

Anti-Abortion Violence Is Gender-Based Violence

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Violence has no place in health care. For generations, abortion providers and patients have been targeted by the opposition through sustained campaigns of harassment, surveillance, and intimidation. These are not isolated incidents or heated protests. Anti-abortion violence is a broad pattern of gender-based violence that undermines access to health care and civil rights. My research shows how anti-abortion violence is enabled by weak enforcement, political inaction, and laws that increase gender inequity. To advance reproductive freedom, policymakers must confront anti-abortion violence directly and invest in strategies that defend bodily autonomy and protect those who provide, seek, and aid in care.

Violence as Policy

The legal and physical threats that shape the post-Dobbs reality are not spontaneous eruptions of extremism. They are strategic expressions of power rooted in a long history of regulating gender, sexuality, and reproduction. Harassment, surveillance, and violence against abortion providers and patients are designed to instill fear and enforce control. My research documents how these tactics operate in tandem with state power, using informal intimidation and formal criminalization to punish care and silence dissent. Together, these harms form a system of reproductive coercion that suppresses gender equity.

Ending national protections for abortion increased violence at clinics. Anti-abortion violence is a nationwide problem documented since Roe by the [National Abortion Federation](#). In the years leading up to the Dobbs decision, abortion providers experienced record levels of obstruction, including a 600% increase in stalking and a 128% increase in clinic invasions. One in five clinics reported an assault or battery. These attacks have escalated. Since Dobbs, clinics have reported nearly 130,000 instances of picketing, over 600 cases of trespassing, 296 death threats or threats of harm, and 38 incidents of assault and battery. These acts are more frequent, coordinated, and increasingly targeted at communities already vulnerable to state and social control.

At a Midwestern clinic, I observed how gendered violence was normalized by inaction. Police refused to intervene as protestors blocked patients from leaving the driveway until they could “counsel” them. Local laws were weaponized to cite clinics for overgrown hedges and signage violations, but never to protect those threatened inside.

Harassment extended beyond the sidewalk. Protesters photographed people at the clinic without consent and posted their images online. Providers were surveilled, identified, and targeted in online forums, where their names and workplaces were distributed to incite further intimidation. Activists live-streamed “funerals for the unborn,” inventing baby names based on the racial appearance of patients. A woman holding a clipboard documented every car that entered the parking lot for reasons unknown. Privacy could not be protected

outside the clinic doors.

Clinics must manage risk without state support at high operational and emotional costs. Staff and volunteers engage in time-intensive safety work, including de-escalation training, coordinated entry protocols, and spatial management of protest zones. These practices divert resources from care delivery and contribute to chronic burnout, as workers are asked to absorb both the threat and the labor of violence prevention without institutional support.

At the same time, clinics must devote scarce resources to staying open. Clinics must keep abortion affordable, absorb the costs of legal battles over medically unnecessary regulations, and prepare for sudden shifts in law that threaten licensure or criminalize care. Providers must defend their facility while simultaneously offering care, managing legal risk, and fighting to preserve their existence.

This reliance on providers and volunteers to shoulder these burdens underscores a deeper, systemic problem. Local and state governments, as well as law enforcement, often fail to intervene. Government inaction leaves providers and patients vulnerable to ongoing harassment and threats. The lack of coordinated public response to anti-abortion violence allows these tactics to continue unchecked, resulting in the further entrenchment of fear and stigma around reproductive care.

Abortion bans require violence to enforce, and the absence of clinics does not protect communities from anti-abortion violence. A post-Dobbs justice system is primed to treat pregnant people as suspects rather than patients. These actions erode gender equity, undermine public trust, and threaten civil rights. In Georgia, a 24-year-old woman was **arrested and charged** with concealing a death after experiencing a miscarriage at 19 weeks, despite later confirmation that the miscarriage was natural and the fetus showed no signs of life. Law enforcement in Texas used license plate readers to track abortion seekers across state lines, including a **2025 case** where a sheriff's office searched a nationwide camera network to locate a woman who had self-managed an abortion. The Sheriff defended his actions by claiming concern for her safety. These are examples of enforcement that polices gender rather than protect life.

Strategies for Reproductive Safety

Access to the full spectrum of reproductive health care must become a national priority, and safety is vital to access. Safety includes enforcing laws protecting clinics from violence, such as the **Freedom of Access to Clinic Entrances (FACE) Act**. Providers, patients, and abortion aid groups need expanded protections for digital harassment and stalking and dedicated resources to address repeat offenses. Equally important is investment in local, community-based safety strategies that respond to the risks people face on the ground without involving law enforcement. In South Bend, a zoning variance to install a short fence and a row of prickly bushes provided safety infrastructure to control crowds without dialing 911.

Policy reform should start with bodily autonomy, a key principle of gender equity, to protect people's right to make decisions about their own bodies without coercion or control. Law enforcement is decisive in determining whether bodily autonomy is respected or violated. When police choose not to pursue investigations or arrests related to personal health decisions, they help reduce harm. Conversely, when the justice system surveils abortion seekers, shares patient data across state lines, or stands by as protestors intimidate patients and staff, they transform public safety infrastructure into a tool of coercion. In these

moments, the state actively authorizes the violation of bodily autonomy through the selective application of the law and order.

Confronting Violence

Anti-abortion violence operates as a method of gendered control. It reinforces gender hierarchies, undermines bodily autonomy, and isolates the people and institutions that provide care. The same states advancing abortion bans are often leading attacks on trans rights, LGBTQ+ youth, and racial equity. These are intersecting threats that demand an integrated policy response.

Abortion restrictions are enforced through violence that targets people for their gender, identity, and reproductive decisions. Policy choices, institutional neglect, and political indifference sustain gender-based violence. Reproductive freedom requires bold, coordinated action to transform the systems that enable harassment, surveillance, and punishment. Building a future rooted in gender equity means confronting violence directly and creating conditions where everyone can live, parent, and seek care without fear.