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Abstract

This paper examines the stigma of abortion among professionals who are providers of the service, considering, in particular, the time when they joined the Network of Healthcare Professionals for the Right to Decide. This network was created in Argentina at the end of 2014 by a joint alliance of women's and feminist organizations and healthcare professionals. We have conducted an exploratory study, of a descriptive type, based on a qualitative strategy. From 2016 to 2018, we carried out interviews with healthcare professional, with a view to addressing the relationship between the stigma of abortion and the healthcare professionals who are members of the Network. The main results indicate that the professionals have changed their perception of the stigma of abortion by becoming members of a group made up of peers among whom there exists homogeneity regarding their goals, and objectives in their profession. They admit to gaining confidence to resist stigma indicators, such as a negative self-perception of the job done, the fear of information disclosure and the silencing of,

and detachment from fellow professionals. The experience permits to show how it is possible to resist stigmatization effects, by performing an active role regarding professional identity.

Keywords: abortion stigma - unsafe abortion - healthcare professional - abortion provider - reproductive rights - induced abortion.

Estigma y aborto en Argentina

Resumen

En este trabajo se analiza el estigma del aborto entre los profesionales que prestan el servicio, considerando, en particular, el momento en que ingresaron a la Red de Profesionales de la Salud por el Derecho a Decidir. Esta red fue creada en Argentina a fines de 2014 por una alianza conjunta de organizaciones de mujeres y feministas y profesionales de la salud. Hemos realizado un estudio exploratorio, de tipo descriptivo, basado en una estrategia cualitativa. De 2016 a 2018, realizamos entrevistas con profesionales de la salud, con el objetivo de abordar la relación entre el estigma del aborto y los profesionales de la salud miembros de la Red. Los principales resultados indican que las profesionales han cambiado su percepción del estigma del aborto al integrarse a un grupo conformado por pares entre los que existe homogeneidad en cuanto a sus metas y objetivos en su profesión. Admiten haber ganado seguridad para contrarrestar indicadores del estigma como la autopercepción negativa de la tarea realizada, el temor a la divulgación, y el conocimiento de la abierta desaprobación social frente a su tarea. La experiencia permite mostrar cómo es posible resistir los efectos de la estigmatización, desempeñando un papel activo en la identidad profesional.

Palabras clave: estigma del aborto - aborto inseguro - profesional de la salud - proveedor de servicios de aborto - derechos reproductivos - aborto inducido.

Introduction

Depending on the context, people who are related to an abortion in some way experience stigma in various forms. Women and girls who decide to have an abortion, together with those who intervene supporting them or healthcare providers and pro-choice activists, among others, may suffer from it. However, all of them have the possibility of resisting or reversing such stigma.

The stigma that is linked to abortion must be identified as the cause of many negative consequences that women bear due to the delay they experience when accessing the practice (Fiala y Arthur 2014). The Social Sciences literature focused on the study of health has determined that "stigma related to seeking or provision of abortion is increasingly being recognised as having an effect on how and where women access care and who provides care" (Ganatra et al., 2017, p.2373). It has also warned of the need for stigma to "be considered, acknowledged, and addressed as a predictive factor in abortion safety and in reproductive morbidity and mortality risk" (Ostrach 2016, p.1).

When women and girls seek access to legal abortion in Argentina today, they face barriers imposed by both professionals, through their attitudes toward abortion, and the institutional culture. Examples of such barriers are the following: women are not provided with information in a clear or complete way, or what they are told is not based on evidence; they experience delays of all sorts; they are required to either have a legal permit or mediation by ethical committees is imposed; they are asked to undergo unnecessary medical examination, among other examples of impediments to accessing an abortion.

The professionals' lack of knowledge about current legislation and attention protocols leads to serious violations of the law, such as women's judicialization when they arrive at healthcare centers with an obstetric emergency or the breach of medical confidentiality by which the providers ought to be bound. This situation has given way, in the last few years, to the criminal accusation of at least fifteen young and poor women, accused of having had an abortion (Centro de Estudios Legales y Sociales, CELS, 2017). Conscientious objection is frequent in health institutions and, on occasion, it takes place in a general manner in an entire department, thus becoming one of the major obstacles to provide the

service of abortion. The existence of professionals who are conscientious objectors contributes to the stigma of abortion and promotes the idea that abortion is banned (Fiala y Arthur 2014; Morán Faúndes y Peñas Defagó 2016).

The Penal Code of Argentina has been in place since 1921 and it establishes that abortion is non-punishable if performed to avoid risks to the life or health of a woman or if the pregnancy is the result of rape. However, for decades, the service has not been offered as an option by the healthcare system, resulting in the practice being equated with a total-ban model (Bergallo y Michel 2009). Even when the causal model would allow to include a great number of abortions currently performed clandestinely[1], women and girls are frequently put under pressure and their privacy inside public healthcare institutions is violated, when they actually resort to them seeking a non-punishable abortion. Given this context, in the last few years, action strategies have been devised with a view to establishing joint-work relationships among women's movement activists and healthcare professionals working in public institutions. One of the most successful ones has given way to what is today known as the "Red de profesionales de la salud por el derecho a decidir" (Network of Healthcare Professionals for the Right to Decide, henceforth, the Network), with respect to which the results of research work are here presented.

Materials and Methods

We have conducted an exploratory study, with a view to addressing the relationship between the stigma of abortion and the healthcare professionals who are members of the Network. By accessing these professionals' accounts, we sought to understand how healthcare providers relate themselves, from their job, to the stigma of abortion, prior to and after, their becoming members of this group. A negative self-perception of the job done, fear of information disclosure and a strong social disapproval of their

[1] Mario and Pantelides estimate, via two different methods, that around 400,000 induced abortions were performed in 2014.

job, together with detachment from their fellow professionals (O'Donnell, Weitz, Freedman 2011), are included as indicators of the stigma of abortion.

From 2015 to 2018, we carried out interviews with 13 healthcare providers living in the province of Córdoba and the Autonomous City of Buenos Aires. They are general practitioners and gynecologists and obstetricians, clinical doctors, psychologists and social workers. The study entailed incorporating the report of other professionals, apart from that presented by medical staff. Public health teams in Argentina are interdisciplinary; thus, professionals with different specializations may be involved in some part of the abortion service provision process.

The interviewee selection criterion springs from a non-probability sample design by purpose, based on accessibility and feasibility (Strauss and Corvin 2002), through the sampling technique called chain-referral sampling or snowball sampling[2]. An instrument was designed to conduct semi-structured interviews. These interviews were carried out in the workplaces and the places of residence of the members of the Network, and also during the meetings held by Network members. In certain cases, several meetings with the same professional were agreed on, with the purpose of expanding the data collection. Each meeting and interview lasted 40 minutes on average. Interview recording and transcription were carried out for the analytical work. So as to complement the data obtained, civil society and women's organization leaders were interviewed and documents produced and distributed by the Network and other organizations were revised, particularly those by the "Campaña Nacional por el Derecho al Aborto Legal, Seguro y Gratuito" (National Campaign for the Right to Legal, Safe and Free Abortion), "Católicas por el derecho a decidir-Córdoba" (Catholics for the Right to Decide-Córdoba) and "Socorristas en Red" (Women Rescuers Network). All interviewees took part in the formation of the Network. A total of 5 additional interviews were conducted with representatives of these organizations. The research project obtained the approval of the Ethics Committee of the Hospital

[2] The "snowball sampling" technique suggests that the representativity is achieved by recruiting one or more key informants at random, who are asked to nominate and connect the researcher with other individuals of the object population, with the purpose of studying characteristics of that population. Its use is discussed in Handcock y Gile (2011).

Nacional de Clínicas (National Hospital of Clinics) of the city of Córdoba, Argentina. Each interviewee was requested to grant a verbal informed consent while the study's scientific objectives were specified, and identity confidentiality was guaranteed. All the participants are healthcare professionals and activists that work for women's sexual and reproductive rights, they are of legal age, and they gave their consent to be part of the study. Before starting each interview I read the informed consent, which included the goals of the research, and the assurance that they would be fully anonymized. They were also informed that their participation was voluntary and that they could interrupt the interview whenever they wanted. Their personal data will only be available for the responsible researcher. All names haven been changed, and it is not possible to identify those interviewed. These remarks and their consent are registered in the recordings of the interviews.

Justification

As a result of previous research (Drovetta 2015a; 2015b), we have put forth that the stigma of abortion constitutes a decisive factor, among others, which prove an obstacle to abortion. We refer to the stigma that healthcare professionals are afraid of suffering from in case they help women or girls seek a non-punishable abortion.

Currently, there is not enough qualitative research done, at a regional level, which allows for knowledge to be available on strategies leading to removing the stigma linked to abortion. In line with this fact, the proposal of the present work is to contribute to such removal, exploring, from the perspective of the professionals involved, their change in the perception of stigma once they joined the Network. This article intends to show how the performance of an active role, together with the defense of one's own activity, constitutes a form of resistance to, and removal of, the stigma of abortion linked to the professional job.

The results obtained allow us to advance an approximation to the phenomenon while they also give way to proposing new elements for future lines of research. In addition, this work makes visible one

professional organization experience that may stimulate an interest among others to replicate it in different contexts.

Background

Considering the extensive literature in English, various studies confirm the existence of fear felt by abortion providers regarding the negative consequences entailed in revealing that they perform abortions. Among such consequences are the discredit brought upon them, and the labor abuse they are subject to, on the part of professionals who oppose abortion. Abortion providers also describe the psychosocial costs they bear individually, as what is at stake is "assistance" tasks that provoke stress and physical and emotional fatigue. As a common analytical axis in all research works, there is the specification of the negative consequences borne in the personal and/or professional lives of the human resources who are members of the healthcare teams that offer this service (Martin, Debbink, Hassinger, Youatt, 2014; Martin, Debbink, Hassinger, Youatt, Eagen-Torkko, Harris 2014; Norris, Steinberg, Kavanaugh, De Zordo, Becker 2011; Harris, Debbink, Martin, Hassinger 2011; O'Donnell, Weitz, Freedman 2011). Research into stigma and abortion in Latin America is still limited (Zamberlin 2015; Adesse, Bonnan, Silveira, Matos 2016). For around a decade, research has been undertaken to focus on showing how women are affected by the link between stigma and abortions performed in contexts of legal restrictions (Palomino, Ramos, Davey, Guzmán, Carda y Bayer 2011; Galli y Sydow 2010; Shellenberg, Moore, Bankole, Juarez, Omideyi, Palomino, Zathar, Shingh, Tsui 2011; Vallejo, Botina, Gómez 2016), while other works tackle the consequences that stigmatizing attitudes entail for healthcare workers (De Zordo, 2012; Faúndes, Alves, Duarte, 2013; Vivas, Valencia, González, 2016).

Theoretical Perspective on Stigma

The pioneering work by sociologist Ervin Goffman collected information on how the translation takes place, in symbolic terms, of certain personal attributes and their categorization for the establishment

of a "social identity". His work shows how an attribute that is questioned at a specific point becomes a stigma, understood as a mark, a fault, which is present in people who are "uncommon" or in those who possess an "unwanted difference" (Goffman 2008). Following the author, the origin of such discredit is explained as a result of a discrepancy between the *virtual* social identity and the *real* social identity that a person should maintain, according to the social expectations formed in each context. This is due to the fact that "not all undesirable attributes are at issue, but only those which are incongruous with our stereotype of what a given type of individual should be" (Goffman 2006, p.132). Although the author equates stigma with an attribute which is deeply discrediting for the people who suffer from it, at the same time he declares that "an attribute that stigmatizes one type of possessor can confirm the usualness of another", therefore such attribute is not "creditable nor discreditable as a thing in itself (Goffman 2006, p.132). This means that discredit acts in relation to the context, pointing as problematic one aspect of the individual, in the eyes of the established norm in that place, among those individuals and for that society. At the same time, he points out that the term is employed from a double perspective: when the stigmatized individual assumes that their difference is already known or evident at a given moment, their situation is that of those who are discredited; in contrast, when the individual supposes that their difference is not known to those who are present nor is it immediately perceptible by them, it is about the situation of those who are discreditable (Goffman 2006). In the latter case, the stigmatized attribute can be hidden from others.

Goffman's ideas have been applied both to analyze aspects that include not only healthcare institutions and their dynamics but also the doctor-patient relationship and to describe the impact that diseases exert at the level of the subjectivity of those who suffer from them.

In this work, we understand the stigma of abortion as "the discrediting of individuals as a result of their association with abortion" (Norris et al., 2011, p.49), and we focused, specifically, on how it is carried by healthcare providers. To account for the dynamics with which it operates in real situations, stigma has been defined by taking into account a convergence of interrelated components, which span

the labeling that people make of human differences, the creation of stereotypes and their association with negative attributes linked to the people so labelled, the consequent separation between "them" and "us", and the disapproval, rejection and discrimination that unfold in conjunction with a power relationship that fosters their growth (Link y Phelan 2001; Phelan, Link y Dovidio 2008). For stigmatization to occur, there must be exercised (or accessed) social, economic and political power, permitting the emergence, the construction and the cultural sustainment of difference through socially-built categories (Link y Phelan 2001). Power, then, becomes essential to guarantee the existence of stigma.

Recent proposals also put forth that it is essential to describe the impact that the categories that are evidenced have, at a structural level, on the definition of the time when a person suffers, or is afraid of suffering, from stigma. This means that it is necessary to point out how an individual's stigma is influenced by the crisscrossing of such categories as race/ethnicity, class, gender, age, among other multiple identities (Collins, Von Unger, Armbrister 2008).

In contrast to studies that analyze stigma at an individual level, occupational stigma unfolds when it befalls the job done and it affects workers. Workers are perceived as people who have voluntarily chosen their jobs, therefore it would be a "controllable" stigma (Kreiner, Ashforth y Sluss 2006, p.619). In various contexts, the medical profession has acquired the status of a reference point, a status which is built and maintained thanks to the accumulation of a strong symbolic capital over the years. This capital may be affected with the disclosure of news that link the medical professional to the practice of abortion. As O'Donnell claims, the fear of stigma also affects professionals working in a peri-abortion situation, which encompasses people who take part in the abortion itinerary but are not directly involved in the practice itself, such as social workers and other people responsible for counselling tasks, ultrasounds or the patient's recovery stage (O'Donnell, Weitz, Freedman 2011). In this context, to be accused, by one's own peers, as "abortionist" carries a weight and a discredit that

disturb professionals. In addition, the family constitutes another front with respect to which professionals also worry about safeguarding the accumulated "symbolic capital" (Drovetta 2015a).

The stigma of abortion manifests itself, among other ways, through the low prestige associated with the applicability assigned to the medical knowledge learned in school. As O'Donnell shows, workers linked to the practice of abortion are described according to the stereotype of being "morally deficient, profit-motivated, and/or technically incompetent 'back-alley' physicians" (O'Donnell, Weitz, Freedman 2011, p.1358). Therefore, a stigmatized group may be defined as "one whose identity or image calls into question the full humanity of its members; in the eyes of others, the stigmatized group and its members are spoiled, blemished, devalued, or flawed to various degrees" (Kreiner, Ashforth y Sluss 2006, p.620).

The importance of research connected to the study of how the stigma of abortion operates in professionals lies in, as Kumar, Hessini y Mitchell (2009) state, the fact that stigma ought to be deemed as an element that contributes to eliminating abortion from the repertoire of practices or services provided by institutions, demoting it to clandestinity, creating a disincentive for healthcare workers to take part in some part of the trajectory or itinerary of abortion (Heilborn et al., 2012; O'Donnell, Weitz, Freedman 2011). Consequently, what ought to be deemed as the right to a medical practice becomes an anomaly or an exceptional event, clouded by moral judgement.

Results

Creation of the Network of Healthcare Professionals for the Right to Decide

With a view to creating new instruments that contribute to overcoming the obstacles to the access to non-punishable abortion in Argentina, the "National Campaign for the Right to Legal, Safe and Free Abortion", a federal coalition of more than five hundred organizations and personalities that have been doing advocacy work since 2014, promoted the creation of the Network. The proposal was originally thought of as a strategy which would produce a response for those who request an abortion in public institutions.

In general terms, the formation of the Network was the result of work conducted by civil and women's organizations, which showed a strong territorial presence and entered into alliances with local professionals. Among these organizations is "Catholics for the Right to Decide", which had been carrying out education and awareness-raising actions for more than a decade prior to the Network establishment.[3]

The Network of professionals was created at the end of 2014. It is an interdisciplinary space, including gynecologists and obstetricians, clinical doctors, nurses, social workers and psychologists who work in the public sphere. The interdisciplinarity of the space constitutes a positive aspect, since it does not cast abortion as the specific field of interest or action of one area of specialization only; instead, interdisciplinarity involves, and at the same time makes visible, the role played by all specialists who can make up a health team. The diversity of specializations prevents professionals with less accumulated symbolic capital than others (for example, psychologists, social workers, and nurses) from suffering greater stigmatization due to their becoming involved in the abortion itinerary. The symbolic capital ought to be understood as "the form that the different types of capital take when they are perceived and recognized as legitimate" (Costa 2015, p.2), something which positions those who possess it at an advantage. Inside the Network, a considerable number of general practitioners stand out, whose training as specialists in community health defines their work at the first level of healthcare. Because of their role, they focus on preventive actions, oriented to promoting health within the framework of the Primary Healthcare Service Program (APS is its acronym in Spanish). Currently, a

[3] A pioneering feminist organization in the establishment of joint work with healthcare providers was "Lesbianas y Feministas por la Descriminalización del Aborto" (Lesbians and Feminists for the Decriminalization of Abortion), which, for ten years, maintained an information line on safe abortion and contacted professionals so as to set up counselling offices and post-abortion care services in Buenos Aires. In the country's interior, feminist activists "La Revuelta" (The Distrubance, in Neuquén) and "Socorro Rosa" (Pink Rescue, in Córdoba), then joined by "Socorristas en Red" (Women Rescuers Network) at a national level, were also precursors in the establishment of contact networks with local professionals.

large number of non-punishable abortions are performed at this primary level of care, by means of the use of misoprostol in an ambulatory manner (Amnesty International 2017).

As it can be understood in its foundational charter (Carta Pública 2015), the Network's proposal differs, in many ways, from the medical corporation or hegemonic medicine and puts forth new senses for abortion to be deemed a matter of health. Therefore, the Network aspires to adopt new practices so as for these to become "normalcy" inside the institutional culture. But who creates normalcy? Creating a sense of normalcy is probably one of the greatest challenges facing the Network, which has managed to allow for members to experience a "there-are-others-like-me" feeling.

"In the same way that there exist healthcare providers who are conscientious objectors, there are others who perform abortions and offer services based on a framework of women's sexual and reproductive rights, and this is something that ought to be known" (B. female, physician. Interview, Buenos Aires, September 2016).

"It is not bad nor illegal; abortion is a very frequent problem which is treated, however, as if it didn't exist. It involves the health system and physicians and a lot of women resort to it" (J. female, general practitioner/ physician. Interview, Córdoba, July 2016).

Finding a professional community that "normalizes" their work produces an effect described as that one capable of mitigating the vulnerability linked to stigma (O'Donnell, Weitz, Freedman 2011). A female professional declares that *"if the so-called abortionists, that is to say we ourselves, are 300 and come out and stick up for this cause (women's right to abortion), we cannot be that bad… that is what is entailed by the idea of 'common sense'" (S. female, social worker. Interview, Córdoba, August 2017),* highlighting the importance given to a collective declaration of support for the task done.

By 2017, the Network was made up of around 800 professionals.[4] Its primary goal is to guarantee, in practice, women's and girls' access to non-punishable abortions with professionals who perform the Legal Interruption of Pregnancy (medical or surgical abortions) in public healthcare institutions around the country. This means that the members of the Network are known as providers of the Legal Interruption of Pregnancy service in the institutions where they work.[5]

The professionals who are members of the Network tend to show their membership openly and they take part in the occupation of public space, such as in demonstrations that commemorate significant dates for the feminist movement or by attending the national meetings of the organization. All these actions are in line with pro-choice activism.

The Network is constantly growing; thus, it is expanding its territorial presence. The wide geographical distribution of the members is a key element to making the possibilities for accessing abortion truly federal. In some cases, the Network members work in rural areas, isolated destinations, indigenous and *campesino* communities, where the Legal Interruption of Pregnancy, at a public institution, has powerful symbolic effects in the community.

Another way to expand the scope of its work is through social media, for example, by employing a Facebook account to state the Network's position on current matters and to issue statements on abortion, gender violence, and obstetric violence, among others. In addition, we have also noticed that the Network sends messages to those who are not members.

"It was difficult for me to understand that abortion is legal and ought to be performed in a hospital; many barriers must be overcome, every day. But, first of all, one must believe in one what does and

[4] Since 2018, as a consequence of the congressional debate of a bill for the decriminalization and legalization of abortion, both in Argentina's lower House of Representatives and in the Senate, there has significantly increased the visibility of professionals who are members of the Network.

[5] In the Argentinean context, "abortion providers" is a label with a broad scope, including all the interdisciplinary health team, even when the figure that stands out is that of the doctors.

that it is line with the current law and with one's own beliefs" (R., female, social worker. Interview, Buenos Aires, May 2017).

Whoever joins the organization goes through a process which makes their stance on abortion public: it is made clear that they support the demand for legal abortion. In contrast, whoever remains outside the Network runs the risk of being stigmatized as a professional who makes a profit with women's need.

When health systems include Network professionals, there exist stronger possibilities that professionals be influenced by their own peers, by the latter's actions, opinions and public declaration as abortion service providers. This means they generate a symbolic effect inside the institutions and health teams where they work and, at a community level, too, as a consequence of this visibility. At the same time, changes in public opinion are also sought after over the legitimacy of the demand for the Legal Interruption of Pregnancy.

"We have had meetings with colleagues from the Network, with lawyers, and in these meetings we began to see that we were all involved in solving matters related to abortion, without being aware of this; all this time we were trying to make our contribution, from our position in the medical consultation, but we lacked organization and knowledge on what the other, sitting opposite us, needed. It is different now, because the counselling sessions provided a framework to the practices we were following individually…" (P. male, clinical doctor. Interviews, Córdoba, September 2018).

Having a greater number of providers who publicly position themselves as willing to offer the abortion service helps increase the chances of changing the negative image that these professionals have. The task also entails getting other professionals to join in. Establishing a "face" before society is a way to work for the future, creating conditions of improved legitimacy that lead to an increase in the social backing for the Network.

Discussion

Reasons to Create the Network

From the professionals' point of view, one of the reasons leading to the establishment of the Network was the need to rethink the role played by healthcare providers to meet the demand made by women with unplanned pregnancies. Therefore, their lack of specific training during the pre-professional stage became evident: this would be training that would allow them to offer assistance, from their position within the public health system, to women and girls in an abortion situation. The workers showed a disposition to offer solutions but had little knowledge on the available tools (medical abortion) nor did they know about the normative and legal advances regarding abortion provision (Drovetta 2015a, 2015b). Among these, the following stand out: Action Protocols in the Guide for the Improvement of Post Abortion Care (2005), Guide for Non-Punishable Abortion Integral Care (2010), and Protocol for Integral Care of People with the Right to a Legal Interruption of Pregnancy in Argentina (2015), all of them produced by the Ministry of Health of Argentina.

Inside the Network, there occurred a promotion of the debate over the official documents regarding abortion provision, produced by the Ministry of Health. At the same time, through training sessions organized by lawyers, knowledge about a different interpretation of criminal law was promoted, together with information on the successful experiences enjoyed in the public health system of other countries (mostly the cases of Colombia and Spain). This process was fostered by interdisciplinary work, including meetings with lawyers and other legal operators. The work done by feminist women lawyers stood out as they became organized to face the hegemony of conservative sectors in the legal field, particularly regarding matters linked to the debate over sexual and reproductive rights. In other words, the socialization of information on legal aspects and on institutional protocols led the members of the Network to strengthen their professional practice in relation to abortion, finding support in the very tools proposed by the State. These actions demonstrate the pros associated with belonging to a space that provides opportunities for professional training and development.

Every professional meeting constitutes an opportunity to share and analyze various experiences springing from the care offered in doctors' offices around the country. Based on this information exchange, it was possible to establish similar criteria regarding the need to meet the demand for access to safe abortions. We are talking about the counselling pre and post abortion sessions, in the very same workspaces of the professionals in the Network. Even when the counselling sessions differ in accordance with the context and the possibilities to have human and material resources, these sessions are based on a risk and harm reduction approach, as a strategy to minimize the negative effects of the abortion practice in contexts of restrictive laws[6] (Briozzo, Labandera, Gorgoroso, Pons 2007). In practice, the sessions amount to offering evidence-based information regarding the use of medicine to perform an abortion, the prescription of medicine to be bought in drugstores, and, finally, the setting of a date for the post-abortion ultrasound control two weeks later. The second step is more complex, since it requires that women have access to the economic resources necessary to buy Misoprostol, a patented medicine, whose off-label use allows for a self-induced abortion. Other resources that may be necessary could be an adequate physical space for the practice, access to a support network and the possibility to notice the alert signs which could lead to an obstetric emergency.

Resisting stigma. The sense of belonging to the group and occupational identity

Current proposals show how it is possible to respond to stigma with "an equally diverse set of cognitive, affective and behavioral strategies" (Kreiner, Ashforth y Sluss 2006, p.619) at an individual level and at a collective level. It is in this sense that Ashforth and Kreiner point to the importance of adopting a set of useful tools to promote strong identification bonds with the job done, together with the conceptual construction of sufficient justification that assigns meaning to the work choice, which corresponds to the belief in the importance of the task developed and the need for such task (1999).

[6] "A harm reduction approach to unsafe abortion seeks to reduce abortion-related death and disability without prohibiting or otherwise seeking to restrict women from engaging in unsafe abortion, which by the WHO definition may include self-induction. The objective rather is to make unsafe abortion as safe as possible" (Erdman 2012, p.84).

Specifically, the proposals that originate in studies conducted, and the work done, by the organizations have documented how, in the face of discredit, the collectivization of certain actors represents a way of offering resistance to stigmatizing attitudes.

The results of our research point in the same direction. In accordance with the results obtained in the present work, professionals highlight the positive aspects springing from their belonging to the Network. Fundamentally, their reports attest to the idea that work conducted together with a group of peers promotes a sense of belonging among those who choose similar options in their professional life. At the same time, it is possible to recognize, among the members, that the perception of a common threat contributes to promoting cohesion (Ashforth and Kreiner 1999) and facilitates the development of a strong occupational culture.

Among the professionals interviewed, there prevails the idea that, should they have performed an abortion or participated in its provision, they would have run the risk of becoming that discredited person to whom Goffman refers (2008, p.14-16).

"We started off alone, on our own, by talking to women about how to use Misoprostol correctly, what it was they had to detect, what was going to happen to them. After this, we began getting in touch among ourselves and it turned out that there were plenty of us doing this in the office, the only thing was we didn't talk about this in public" (A. female, clinical doctor. Interview, Buenos Aires, October 2018).

Having this into account, they initially chose not to publicly take on the counselling work regarding abortion that they perform in their offices, which is protected by the duty of confidentiality. However, once they join the Network, the self-perception they have of their job puts them in a position which prevents them from thinking of themselves as discredited. In contrast, they know they are not violating any norm and highlight, emphatically, that joining the group has entailed a radical change in their professional life.

Reports show that stigma indicators, such as the negative self-perception of the job done, the fear of information disclosure and of detachment from fellow professionals, together with the fear of an open disapproval of their job (O'Donnell, Weitz, Freedman 2011), are not discursively present among the members of the Network. These providers of the service of abortion do not consider their job as sinful, dirty or polluted (Hughes 1958). These conceptualizations are, in the end, social constructions, historically situated and attributed, which they know they face, but they have not internalized. They state that forging greater professional bonds, which entail the possibility of disclosing, among their peers, what they do in their workplace, serve as strategies that allow to fight the interpersonal disconnections produced by the stigma of abortion (Martin, Debbink, Hassinger, Youatt, 2014).

"The question of stigma, we have talked about it for some time now, with the team. We organized a meeting, to review this, because some of us wanted to handle it or learn about how others dealt with it, i.e. this situation of telling people, family members, what one does. In my case, my family is totally aware that I perform the legal interruption of pregnancy, but I think that little by little others were also able to tell their own people, too, while the Network permitted that we come out in favor of an increased visibility" (M. female, general practitioner. Interview, Córdoba, June 2017).

Finally, the importance attached, by healthcare providers, to women's organizations as an ally in their work is key. Healthcare providers refer to the frequent joint-work strategies the two groups have drawn up together, focused on achieving solutions for low-income women who have requested a safe abortion.

"I know many feminist women who have forged bonds among them to be able to get Misoprostol and help other women get it, too. We ended up working together, because the end of the process should be overseen by a doctor, as the post-abortion care is really important. At the beginning, I was alone, or at least I felt alone, and I wasn't sure of the way I could help a woman to cater to her specific needs, because she was a poor woman who was alone in this, etc. And I started getting in contact with a

feminist activist I knew: she and her group were able to provide help to women, when I couldn't do anything else from my position" (F. female, clinical doctor. Interview, Córdoba, October 2017).

When reporting about, and experiencing themselves, the provision of the service, the members of the Network promote the idea of "putting a face" to abortion, so as to counteract the stereotypes and negative perceptions linked to this practice. Thus, abortion is, for many of these professionals, a right to which is worth being committed.

"When I was doing the practicum during my specialization stage, we went to the hospital and I watched how a doctor treated a woman through her delivery of her baby. I ended up in shock at the way that woman was treated; I couldn't do anything, I was a student, but I think that I decided then not to take up obstetrics. However, I eventually ended up offering the abortion service because it is a way of fighting so much injustice. To me, medicine is useful to do a little bit of justice to women who are so ill-treated in the health systems" (L. female, clinical doctor. Interviews, Córdoba, November 2018).

"I really know that it is not that I am better or more tolerant, or whatever; what I know is that access to abortion is a right, guaranteed by law, and that women must have such access safeguarded. My job is simply a medium so that women find a solution to a problem, which the State is obliged to solve" (M. male, OB/GYN doctor. Interview, Córdoba, October 2018).

At the same time, what stands out from these professionals' reports is the notion that "helping women", which O'Donnel describes as a "redemptive quality of the job" (O'Donnell, Weitz, Freedman 2011), is done so as to justify a choice (not made for money) in contrast to a widespread stereotype that deems clandestine abortion providers as being exclusively interested in making a profit. Believing in the benefits of, and the need for, their own job consolidates itself as a strategy that is conducive to removing the stigma. This capacity to be active agents who resist and transform a negative experience contributes to developing healthcare providers' ability to reduce vulnerability in the face of stigmatization.

Conclusion

Throughout this work, we intended to characterize, in general terms, the practices adopted by members of the "Network of Healthcare Professionals for the Right to Decide." Our study sought to inquire about, from the very perspective adopted by the professionals, the main changes they have experienced regarding the perception of the stigma of abortion since they joined the organization.

These reports have allowed us to show how it is possible to resist the effects of stigmatization by taking an active role in relation to professional identity. This gets to be translated in the increase of possibilities for women and girls to be accompanied by a professional from the Network in their access to a non-punishable abortion in a public institution. Such active role has also permitted the provision of pre and post abortion counselling sessions in many healthcare centers across the country.

We consider that the creation of the Network is the result of having overcome obstacles for the group and the organization with fellow professionals, leading to the abandonment of invisibility. The reports compiled show a true understanding of the effects that silencing produces, silencing which then turns into isolation and the social reproduction of discredit. Belonging to the Network enhances professional identity inasmuch as these professionals can support one another and contribute to the goal of defeating the discredit they could face.

This article also shows the need to work on research aimed at analyzing the results obtained by the local alliance established between feminist organizations and other grassroots organizations and health care providers committed to sexual and reproductive rights. The creation of a network was the result of an initiative undertaken by feminist activists who had already started to work with health professionals, convinced that it was necessary to include them as part of the work done for the immediate change of the conditions surrounding the provision of non-punishable abortions. Sectors of the local activism even understand that social legitimacy in the demand for legal abortion will not be achieved by leaving health professionals out. While the creation of coalitions does not solve the problem of clandestine abortion in the country, they still constitute a gradual process of change

unfolding in women's concrete reality. These coalitions also help promote the cultural change connected to the practice of abortion.

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