Research Square

Preprints are preliminary reports that have not undergone peer review.
They should not be considered conclusive, used to inform clinical practice,
or referenced by the media as validated information.

Stigmatisation in Connection with Abortion: Internalised, Anticipated, and Experienced Dimensions among Women in Germany – A Cross-Sectional Analysis of the ELSA Study

Daphne Hahn

daphne.hahn@gw.hs-fulda.de

University of Applied Sciences Fulda

Laura Olejniczak

Cornelia Helfferich Institute for Gender and Family Research

Rona Torenz

University of Applied Sciences Fulda

Ines Thonke

University of Applied Sciences Fulda

Sarah Eckardt

University of Technology Dresden

Anke Wyrobisch Krüger

University of Applied Sciences Fulda

Ulrike Busch

Merseburg University of Applied Sciences

Heike Vollmer

University of Applied Sciences Fulda

Research Article

Keywords: Stigmatisation, Abortion Stigma, internalised Stigmatisation, cross-sectional study, anticipated stigmatisation, experienced Stigmatisation, socio-economic dimensions

Posted Date: November 12th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-11154578/v1

License: This work is licensed under a Creative Commons Attribution 4.0 International License.
Read Full License

Additional Declarations: No competing interests reported.

Abstract

Background: The legal restrictions and moral constraints associated with abortion expedite various forms of stigmatisation. Stigmatisation is potentially associated with considerable psychosocial stress and can impede access to appropriate care. Existing research indicates that social norms – especially expectations around motherhood and “responsible” reproduction – are central drivers of such stigmatisation processes.

Objective: The objective of the present study was to quantify the extent of internalised, anticipated, and experienced stigmatisation among women in Germany who have had an abortion, to analyse the relationship between the three forms, and to identify possible influencing factors.

Methods: The data was gathered through a survey of 608 women who had aborted an unwanted pregnancy, conducted in the scope of the ELSA study Internalised, anticipated, and experienced stigmatisation was recorded using standardised items. Statistical analysis was conducted using means, indices, and correlational analysis; the potential influence of sociodemographic characteristics was investigated.

Findings: 83.5% of respondents reported internalised stigmatisation in the form of feelings of shame and guilt, while 78% reported anticipated stigmatisation. Experienced stigmatisation, in the form of disappointment and condemnation, was rarer. Statistical analysis revealed significant correlations between the three forms of stigmatisation, in particular between internalised and anticipated stigmatisation ($p=0.387$).

Conclusion: Internalised and anticipated stigmatisation are found to be the most prevalent forms, while experienced stigmatisation is rarer. The clear correlation between internalised and anticipated stigmatisation suggests mutual reinforcement processes. Given that sociodemographic characteristics play no role in those two forms, stigmatisation appears to be a universal phenomenon.

1 Introduction

The availability of safe abortion without stigmatisation is a central element of reproductive healthcare [1]. Stigmatisation is frequently observed, in particular in countries with restrictive legislation, where criminalisation engenders social disapproval [2, 3]. While abortion is strictly speaking illegal in Germany, it is decriminalised during the first trimester (and later for health reasons). A three-day waiting period must be observed after mandatory state-regulated counselling [4]. The cost must be covered privately, although public funding for low-income women is available.

The stigmatisation of unwanted pregnancy – especially in cases that end in abortion – can have far-reaching emotional, social, and health consequences for the affected women [5–9]. Fear of condemnation and rejection is a central aspect, frequently leading women to keep their decision to have an abortion secret. Such secrecy significantly restricts access to information, support, social resources,

and healthcare, and can even lead women to resort to illegal abortion options [6–13]. The impacts range from social isolation and lack of emotional support to an elevated risk of feelings of guilt and shame. The latter can have negative effects on psychological wellbeing and increase the risk of long-term psychological symptoms [8, 10, 14, 15]. Fear of judgement and disapproval can also lead women to avoid contact with the healthcare system altogether or to delay seeking treatment, which can have negative effects on the quality and safety of medical care [8, 12, 16]. So stigmatisation is not only a personal and social matter, but also a dimension of relevance to health. In fact, stigmatisation represents a central obstacle to safe, accessible quality care [12]. Education-related differences in the experience of stigmatisation are not described in the literature, although effects of religion, age, and ethnicity are reported [17].

In Germany women seeking abortions must often overcome significant obstacles [18]. Access to abortion care differs widely between the federal states. Women seeking abortions in regions with poor provision – especially in the southwest of the country – are confronted with the greatest hurdles to access [18, 19]. Despite the availability of abortion in Germany, women also seek provision outside the regular system. This phenomenon is internationally recognised [12]. Every year more than 2,000 women in Germany obtain abortion pills and online advice from the Canadian NGO Women on Web, while 1,000 travel to the Netherlands for their abortion. To contextualise the figures: the annual number of abortions in Germany is roughly 100,000 [20].

To date there has been little research into stigmatisation of women who abort an unwanted pregnancy in Germany. Hanschmidt et al [21] note that negative attitudes towards abortion increased in the two decades following reunification in 1990. The German ELSA study included stigmatisation in a wide-ranging survey of women and doctors. One of goals of the ELSA study is to describe stigmatisation from the women's perspective and investigate sociodemographic and socioeconomic aspects. Findings from that part of the study are presented below.

1.1 Conceptual and theoretical framing

The ideas of Erving Goffman are key to any research into stigmatisation. He described "stigma" as a social attribute that is "deeply discrediting", marking the individual as deviant in the eyes of others and diminishing their social status [13, 21, 22]. Goffman shows that stigmatisation is a relational – rather than individual – phenomenon. It arises in the social process of attribution of deviation from accepted norms. Michel Foucault's concept of discipline and punish expands this perspective by showing that social norms not only reflect what is regarded as "normal", but also intervene actively to regulate processes of subjectification. Norms the function as powerful mechanisms shaping behaviour, disciplining individuals, and enforcing the social order [23].

The term "abortion stigma" describes negative moral judgement of women who are contemplating an abortion or have had one [5]. Such assessments are rooted in social and cultural norms [24] that produce a specific complex of femininity, sexuality, and motherhood [25, 26]. These norms are based on the

assumption that women have a “natural” disposition for motherhood, which is challenged by the decision to have abortion [27]. An abortion thus transgresses the normative paradigm of feminine fertility and nurturing [5, 14] and disrupts the delicate balance between personal autonomy and social regulation.

Women who transgress these norms are frequently labelled as irresponsible, egotistic, and/or immoral. The associated stigmatisation processes are closely bound up with other sexual and reproductive norms [28] and are manifested in negative attributions such as inadequate contraception and “deviant” sexuality, and moral qualms over preventing the creation of a life [5]. This produces judgemental social practices that lead to discrimination, social exclusion, and moral condemnation, and treat women as inferior, damaged, and/or promiscuous [21].

Building on Hanschmidt et al. (2016), we distinguish between internalised, anticipated, and experienced stigmatisation. Internalised stigmatisation describes the assimilation of social judgements and stereotypes into a person’s own self-image. This may be manifested in feelings of guilt and shame, and a sense that one is behaving egotistically and immorally [21]. Guilt and shame are central because they have direct effects on psychological wellbeing, as well as affecting coping strategies and access to information and services. Anticipated stigmatisation describes the expectation or fear of being judged or seen negatively by others, which can lead affected women to delay revealing their pregnancy or to keep their abortion secret. Finally, experienced stigmatisation describes personal confrontation with real discrimination and condemnation. As well as structural aspects such as criminalisation [21].

In the following we describe the findings of our survey of women with unwanted pregnancies (which was part of the ELSA study) and lay out the extent of internalised, anticipated, and experienced stigmatisation associated with abortion in Germany. We also tease out the relationship between the different forms of stigmatisation.

2 Data gathering and analysis

The multi-disciplinary ELSA research project is the first in Germany to investigate the life situations, stresses, resources, and psychosocial and medical support needs of women with unwanted pregnancies. The findings are consistently contextualised to produce an all-round picture of the complex experiences of the affected women. To gather data on unwanted pregnancies and abortions, several standardised surveys were conducted. The starting point was a representative online survey of 4,589 women living in Germany who had at least one child under six years of age (using a population sample selected from the population register). After screening all lifetime pregnancies, the respondents were interviewed in detail about one selected pregnancy. In the survey, 160 respondents chose to speak about a pregnancy they had aborted.

Various additional strategies were employed to gather further data. Women were contacted through abortion clinics (253 respondents), pregnancy counselling centres (28), the international online platform Women on Web (24), and social media (186), as well as a special sample of women who had

experienced violence and/or been refugees (11). Altogether 662 women who had had an abortion participated in the online survey. 47 women who had aborted an intended pregnancy and seven women whose pregnancy intention remained unclear were excluded from the final sample, which thus comprised solely women who had aborted an unwanted pregnancy. The chosen combination of different recruitment paths enabled systematic control and compensation of potential distortions. Although the sample was not strictly random or representative, it closely corresponds to the demographic and structural characteristics of women having abortions, as reported by the Federal Statistical Office. Therefore, it can be assumed that the sample is sound and the findings are generalisable.

The data was gathered between November 2021 and September 2022 using a validated multi-lingual online survey (CAWI) that enabled participation by women with different language abilities. The respondents received appropriate compensation for their effort. The respondents' involvement was restricted to participation in the survey, although the study's preparation and findings were discussed in detail with family planning organisations, charitable organisations, and medical associations.

To record stigmatisation, we used the validated ILAS scale (Individual Level Abortion Stigma). For practical reasons, we used a selection of items from the very long full questionnaire. In order to achieve a balance between duration of respondent engagement and coverage of the issues, a reduced set of items was selected. The selection was guided primarily by the question of item validity, in order to include all the central dimensions of stigmatisation described in the literature.

Internalised stigmatisation was recorded using items that measure personal acceptance of social disapproval, concentrating on shame, guilt, self-deprecation, and feelings of failure to satisfy social expectations. The selected items encompass emotional as well as cognitive dimensions, and enable differentiated analysis of personal thought processes. Anticipated stigmatisation was operationalised through questions on expected negative judgement and discrimination. This was intended to reveal potential withdrawal and avoidance strategies, such as holding back information or delaying seeking medical treatment and social services. Experienced stigmatisation was differentiated by context and setting: personal (e.g. family and friends), social (e.g. neighbourhood, community), and professional (e.g. medical staff). This enabled us to map the diversity of stigmatising experiences and their concrete expressions – from blunt direct discrimination and negative comments to subtler forms of social distancing and restricted access to services.

A balanced mix of positively and negatively formulated items was employed in order to neutralise response bias. This allowed us to uphold the theoretical foundation of the ILAS scale while at the same time adapting it to the specific survey conditions of the present study.

The statistical analysis was conducted using IBM SPSS Version 28 (Cramer's V with Chi-square tests, Spearman's rho (ρ), two-sided tests with 5% significance level). Given the composition of the sample, significant findings can be assumed to be representative for the population.

3 Findings

Internalised stigmatisation was measured using survey questions addressing the respondents' emotional experiences following their decision to have an abortion. They were asked about feelings of guilt and shame, and whether they reproached themselves. Their responses were given on a five-point Likert scale from 1 ("not at all") to 5 ("very much"). The means of the two items were used to create an index of internalised stigmatisation, with four categories from "none" to "very strong".

[Table 1 **about here]**

Table 1
Index of internalised stigmatisation

Index of internalised stigmatisation		
Index value	**Category**	**Proportion (%)**
1	none	16.5
1.5 to 2.5	weak	23.8
3 to 4	strong	30.3
4.5 to 5	very strong	29.5
Total		100.0
n = 601 women who had had an abortion		
Source: ELSA Survey 2022/2023		

83.5% of respondents reported some form of internalised stigmatisation in the form of shame and guilt. About 30% reported very strong feelings of internalised stigmatisation (index value ≥ 4.5), while another 30% reported strong feelings of internalised stigmatisation with values between 3 and 4. Only 16.5% of respondents reported no feelings of internalised stigmatisation (index value = 1).

The survey used three items to investigate anticipated stigmatization. To assess the extent of anticipated stigma, understood as expectations of negative or stigmatizing responses from one's social environment, the ELSA study, drawing on the conceptualization by Cockrill et al., examined three dimensions. These included concerns about disappointing others, expectations of being treated negatively by others, and apprehensions that others might hold or express negative views about the individual. (see [8]). An index of anticipated stigmatisation was created, on the basis of the number of concerns named (see Table 2). 78% of respondents had feared some form of negative response, while about 22% said they had not. 38.6% had feared stigmatisation in one area, 23.1% in two, and 16.3% in all three.

[Table 2 **about here]**

Table 2
Index of anticipated stigmatisation

Index of anticipated stigmatisation		
Index value	**Category**	**Proportion (%)**
0	none: no expectation of stigmatisation	22.0
1	weak: expectation of stigmatisation in one area	38.6
2	strong: expectation of stigmatisation in two areas	23.1
3	very strong: expectation of stigmatisation in three areas	16.3
Total		100.0
n = 559 women who had had an abortion		
Source: ELSA Survey 2022/2023		

22.0% of respondents reported not having expected any stigmatisation. 38.6% had expected weak stigmatisation, about one quarter (23.1%) strong stigmatisation, and 16.3% very strong stigmatisation.

The survey also recorded the forms and prevalence of experienced stigmatisation in the social milieu and in healthcare settings. Experienced stigmatisation was reported significantly less frequently than the internalised and anticipated forms. The most commonly reported form of experienced stigmatisation (reported by 13.3% of respondents) was disappointment expressed by friends and relatives. 11.8% reported condemnation within their social milieu. 7.7% reported having experienced pressure from medical staff to not to have an abortion during the early stages of pregnancy, and 5.7% reported reproachful reactions from medical staff.

An index of experienced stigmatisation was created, on the basis of the number of situations in which respondents reported having had negative experiences. Almost three-quarters of respondents (72.8%) reported having experienced no actual stigmatisation. 27.2% had experienced stigmatisation: 14.9% in one situation, 7.5% in two different situations, and 4.8% in three or more situations.

[Table 3 **about here]**

Table 3
Index of experienced stigmatisation

Index of experienced stigmatisation		
Index value	**Category**	**Proportion (%)**
0	no experienced stigmatisation	72.8
1	experienced stigmatisation in one situation	14.9
2	experienced stigmatisation in two situations	7.5
3	experienced stigmatisation in three or four situations	4.8
Total		100.0
n = 545 women who had had an abortion		
Source: ELSA Survey 2022/2023		

Statistical analysis revealed correlations between the three forms of stigmatisation. The correlation between internalised and anticipated stigmatisation is particularly strong ($p = 0.387$): the stronger the personal feelings of shame and guilt, the greater the concern about being judged negatively by others (and vice versa). Significant (albeit weaker) correlations were also found between anticipated and experienced stigmatisation ($p = 0.191$) and between internalised and experienced stigmatisation ($p = 0.131$). Overall, greater experienced stigmatisation is associated with greater internalised and anticipated stigmatisation.

[Table 4 **about here]**

Table 4
Correlations with socioeconomic and sociodemographic characteristics

Total	**n**	**%**	**Internalised stigmatisation**		**Anticipated stigmatisation**		**Experienced stigmatisation**	
	608	**100**	**V**	**p**	**V**	**p**	**V**	**p**
Age			0.081	*0.267*	0.059	*0.578*	0.173	*0.001*
under 22 years	86	14.1						
22 years and over	520	85.5						
Education			0.075	*0.334*	0.093	*0.103*	0.113	*0.013*
low	104	17.1						
medium	108	17.8						
medium-high	145	23.8						
high	249	41.0						
Employment status			0.070	*0.406*	0.051	*0.688*	0.179	*0.001*
working	335	55.1						
not working	273	44.9						
Welfare benefits			0.063	*0.496*	0.068	*0.462*	0.069	*0.462*
receiving	119	19.9						
not receiving	480	78.9						
Region of Germany			0.067	*0.441*	0.151	*0.005*		
eastern	183	30.1					0.058	*0.609*
western	421	69.2						
Migration background			0.110	*0.063*	0.077	*0.351*	0.069	*0.465*
yes	143	23.7						
no	457	76.3						
Religiosity			0.101	*0.109*	0.022	*0.966*	0.044	*0.792*
more religious	131	21.5						
less religious	472	77.6						
Long-term relationship			0.065	*0.466*	0.063	*0.529*	0.027	*0.939*
yes	501	82.4						

Total	n	%	Internalised stigmatisation		Anticipated stigmatisation		Experienced stigmatisation	
	608	**100**	**V**	**p**	**V**	**p**	**V**	**p**
no	103	16.9						
Marital status			0.053	*0.635*	0.093	*0.184*	0.231	*0.000*
married	171	28.0						
not married	433	71.2						
Child(ren) before abortion			0.113	*0.053*	0.065	*0.496*	0.180	*0.001*
yes	248	40.8						
no	359	59.0						
Previous abortion			0.087	*0.206*	0.106	*0.099*	0.081	*0.306*
yes	90	14.8						
no	518	85.2						

As Table 4 shows, internalised and anticipated stigmatisation were not found to correlate significantly with the investigated sociodemographic characteristics (with one exception, see below). Experienced stigmatisation correlates significantly with age (V = 0.173), with younger respondents (under 22 years of age at the time of the abortion) more likely than older respondents to report experiences of stigmatisation (34.6 vs. 26.0%). In particular, younger respondents were more likely to report experiencing stigmatisation in multiple situations. 12.8% of younger respondents reported having experienced stigmatisation in three or more contexts, compared to just 3.4% of women aged 22 and older. Statistically significant correlations were also found between experienced stigmatisation and education (V = 0.113), employment status (V = 0.179), marital status (V = 0.231), and having had one or more children before the abortion (V = 0.180). One statistically significant correlation was found for anticipated stigmatisation: respondents living in eastern Germany were less likely to anticipate stigmatisation than those living in the former West Germany (V = 0.058).

4 Discussion

The survey findings reveal that stigmatisation is very common in connection with abortion. 83.5% of respondents – all women who had had an abortion – reported internalised feelings of stigmatisation of some kind, with 29.5% reporting these as being very strong. 78.0% of respondents reported expecting stigmatisation in at least one area, while 27.2% reported actual experience of negative, judgemental reactions. These findings align with the prior research: women who have had or intend to have an abortion are more likely to internalise and/or anticipate stigmatisation than they are to actually experience it [29].

The findings show clear correlations between internalised, anticipated, and experienced stigmatisation, with the strongest correlation being that between internalised and anticipated stigmatisation. This suggests that personal feelings of shame and guilt are closely tied to the expectation of being judged by others. The correlations between internalised/anticipated and experienced stigmatisation are significant, although less so. Taken together, these findings support the understanding of stigmatisation as a complex process, in which internalised attitudes and anticipated social reactions shape and potentially reinforce one another.

With just one exception, neither sociodemographic nor socioeconomic characteristics had any significant influence on internalised and anticipated stigmatisation, suggesting that stigmatisation processes are broad-based and operate independently of personal circumstances. That underlines the power of the normative expectations associated with abortion. The difference in prevalence of anticipated stigmatisation between eastern and western Germany is very likely attributable to the differences in abortion legislation prior to reunification. The legacy of East Germany's policy of unequivocally legal first-trimester abortion available on demand is still felt today.

The persistence of normative expectations around abortion is also reflected in the effect of age on experienced stigmatisation. Younger women (aged under 22 years at the time of the abortion) were significantly more likely to report experiencing stigmatisation (34.6% vs. 26.0% among older respondents) and also more likely to report experiencing stigmatisation in multiple settings (12.8% vs. 3.4%). This is indicative of greater vulnerability in earlier life phases, and could be associated with having less experience dealing with social pressure and/or being more dependent on the prevailing norms of the family and peer group.

The great prevalence of internalised and anticipated stigmatisation reflects the influence of social norms and moral regimes. Many women assume adopt the prevailing social attitudes, feeling guilty and/or ashamed, and expecting social disapproval. The survey findings confirm that the normative expectations of motherhood and "responsible" reproduction are deeply entrenched in societal discourse [5, 25], and that stigmatisation is transported in the first place through discursive and structural mechanisms rather than through direct interactions. Although experienced stigmatisation is less prevalent, it is manifested both in the social milieu and in the professional context, for example in the form of expressions of disappointment or reproach by medical staff.

The findings cast a spotlight on the need to address social structures and normative discourses if stigmatisation is to be effectively counteracted. That means that practical and policy interventions should not only aim to avoid open discrimination, but must in particular address mechanisms of self-stigmatisation. Political and health strategies should challenge the social norms that contribute to internalised stigmatisation. Approaches such as non-judgemental communication, barrier-free advice services, and public affirmation of reproductive autonomy can also contribute to reducing internalised and anticipated stigmatisation.

Declarations

Ethics approval and consent to participate

Approved by the Ethics Committee of Fulda University of Applied Sciences on 27 April 2021 and conducted in accordance with the Declaration of Helsinki.

Informed consent to participate in the study was obtained from participants.

Consent for publication

Written informed consent for publication was obtained from all participants

Competing interests

The authors declare no competing interests.

Funding

The study is funded by the Federal Ministry of Health Germany under Grant Agreement No ZMVI1-2520FSB11A.

Author Contribution

DH conceived and led the study and conceived and drafted the manuscript. LO conducted the data analysis and revised the manuscript. RT, IT, SE, AW-K and UB were centrally involved in the conception of the standardised survey instrument and the discussion of the results, and read and revised the manuscript. HV contributed to data collection. All authors read and approved the final manuscript.

Acknowledgement

We would like to thank all the women who participated in the ELSA study for sharing their experiences. We would also like to express our gratitude to the cooperating medical practices, hospitals and counselling centres, whose support in providing access to potential participants was essential to the successful conduct of this study.

Data Availability

Data availabilityThe datasets generated and analysed during the current study are not publicly available due to data protection and ethical restrictions but are available from the corresponding author on reasonable request.

References

1. WHO. Abortion care guideline. Geneva: World Health Organization Human Reproduction Programme; 2022.
2. Busch U. Handlungsbedarfe bei Schwangerschaftskonflikten 2009.
3. O'Donnell J, Weitz TA, Freedman LR. Resistance and vulnerability to stigmatization in abortion work. Soc Sci Med. 2011;73(9):1357–64. 10.1016/j.socscimed.2011.08.019 . [published Online First: 10 September 2011].
4. Busch U, Hahn D. Schwangerschaftsabbruch in BRD und DDR: Ein Vergleich der Entwicklungen und die Neuregelung der 1990er Jahre. Ariadne Form für Frauen- und Geschlechtergeschichte 2022(77):81–101.
5. Kumar A, Hessini L, Mitchell EMH. Conceptualising abortion stigma. Cult Health Sex. 2009;11(6):1–15.
6. Moseson H, Mahanaimy M, Dehlendorf C, et al. … Society is, at the end of the day, still going to stigmatize you no matter which way: A qualitative study of the impact of stigma on social support during unintended pregnancy in early adulthood. PLoS ONE. 2019;14(5):e0217308. 10.1371/journal.pone.0217308 . [published Online First: 23 May 2019].
7. Sorhaindo AM, Juárez-Ramírez C, Díaz Olavarrieta C, et al. Qualitative evidence on abortion stigma from Mexico City and five states in Mexico. Women Health. 2014;54(7):622–40.
8. Cockrill K, Nack A. I'm Not That Type of Person: Managing the Stigma of Having an Abortion. Deviant Behav. 2013;34(12):973–90.
9. Shellenberg KM, Moore AM, Bankole A, et al. Social stigma and disclosure about induced abortion: results from an exploratory study. Glob Public Health. 2011;6(Suppl 1):S111–25.
10. Major B, Gramzow RH. Abortion as stigma: Cognitive and emotional implications of concealment. J Personal Soc Psychol. 1999;77(4):735–45.
11. Sorhaindo A, Rehnstrom Loi U. Interventions to reduce stigma related to contraception and abortion: a scoping review. BMJ Open. 2022;12(11):e063870. 10.1136/bmjopen-2022-063870 . [published Online First: 17 November 2022].
12. Sorhaindo AM, Lavelanet AF. Why does abortion stigma matter? A scoping review and hybrid analysis of qualitative evidence illustrating the role of stigma in the quality of abortion care. Soc Sci Med. 2022;311:115271. 10.1016/j.socscimed.2022.115271 . [published Online First: 24 August 2022].
13. Aiken ARA, Broussard K, Johnson DM, et al. Motivations and Experiences of People Seeking Medication Abortion Online in the United States. Perspect Sex Reprod Health. 2018;50(4):157–63. 10.1363/psrh.12073 . [published Online First: 11 July 2018].
14. Rocca CH, Samari G, Foster DG, et al. Emotions and decision rightness over five years following an abortion: An examination of decision difficulty and abortion stigma. Soc Sci Med. 2020;248:112704.

15. Steinberg JR, Tschann JM, Furgerson D, et al. Psychosocial factors and pre-abortion psychological health: The significance of stigma. Soc Sci Med. 2016;150:67–75.
16. Kjelsvik M, Sekse RJT, Moi AL, et al. Women's experiences when unsure about whether or not to have an abortion in the first trimester. Health Care Women Int. 2018;39(7):784–807. [published Online First: 18 May 2018].
17. Cockrill K, Upadhyay UD, Turan J, et al. The stigma of having an abortion: development of a scale and characteristics of women experiencing abortion stigma. Perspect Sex Reprod Health. 2013;45(2):79–88. 10.1363/4507913 . [published Online First: 2 May 2013].
18. Hahn D, Torenz R, Thonke I et al. Zugangsbarrieren zur Schwangerschaftsabbruchversorgung: Eine Analyse aus der Perspektive ungewollt Schwangerer – Erkenntnisse aus der Studie „Erfahrungen und Lebenslagen ungewollt Schwangerer. Angebote der Beratung und Versorgung (ELSA). *Bundesgesundheitsbl.* 2024. 10.1007/s00103-024-03987-2 [published Online First: 4 December 2024].
19. Torenz R, Vollmer H, Eckardt S et al. Data on regional availability and accessibility of abortion providers in Germany. Res Health Serv Reg 2023;2(1).
20. Hahn D, Thonke I, Das Projekt ELSA-. Erfahrungen und Lebenslagen ungewollt Schwangerer. Angebote der Beratung und Versorgung: Konzept und Hintergründe der Studie. In: Repschläger U, Schulte C, Osterkamp N, eds. Beiträge und Analysen: Gesundheitswesen aktuell 2023. Köln 2023:190–209.
21. Hanschmidt F, Linde K, Hilbert A, et al. Abortion Stigma: A Systematic Review. Perspect Sex Reprod Health. 2016;48(4):169–77. 10.1363/48e8516 . [published Online First: 31 March 2016].
22. Goffman E. Stigma: notes on the management of spoiled identity. Goffman E. editor: New Jersey: Penguin Books; 1963.
23. Foucault M. Der Wille zum Wissen. 1st ed. Frankfurt am Main: Suhrkamp; 1983.
24. Goffman E, Stigma. Über Techniken d. Bewältigung beschädigter Identität. 26th ed. Frankfurt am Main: Suhrkamp; 2018.
25. Helfferich C. Familie und Geschlecht. 1st ed. Stuttgart: UTB GmbH; Barbara Budrich; 2017.
26. Hahn D. Modernisierung und Biopolitik: Sterilisation und Schwangerschaftsabbruch in Deutschland nach 1945. Frankfurt, New York: Campus; 2000.
27. Kumar A. Disgust, stigma, and the politics of abortion. Feminism Psychol. 2018;28(4):530–38. 10.1177/0959353518765572 . [published Online First: 19 April 2018].
28. Strong J, Coast E, Nandagiri R, Abortion. Stigma, and Intersectionality. In: Handbook of Social Sciences and Global Public Health. Cham: Springer International Publishing 2023:1579–600.
29. Bernard M, Niemann J-K, Weinhold L et al. Abortion stigma among abortion seekers, healthcare professionals and the public in high-income countries: A mixed-methods systematic review protocol. BMJ Open 2024.