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From stigma to pride: health professionals and abortion policies in the Metropolitan Area of Buenos Aires

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Abstract: *Abortion stigma is experienced not only by women but also by providers and health professionals in a wide range of legal contexts. This paper analyses interviews with providers who work in the public health system in the Metropolitan Area of Buenos Aires, Argentina. A court ruling in 2012, FAL/12, changed the interpretation of abortion's legal status, clarifying the decriminalisation of abortion in cases of rape, and also requiring public policies and procedures to speed up access to legal abortion. Between 2014 and 2017, we conducted 27 in-depth, semi-structured interviews with abortion providers in public facilities across healthcare services in the Metropolitan Area of Buenos Aires. We found the way that health providers dealt with abortion stigma evolved over the course of time, as the abortion debate moved from the margins to the heart of political debate and public policies in Argentina between 2007 and 2017. Providers' experiences changed as the social and legal context changed. FAL/12 – as a clear, legal ruling – was a landmark and turning point in the way health professionals in public health facilities conduct their activities, making it possible for them to move from providing silent and hidden abortion care, to acknowledging it with pride.*
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Introduction

Although stigma research has a long history, abortion stigma is an emergent field of study, most of which focuses on women.[1–5] In Latin America in general, and in Argentina in particular, research in this area is quite new.[6]

Goffman[7] explained stigma as an attribute which is deeply discrediting and a result of non-compliance with certain social expectations. The lack of alignment with social expectations categorises those who are stigmatised as undesirable and despicable. The concept of and pathways to stigma have been traced in many kinds of health studies,[1] but have also been disputed, with some authors arguing that it is "individually focused."[8] Others also criticise its definition as being vaguely expressed and/or neglecting to stress the links to power. In response, Cárdenas et al.[9] explain stigma as

"… a social process in which individuals are marked as different, associated with negative attributes, conceived of as 'others', separated from society, and subject to loss of status and discrimination. This process places them in a framework of economic, political, and social power relations that perpetuate stigma in order to maintain the status quo."[9]

Abortion stigma

In the case of abortion, stigma relates not only to the imperative of motherhood, life and death, women's and fetal rights, but also to general socio-economic factors such as poverty, education, place of residence, or access to healthcare facilities. Abortion stigma is linked with gender and with the way society distributes its resources and the status assigned to each person. As Kumar et al.[1] summarised, abortion stigma is a

"compound stigma … it builds on other forms of discrimination and structural injustices. Stigma is dependent on the appropriation and use of different

forms of power. Ultimately, abortion stigma serves to erase and disguise a legitimate medical procedure, discredit those who would provide or procure it and undermine those who advocate for its legality and accessibility."[1]

Parker and Aggleton[10] emphasise the "*social, cultural, political and economic forces that structure stigma, stigmatization and discrimination as a social process inherently linked to the production and reproduction of structural inequalities*". This position is near to Heinjnder's and Van der Meij's[11] proposal which outlines a map of health stigma with different dimensions on which actions may be needed to change or remove stigma. The model was adapted by Kumar et al.[1] and includes the framing of discourses and mass culture, and governmental/structural, organisational/institutional, community and individual level dimensions.

Research has shown that social abortion stigma is the main barrier women face when seeking interruption of pregnancy. In addition, stigma is a challenge for providers of abortion. A study shows that stigma is the main reason that explains the low number of providers.[3] In the case of abortion providers or health professionals (the terms are used here interchangeably, and refer to gynaecologists, obstetricians, general practitioners, sociologists, sonographers, social workers, psychologists, etc.), there are specific features of the stigma experienced, although they share some common characteristics with stigma in women undergoing abortion. The most important difference is that women experience abortion a few times in their lifetime while providers must deal with abortion many times during their everyday work. So, far from being something exceptional, it is a daily experience for health professionals. In this sense, "*their work identity is connected to abortion, and exposure to stigmatizing behaviours may be continual*."[2] The legal status of abortion affects the stigma surrounding the provision of abortion. Commercialisation of abortion in clandestine contexts stigmatises those who profit from what is outside the law. This contributes to the perception of abortion as "dirty work", work which is immoral or even contrary to the precepts which should be pursued by a health professional.[2,3] This could exclude providers from full participation in professional communities. The decrease in occurrence of some factors (for example, the decriminalisation of abortion) can mitigate stigma, but not eliminate it.[5]

Despite the high incidence of abortion, stigma continues to affect women and providers even when the practice is legal. Restrictive legal contexts may reinforce it. Yet abortion stigma is a social process which relates to other inequalities and is linked to cultural, legal and political processes.[1,8] As Kumar et al.[1,p.626] asserted, "*there is limited understanding of how it takes root in particular communities, what its impact is and how it can be countered*". Although abortion stigma is relatively universal, the way in which it is expressed depends on the context.

Social and legal situation in Argentina

The legal status of abortion in Argentina has been the same since it was first legislated in 1921, as part of the Argentine Criminal Code. Abortion is prohibited overall but not criminalised in certain situations, such as in cases of risk to health or life, or in cases of rape. As the Argentine Criminal Code specified special conditions for rape in women with mental illness, it is often construed that abortion was only permissible in this special situation and not always permissible in all cases of rape. So, although it could have been permissive, abortion rules in Argentina were thought of, and interpreted as, prohibitionist during most of the twentieth century, and most of the very few pregnancy interruptions carried out legally had to undergo a judicial process.[12]

When democracy was established in Argentina once again in 1983, feminism and other social movements intended not only to modify the restrictive interpretation of abortion rules but also to replace them with a clear set of rules with a strong legal basis. In doing so, they carried out social and legal activism.[13] Feminists worked hard to establish abortion as a social issue in the first decade of democracy. As the groups of activists and alliances built up, they presented abortion as a health issue at international conferences on population (Cairo, 1994) and women (Beijing, 1995). Eventually, a Sexual Health and Responsible Procreation Law was passed in Congress in 2002. The small group of feminists and their alliances expanded and after 2010 became a big movement which finally, in 2018, when the abortion congress debate took place, was known as the "Green Tide" on the streets. Hundreds of thousands of women were on the streets demanding legal abortion, using a green handkerchief as a symbol, hence the name of "Green Tide". The Congress debate was the result of actions and activism developed

over more than ten years by the National Campaign – a coalition of over 300 feminist, social and human rights movements and other non-governmental organisations (NGOs) from around Argentina – for the right to legal, safe and free abortion.

Feminism has had a hard battle to change public understanding and attitudes toward abortion. The goal has been to shift concepts from ideas of murder and horror, where conservative and religious movements wanted to place abortion, to the field of human rights; and from debate on the right to life of the fetus, to the right to life and choice of women. The National Campaign for the right to legal, safe and free abortion had also developed a legalisation and judicialisation process whereby they introduced an abortion bill in Congress every two years and supported people who had started judicial proceedings to get their right to decriminalised abortion respected. After several favourable judgments, especially in relation to rape cases, a case reached the Argentine Supreme Court of Justice (CSJN) in 2012. In the judgment known as FAL/12, the court's decision was a turning point in the correct interpretation of the grounds for legal abortion when read in light of the Argentine Constitution. The decriminalisation of abortion was clarified in all rape cases, not only in cases where mental health was a factor, thus removing any doubt.[14] The decision also stated that abortion was not punishable in cases of risks to health and life, and that health must be understood in a broader sense, as the World Health Organization has established. Moreover, it demanded that governments set mechanisms that guarantee the right to abortion in all cases without a prior judicial procedure. Meanwhile, the achievements of social and legal activism were mirrored in the functioning of public health services in the Metropolitan Area of Buenos Aires, including the use of misoprostol as medical technology for safe abortion, while misoprostol was already being used in underground contexts.

The literature confirms that the legality of abortion helps to reduce risks and related abortion stigma. There has also been some research on how the legal framework favourably influences the social meaning of abortion, the way women and providers feel about it, and how they perceive their experiences.[1,8] This paper follows that track. Between 2007 and 2017, the legal context of abortion in Argentina changed from a restrictive to a permissive interpretation which probably contributed to greater social acceptance of decriminalisation. The purpose of this paper is to describe and analyse the link between the social and legal contexts and health providers' abortion stigma. The paper describes some key moments of change in the social and legal contexts, allowing providers in the public health system in the Metropolitan Area of Buenos Aires to go from invisibility to visibility, and from hiding their experiences to showing them with pride.

Methods

We analyse 27 interviews with health providers, conducted between 2014 and 2017, that were originally carried out with the aim of understanding abortion policies in Argentina between 2007 and 2017. The Congress debate that took place in 2018 was thus excluded. The 27 in-depth interviews were semi-structured and lasted 30–90 min. Health providers were recruited as a convenience sample, by previous contact and following the snowball technique. The final number of 27 was due to theoretical saturation. The only requirement for inclusion was that the health professionals had to be working to provide access to abortion in the public health services system.

Argentine healthcare facilities are divided into first and second levels of health care. The first level comprises healthcare facilities which deal with lower risk cases. In cases of greater risk, emergencies, where patients need more equipment, and/or if the cases involve more complexity, there are hospitals which make up the second level of care and are often more hostile in abortion situations. Generally, abortion counselling is carried out in first level healthcare facilities, but if there is a clinical complication women are referred to hospitals.

All interviews were recorded, transcribed, and coded for analysis using ATLAS.ti software. The research team jointly developed the codebook. The codebook was created independently to capture topics in the semi-structured interview guides and in vivo codes that emerged directly from the participants. The codebook also reflected overarching topics including attitudes towards abortion law, practices such as counselling, providers' knowledge about the legal status of abortion, links between counselling and other actions, and personal experiences. The analysis was led by a team of two researchers who jointly carried out thematic data analysis. Each of the codes was

individually scrutinised first. Subsequently, the team identified key themes and patterns in the responses.

This study respected current ethical guidelines for research and was approved and financed by the National Council of Scientific and Technical Research (CONICET). The participants were informed of the aim of the research, asked if they were interested in taking part and gave their consent. The interviews were conducted face to face in their workplace or other agreed place, in Spanish. The quotes appearing in this paper were translated.

Results

Seventeen participants worked outside Buenos Aires City, in what is called the Metropolitan Area of Buenos Aires (MABA, e.g. Morón, San Martín, Lanús, La Plata, Lomas de Zamora, La Matanza) and 10 in Buenos Aires City. Of the 27 interviewees, 22 work in primary health care and the remaining five in secondary level care (one in Buenos Aires City and four outside Buenos Aires City). Participants were aged 30–60, although most were younger than 40. The 27 interviewees were abortion providers with different academic backgrounds: 16 general practitioners (GPs); four gynaecologists; two social workers; two psychologists; one sociologist; a paediatrician who attends counselling for adolescents; and a pharmacist responsible for the family planning programme in a primary care facility. Twenty-two of the participants were women and five were men. Although the sample was not expected to be representative, the fact that more respondents were women could be an indication that women are more involved in abortion activism and policies than men.

General experiences of providers

All health professionals had a positive attitude towards abortion and women who have abortions, and that was one of the reasons why they work as providers in public healthcare services. None, including social workers and psychologists, had ever received specific abortion counselling training, at any stage of their career and regardless of age, although some had been given information relating to legal aspects. As one GP reported, "*the only moment we heard about it … was in legal medicine … not linked with gender or rights perspective.*" (GP 1, woman, Buenos Aires city)

Providers remarked on the recent changes to abortion law: "*things changed a lot during these last years … I did not learn anything when I was studying but now everybody talks about abortion … since women's movements that allow social debate*". (GP 2, woman, Buenos Aires City)

For some of the respondents, the first contact they had with abortion was in clinical shifts where they had seen women with abortions dying:

"My first contact with death … was an abortion case … in clinical residence." (Gynaecologist 1, woman, MABA)

"During my residence … I saw a woman die … because of abortion … an infection … " (Social worker 1, woman, MABA)

It became clear that, behind the maternal mortality and morbidity statistics, abortion was a social problem in which power played a part. The women suffering or dying in hospital emergency rooms were poor, uneducated, and young, among other vulnerabilities:

" … they put their lives at risk only because of their social class situation, of poverty and of women … " (GP 3, woman, MABA)

"[a woman says] … because I do not have money, I do not have work … my husband does not have work either." (GP 4, woman, MABA)

For some of the health professionals, their first experiences with pain or death because of abortion were what pushed them to work as providers, even when abortion stigma was strong and those who provided abortion were seen as murderers and were persecuted. Others first noticed issues about abortion through feminist activism or by participation in social movements that worked to reduce social inequalities:

"[abortion] … I know it because of feminism … " (Psychologist 1, woman, Buenos Aires City)

"(…) I was in a popular education team … I was taking part in Women National encounters [places where women discuss problems together, held every year in a different province of Argentina] … and there I knew about misoprostol … " (GP 5, woman, MABA)

Once people who worked as health providers were involved, feminist NGOs took on a new function, helping health professionals to offer medicine (that is, misoprostol) when it was not available at a

healthcare facility, or when a prescription could not be provided, or for other things providers could not solve within a public institution:

"when women could not afford … [the medicine] … Violeta [fictional name of a feminist non-governmental organisation] did." (GP 6, woman, MABA)

"[La Violeta] could always afford everything we can't … . but they also referred to us in other cases … " (GP 4, woman, Buenos Aires City)

Most of the respondents worked at a feminist NGO or had links with activism, in addition to their work in public healthcare facilities. This may explain why communication and collaboration between members were close and how they could influence ministry guidelines.

Pre and post-abortion counselling

Initially, counselling was carried out on the basis of what was known as harm and risk reduction, where providers gave information, but nothing else. As one respondent explained:

"it is the woman who carries out abortion, in her house, with the medicine … we only give information before … and provide post-abortion care in order to avoid complications … " (Social worker 1, woman, MABA)

An early experience emerged from 2003:

"(…) It emerged from research we did to understand what was happening with teenagers that we knew had used misoprostol to perform abortion (…) so we travelled to Uruguay where we learnt about the harm and reduction model (…) and we adapted it … " (Gynaecologist 2, woman, Buenos Aires City)

Other experiences were from 2005 or later:

"(…) we started in 2005/2007 doing harm and risk reduction in a silent way … " (Psychologist 1, woman, Buenos Aires City)

" … I started in 2014, after I graduated … [counselling] it was running … since 2007 … " (GP 1, woman, Buenos Aires City)

It is not clear why counselling started earlier or later within the timescale of our study, but activities frequently coincided with the arrival at a health facility of an individual willing to practice abortion. Some participants linked the early starting points with feminist and women's activism:

" … it was when feminist and women's movements started to demand loudly women's autonomy … " (GP 7, woman, Buenos Aires City)

Providers' involvement

In the early years, the legal context was not clear and governmental policies were barely more than a guideline for post-abortion care, which very few people remembered. There were very few providers of abortion, and they offered counselling secretly, without telling their colleagues:

" … professionals joined with a lot of fear, because of the illegality of the situation … " (Gynaecologist 2, woman, Buenos Aires City)

" … the first time we did it hidden … " (GP 8, man, MABA);

" … in secrecy … " (Psychologist 1, woman, Buenos Aires City)

These earlier experiences seemed to be mainly shared by women. The few men interviewed had started work in counselling later in the timescale of this study. Most providers were general practitioners rather than gynaecologists, as one participant remarked:

"general practitioners … who have more involvement in women's health and rights … " (Gynaecologist 2, woman, Buenos Aires City)

Perceived risks

The legal question was one that caused fear:

"there was a training … from the ministry … that said that the only way to have no legal risk was not to issue prescriptions … " (GP 9, woman, Buenos Aires City)

Other respondents emphasised that:

"(…) on that occasion, they learned that the Sexual Health and Responsible Procreation Law from 2002 gave them the right and the duty to provide information and all the health care needed … " (Gynaecologist 2, woman, Buenos Aires City).

But, all the same, " *… we hired law firms … "* (Gynaecologist 2, woman, Buenos Aires City). As time went by, providers became less afraid, but were not free from judgment: " *… there is a feeling of tension … "* (Sociologist, woman, Buenos Aires City). "*We had a break in … because of a complaint*," (GP 10, woman, Buenos Aires City) and

"*… there is always some risk … now we have a partner accused of abortion in trial …* " (GP 9, woman, Buenos Aires City)

Institutional authorities

The relationship that providers had with the authorities regarding abortion provision ranged from unspoken, to open support by healthcare authorities for counselling. In general, the relationship was not easy: "*… it was a hard work with the authorities …* " (Gynaecologist 2, woman, Buenos Aires City).

"*… from the director there is a decree not to put impediments … and in general it is like that but …* " (Sociologist, woman, Buenos Aires City)

In some cases, the support was more open and explicit:

"[the director] was totally in favour of counselling". (Gynaecologist 3, woman, MABA)

Support was restrictive in certain ways, as in some areas of Buenos Aires, the authorities let abortion counselling happen but only if done discreetly. Respondents argued that the general position of some important authorities was that support is given, medicine is distributed, but all done discreetly and without publicity.

Medical records and prescriptions

In the early years, participants said that they did not specify what they did in official medical records:

"*… we used medical records that were not official medical records … ".* (GP 11, man, MABA)

In the same way, at the time when harm and risk reduction was emphasised, everything was secretive, nothing was registered, only information was offered, and medication and prescriptions were not given. Only when some years had passed:

"*… we started thinking that we need not only give information … so, we started issuing prescriptions … but we did it under the name of another person and for another reason …* " (GP 11, man, MABA)

Later, the providers issued prescriptions. If they could, the medication was given to the women to avert the costs of purchase, but it was sometimes not available: "*… we issue prescriptions because sometimes there is not enough medicine."* (Sociologist, woman, Buenos Aires City)

After FAL/12 and the 2015 ministry guidelines

"The landmark of the Supreme Court in 2012 marked a turning point … in my personal trajectory but in general too … because after that, most of the experiences started to extend, legitimated … all after that judgment … " (GP 12, man, MABA)

Three years after FAL/12, the Ministry of Health approved an administrative guideline called the "Comprehensive Healthcare of People Entitled to Legal Interruption of Pregnancy". The process of writing this guideline involved the participation of feminists from NGOs and people who worked in public healthcare facilities:

"*… we could collaborate in the writing of the guideline … that gave us such a fundamental tool (…) we succeeded in getting the word 'abortion' out because it is stigmatizing, and we could introduce the word 'legal' [interruption of pregnancy] …* " (Gynaecologist 2, woman, Buenos Aires City)

The providers interviewed remarked that the landmark decision of the Supreme Court did not change the Argentine Criminal Code, but established a new interpretation of the Code without uncertainty and, for providers, this was very important. The situation was the same with the 2015 Ministry Guidelines. These gave health professionals legal and policy support for what they were doing.

"*… and nowadays … with social decriminalization of abortion … history changed …* " (Gynaecologist 2, woman, Buenos Aires City)

"*… it changes when one explains that it is legal, that women do not have to hide …* " (GP 9, woman, Buenos Aires City)

It thus became possible to shift from a harm and risk reduction approach to one where legal interruption of pregnancy was permissible:

"Legal Interruption of Pregnancy is different from the harm and risk reduction model because it is undoubtedly legal … any abortion during the first 12 weeks of pregnancy could be included either as health reason or as rape reason … we could register it, issue prescriptions, etc. … " (Social worker, woman, MABA)

One consequence is that the number of providers increased:

"*… 4–5 gynaecologists do it [abortion care] … now we have created a pro-choice health professionals'*

link where there are more than 700 … " (Gynaecologist 2, woman, Buenos Aires City)

There was also a perception that their jobs had changed:

"(…) When we could start proceeding with Legal Interruption of Pregnancy and have the medicine in healthcare services … it changed a lot … the chance to decriminalize our practices and help to decriminalize women … " (Psychologist, woman, Buenos Aires City)

As these events took place, the relationships with the authorities also improved:

" … in 2015 … we had the chance of travelling with provincial ministers to Uruguay so they could see the process … and it was a success because when we came back a ministry of health … decided to buy misoprostol … " (Gynaecologist 2, woman, Buenos Aires City)

After FAL/12 and the 2015 Ministry of Health Guideline, providers registered cases as Legal Interruption of Pregnancy, or at least as harm and risk reduction care. If possible, medication was also given in almost all the cases in Buenos Aires City.

" … we could give medicine … in almost all legal interruption of pregnancies that we do … " (GP 8, man, Buenos Aires City)

Elsewhere, it was not as simple; some providers could offer pills or medication sometimes, and others, never, although everybody could issue prescriptions without fear or legal risk.

Women as citizens, abortion as a right

The transition from the harm and risk reduction model – which was somewhere in between legal and illegal – to Legal Interruption of Pregnancy also changed the way women and their rights were perceived:

" … ok, this woman has rights … autonomy … women do not have to be mothers and only mothers … it is information that is coming … " (GP 9, woman, Buenos Aires City)

" … we talk about women in the right language … we talk about the Criminal Code and their abortion rights … " (GP 6, woman, Buenos Aires City)

"I think that decriminalization is very important … that every woman has the right to choose … " (GP 12, man, MABA)

" … the 2010 guideline did not have the right vision … this is introduced in the 2015 guideline … with legal acknowledgement … the rights of women … " (Gynaecologist 2, woman, Buenos Aires City)

From individual to collective action

The participants talked about how they built networks inside their workplaces, with other colleagues and with social movements like feminism which had lengthy experience. Earlier, individual efforts had expanded, and individuals started to acknowledge each other and do things together in their institutions. Some clandestine meetings were called for those who were working in counselling:

" … we were invited to clandestine meetings … they have a fictional name, but they were done to talk about abortion … " (GP 9, woman, Buenos Aires City)

Then providers also shared information through their professional links and later, in 2014, they founded the Pro-Choice Health Professionals Network which gave them some ability to propose actions, share information, strategies, and so on.

The perpetuation of stigma

Providers acknowledge that stigma persists affecting both providers and women:

" … people are really bad. There is a physician in Zeta Hospital [fictional name] who shows women the embryo expulsed and tells them that it was their son … " (Sociologist, woman, Buenos Aires City)

"they have to get through lots of barriers … expelled obstetricians … nurses that never see patients … " (Gynaecologist 6, woman, Buenos Aires City)

" … barriers are always on a second level … " (GP 12, man, MABA)

Discussion

Our study documents the transition from a harm and risk reduction approach to abortion care, to the policy termed "Legal Interruption of Pregnancy" which aided in the removal of stigma amongst abortion care providers in Argentina.

The Sexual Health and Responsible Procreation Law, passed in 2002 in Argentina, regulated the right to information on sexuality and reproduction. It allowed providers to give information about

abortion, although they could not perform the procedure. Gradually, pre- and post-abortion counselling started to be conducted in Buenos Aires, following the Uruguayan model based on risk and damage reduction.[15,16] At the beginning, when these first experiences of counselling took place, the interpretation of the Argentine Criminal Code on abortion was predominantly restrictive. The counselling was therefore limited to giving information on how to undergo a safe abortion with pills. Few providers in public health facilities were involved, with restricted institutional support and activities generally carried out in secrecy.

With these activities being conducted at the provider-patient level, the Ministry of Health began developing a few policies, administrative rules and guidelines that supported what providers had already started to do in the public health care system. In 2005, the Ministry of Health published a guide to regulate post-abortion care.[17] A guideline to non-punishable abortion care was published in 2007[18] and re-published in 2010.[19] In 2014, a guide for women who had an abortion was published.[20] After the FAL/12 landmark, the right to abortion was acknowledged in 2015 with the Guideline for Comprehensive Healthcare of People Entitled to Legal Interruption of Pregnancy.[21] The existence of misoprostol and the appropriation of that medical technology by feminist and women's movements contributed to the changes described above.

As cited in the introduction, Kumar et al.[1] and Heijnder and Van Der Meij[12] proposed factors that could modify abortion stigma, including legal and social barriers, and policies. If the legal context changes but is not followed by change in policies or if there is nobody to deliver the services, the situation could improve, but probably in a limited way.[22] Changes in several of these factors were reflected in our study, allowing shifts in perceptions of stigma.

The central role of feminism in all these processes must be underlined. Feminists made abortion move from an intimate space to a public and social place. Their activism changed the social meaning of abortion – and the way in which women and providers are seen – from illegal, exceptional, clandestine and secret to something that was of social importance, which was legal and that could be performed in a hospital or at home, safely and with the help of health professionals. Feminism was also a strong supporter of providers who worked in public healthcare facilities, with providers asking for legal advice, information or medicine. Feminism and women's activism influenced the social arena with their contentious actions, the legal context with their legal activism, and the healthcare facilities' and providers' actions with their insider activism.[23,24] Their strong collaboration also resulted in the formation of public policies and the drafting of ministry of health guidelines.

It is clear that social movements are vital in order to demand and achieve certain rights, as well as to build or design public policies and ensure compliance over time.[25,26] This is linked to citizenship theory[14,26] which emphasises rights language as a universal language, which recognises that rights belong to people and people can demand that the State respect them. The providers in this study highlighted that women have rights and that providers must guarantee their rights, and that this is not only a choice, but a duty. This underscores the importance that FAL/12 had as a legal support for what the providers believed in, and for what they were doing.

In relation to the strategies the providers used, as has been found in other studies,[1,9] when abortion stigma was at its worst, during the early days of harm and risk counselling, there were very few providers who were protected, and then only by silence. Secrecy forced them to work alone and this contributed to maintaining abortion stigma and reducing what they could do as providers. This strategy of secrecy and hiding meant that the providers did not know each other, even though they may have worked in the same place. Not keeping medical records or issuing prescriptions may have resulted in difficulties in documenting the problems and in collecting statistics.[27] As this changed, silence and individual efforts were left behind and professional links were built, developing a sense of pride for the rights of women.

The Argentine process has some similarities with the Uruguayan experience[9,22] when the focus was on a harm and risk reduction model as a strategy used before the law was changed to allow legal abortions. In Argentina, the law has not changed, but what has changed is the interpretation of the existing Criminal Code from a restrictive interpretation to a permissive one. The situation is better than it was a decade before, but providers in Argentina are still not as completely assured as they are in Uruguay because abortion policies are, in the current legal context, *diffuse*, imprecise

policies, which have not been planned and which are characterised by a reduced level of institutionalisation[15] and providers may still be taken to court.

Conclusion

This paper shows that a change in legal context and interpretation, from a restrictive to a more permissive one, reduced abortion stigma. It helped providers feel supported and created better conditions to guarantee women's rights. Nevertheless, obstacles and grey areas remain – the subject of political disputes, but also areas of risk for those who work as providers. All the same, health professionals have experienced change in Argentina: from invisibility to visibility; from silence and hiding to claiming their work with pride. To reverse abortion stigma, providers have used legal discourse to legitimise their work; have gone from individual action to collective action; and have employed political organisation to build pro-choice health professional networks. They have disclosed their practice by allowing affirmative recognition of practices previously despised: promoting the passage from stigma to pride.

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Résumé

La stigmatisation en cas d'avortement est ressentie non seulement par les femmes, mais aussi par les prestataires et les professionnels de santé dans un vaste éventail de contextes juridiques. Cet article analyse des entretiens avec des prestataires qui travaillent dans le système de santé publique dans la zone métropolitaine de Buenos Aires, Argentine. En 2012, une décision de justice, FAL/12, a modifié l'interprétation du statut juridique de l'avortement, en précisant la dépénalisation de l'avortement en cas de viol, et aussi en exigeant des politiques publiques et des procédures pour faciliter l'accès à l'avortement légal. De 2014 à 2017, nous avons mené 27 entretiens semi-structurés approfondis avec des prestataires de services d'avortement dans des établissements publics dans divers services de soins de santé de la zone métropolitaine de Buenos Aires. Nous avons trouvé que la manière dont les prestataires de santé abordent la stigmatisation de l'avortement a évolué avec le temps, en même temps que le débat sur l'avortement passait de la marge au cœur du débat politique et des politiques publiques en Argentine entre 2007 et 2017. L'expérience des prestataires a changé à mesure que le contexte juridique et social changeait lui aussi. L'affaire FAL/12, comme décision juridique claire, a fait date et a marqué un tournant dans la manière dont les professionnels de santé conduisent leurs activités dans les établissements de santé publique, en leur permettant de ne plus prodiguer des soins d'avortement dans le silence et en cachette, et de les assumer désormais avec fierté.

Resumen

El estigma del aborto afecta no solo a las mujeres sino también a los prestadores de servicios y profesionales de la salud en una amplia gama de contextos legislativos. Este artículo analiza entrevistas con prestadores de servicios que trabajan en el sistema de salud pública en el área metropolitana de Buenos Aires, Argentina. En 2012, la Sentencia FAL/12 cambió la interpretación del estatus legal del aborto; aclaró la despenalización del aborto en casos de violación y exigió políticas públicas y procedimientos para acelerar el acceso a servicios de aborto legal. Entre 2014 y 2017, realizamos 27 entrevistas semiestructuradas a profundidad con prestadores de servicios de aborto en unidades de salud pública en diferentes servicios de salud del área metropolitana de Buenos Aires. Encontramos que la manera en que los prestadores de servicios enfrentan el estigma del aborto evolucionó con el paso del tiempo, ya que el debate sobre aborto pasó de los márgenes al meollo del debate político y de las políticas públicas en Argentina entre 2007 y 2017. Las experiencias de los prestadores de servicios cambiaron a medida que el contexto social y legislativo cambió. FAL/12, como sentencia judicial concreta, fue un hito y punto de inflexión en la manera en que los profesionales de la salud en unidades de salud pública llevan a cabo sus actividades, por lo cual les resulta posible cambiar de proporcionar servicios de aborto en secreto y de manera oculta a reconocer con orgullo que proporcionan esos servicios.