clinics which may overrepresent perspectives from those clinics in our sample. We also did not collect demographic information from the participants directly, and thus are limited in the ways their social locations may have influenced their experiences. The healthcare landscape
for both abortion access and transgender healthcare provision is also rapidly changing, which could potentially outdated our data. Future research that specifically asks participants about concepts from the dangertalk framework could help us better understand how stigma travels through the intersection of abortion care and transgender care in family planning clinics.

Conclusions

Previous experiences with abortion provider stigma equip staff to manage the structural stigmas of transgender healthcare via stigma management strategies. At the same time, providing transgender care offers these staff members a potential escape from abortion provider stigma by allowing them to amplify their transgender care work and avoid discussing their abortion care work in situations that may feel stigmatizing. We recommend that future studies examine the impact of abortion stigma on staff who work in clinics that also provide transgender services. Such research should be used to help clinics develop strategies to ensure that the addition of transgender services does not unintentionally increase abortion stigma. This is especially important considering that transgender and non-binary patients may utilize the same clinics for their transgender health care and abortion care needs.

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Table 1: Participant and Clinic Descriptors (n=25)

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<thead>
<tr>
<th>Participant Characteristic</th>
<th>N(%)</th>
<th>Descriptive Statistics</th>
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<td><strong>Role in Clinic</strong></td>
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<td>Administrator or Administrative Support</td>
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<td>Non-Profit Work</td>
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<td><strong>Work History at Current Clinic (years)</strong></td>
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<tr>
<td>Average (SD)</td>
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<tr>
<td>Median</td>
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<tr>
<td>Range</td>
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<tr>
<td><strong>Type of Clinic</strong></td>
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