Feminist initiatives supporting self-managed abortion in legally restrictive settings of Latin America and the Caribbean: Social Inequalities and Quality of Care

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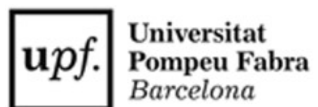

To all the women and gender nonconforming people seeking for an abortion in an unsupportive environment, this work is for you.

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Abstract

In this thesis our aim was to understand social inequalities and quality of care in feminist initiatives supporting self-managed abortion in legally restrictive settings of Latin America and the Caribbean. The thesis includes four studies. In the first one, we conducted a multilevel analysis to examine social inequalities in access and utilization of a feminist telehealth service in Brazil. In the second one, we analyzed post-abortion complications and treatment among Latin American women who used Women on Web service. In the third one, we used a qualitative methodology to understand feminist activists' perspectives and strategies around quality of abortion care. In the last study, also qualitative, we studied abortion trajectories, experiences with self-managed abortion and assessments of the quality of the care among women who were supported by Women Help Women in Chile. We found evidence of social inequalities linked to age, race, social class and territory, in abortion trajectories, experiences, access and outcomes. We also found that feminist activists contribute with novel elements to the conceptualization and practice of good quality abortion care, particularly in the domains of safety and patient-centeredness.

Resumen

El objetivo de esta tesis fue comprender las desigualdades sociales y la calidad de la atención en iniciativas feministas que apoyan el aborto autogestionado en contextos legalmente restrictivos de América Latina y el Caribe. Realizamos cuatro estudios. En el primero, llevamos a cabo un análisis multinivel para examinar las desigualdades sociales en el acceso y la utilización de un servicio de telesalud feminista en Brasil. En el segundo, analizamos las complicaciones tratamientos postaborto entre mujeres latinoamericanas que utilizaron el servicio Women on Web. En el tercero, realizamos un estudio cualitativo con activistas de ocho organizaciones feministas que operan en la región para comprender sus perspectivas y estrategias en torno a la calidad de la atención. En el último estudio, también cualitativo, estudiamos las trayectorias del aborto, las experiencias con el aborto autogestionado y las evaluaciones de la calidad de la atención entre mujeres que fueron apoyadas por Women Help Women en Chile. Encontramos evidencias de desigualdades sociales basadas en la edad, la raza, la clase social y el territorio en las trayectorias, el acceso, las experiencias y los resultados del aborto. También encontramos que las activistas feministas aportan elementos novedosos a la conceptualización y la práctica de la buena calidad de la atención del aborto, particularmente en los dominios de seguridad y atención centrada en las usuarias.

PREFACE

"The willful creation of new meaning,
new loci of meaning, and new ways of being, together, in the world,
seems to me in these mortally dangerous times the best hope we have"

Marilyn Frye (1992, 9)

As a long time activist for abortion access, two common lines of thought regarding abortion particularly piqued my academic curiosity. First, the common idea among the feminist and medical communities that to guarantee good quality care, abortion must be legalized and medicalized. That is, be under the control and authority of medical professionals and be practiced only in the facilities of formal health systems. Although there is extensive experience of autonomous health initiatives and, more recently, of the movement supporting self-managed abortion, this assumption is maintained in the still common feminist slogan "*aborto legal, en el hospital*" (legal abortion, in the hospital). Second, our limited knowledge about abortion-related inequalities. Despite the general "sensitivity" to the issue of inequalities in access to abortion, apparent in the slogan "las ricas abortan, las pobres mujeren" (rich women abort, poor women die), we knew very little about inequalities, and the idea that autonomous access to abortion pills would magically make structural inequalities disappear seemed to be becoming more and more common.

This thesis was born out of academic curiosity, as well as an activist desire to contribute to a better understanding of the quality of abortion care and abortion-related inequalities. It was developed along

the path that links academia with activism, from the certainty that a rigorous study of the functioning of the world in which we live can – and must– be useful to dismantle the injustices this world is plagued with.

My research was developed in two places: First, the *Agència de Salut Pública de Barcelona* (Public Health Agency of Barcelona, ASPB), where I had the invaluable support and guidance of my supervisors, Laia Palència and Carme Borrell in my doctorate and Glòria Perez and Laia Palència in my Master of Public Health.The ASPB is where I have learned most of what I know about how good research is done. Following the work of my supervisors at the ASPB, I have also learned how to apply research to improve people's lives and move toward social justice.

The second place was Women Help Women (WHW), an international activist organization working on abortion access, of which I was a member from the organization's inception until very recently. WHW gave me the opportunity to work side by side with radical and bold feminist activists who are committed to making abortion access possible, despite stigma, restrictive laws, and political and logistical setbacks. My activism with WHW informed and shaped my research work and also gave me the opportunity to apply my learning to practice.

With this thesis, I hope to contribute to the body of research that is making self-managed abortion better understood as a safe and effective abortion method, suitable for diverse contexts and people, and with the potential to disrupt common assumptions about the relationship between healthcare systems and people who use them. I also hope to contribute to the goal that every person who needs it has access to a safe, supported and good quality abortions.

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CHAPTER 1

INTRODUCTION

This thesis examines feminist initiatives providing support for self-managed abortion in legally restrictive settings of Latin America and the Caribbean, using the conceptual frameworks of health inequalities and quality of care. This first chapter introduces the regional context, describes the conceptual frameworks used and explains the rationale for the selection of a research subject. Finally, the objectives and hypothesis are stated.

1. Background

Latin America and the Caribbean is one of the regions with the most restrictive abortion laws in the world. The vast majority of women of reproductive age in the region (approximately 97%) live in countries that penalize abortion highly (Guttmacher, 2018). This means that abortion seekers risk being prosecuted and even incarcerated when deciding to interrupt a pregnancy outside the very limited exceptions to abortion bans (Zaragocin et al., 2018; García et.al., 2019, Casas & Vivaldi 2014). In addition to the legal restrictions, there is also social and individual stigma, making abortion more difficult to access and an intervention carried out in secrecy by most pregnant people (Hanschmidt et.al., 2016; Rossier et.al., 2021).

Despite the legal restrictions and widespread stigma, the region has one of the highest incidences of abortion in the world: The abortion rate for Latin America from 2015-2019 was 32 abortions per 1,000 women of reproductive age (Bearak et. al., 2020). For comparison, in Europe and North America, where most territories have relatively liberal abortion laws, the abortion rate in the same period was 17 abortions per 1,000 women of reproductive age (Bearak et. al., 2020).

Figure 1: Map of legal regulations for abortion in Latin America and the Caribbean. In green, countries that allow abortion on demand, in yellow countries that allow abortion on some grounds and in red countries that ban abortion altogether. Reproduced from Tactical Technology Collective, 2018.

This complex relationship between legality, morality and women's desires may explain why this region was also the breeding ground for a discovery that radically changed abortion access and experiences. In an attempt to fulfill their reproductive desires despite the legal and social norms, Brazilian women discovered the

abortifacient effect of misoprostol, a prostaglandin analog that was at that time (the 1980s) approved to treat gastric ulcers (Barbosa & Arilhia, 1993). In the next decade, health professionals identified a change in abortion methods: instead of the then common invasive and risky practices that occurred at private clinics or were performed by women themselves, such as the use of herbs, injections and perforating instruments, more and more women were arriving at hospitals after having used misoprostol to induce abortions (Ministerio da Saúde, 2009). Researchers then started documenting this practice and now, decades after the Brazilian women's revolutionary discovery, misoprostol is recognized as a safe method to induce abortions with limited involvement by health professionals (World Health Organization, 2012). Currently, misoprostol alone or in combination with mifepristone is the method of choice in a wide variety of contexts globally, including in countries where abortion services are offered legally (Popinchalk & Sedgh, 2019). Moreover, misoprostol has been credited with decreasing abortion-related morbidity and mortality, particularly in low and middle-income countries, which are also those with more restrictive abortion laws (Singh, 2006).

Despite being a moral property of women[1], access to medication abortion is still limited for hundreds of thousands of abortion seekers, including those in Latin America and the Caribbean (Berer, 2017). To overcome this and other barriers to abortion access and women's rights, feminist organizations and networks around the world have developed initiatives that provide support for self-managed abortion.

Self-managed medication abortion has been defined as the "overall management of the medical abortion when one or more aspects of the process occurs outside of a clinical context" (Wainwright et.al.,

1 In 1988, the French government rightfully declared mifepristone the "moral property of women" and forced the French branch of the company holding the patent to continue producing the drug when the company refused to do so. While the moral property of Brazilian women over their own discovery of the abortifacient effect of misoprostol has never been formally recognized, the tremendous advance in science they ignited should also be acknowledged as women's moral property.

2016). The feminist organizing around self-managed medication abortion, or—in public health terms—their models of care, are diverse and are always tailored to specific sociopolitical environments. In this thesis, three types of feminist models of care are studied.

The first type is abortion hotlines, which are local or national organizations providing telephone information on how to buy and use misoprostol to pregnant people who can access the drugs through other sources (local pharmacies, parallel market, Internet). Their legal basis are the human right to information and to benefit from scientific advances (Drovetta, 2015; Mines Cuenya et al., 2013) and they generally operate openly in restrictive contexts. This means that they publicize their telephone number so that they can be contacted by pregnant people.

The second type are accompaniment groups. These are local and national groups and activist networks that, in addition to providing information on medical abortion, accompany pregnant people in person during their abortion processes and, in many cases, facilitate access to medications. Although some of these groups are public and visible (Zurbriggen et al., 2019), most of them operate clandestinely, meaning they do not publicly disseminate their work or their identities, and pregnant people can only access their support through acquaintances and mutual support networks (Walsh, 2020).

Finally, the third type are e-health services. These are international Internet-based organizations that provide access to medical abortion to pregnant people living in restrictive contexts. They operate from territories where abortion is legal and deliver medications by mail in exchange for a donation. Most of these services also provide information and accompaniment to women during the abortion process electronically (e-mail, instant messaging systems, etc.) (Jelinska & Yanow, 2017). Many organizations operating in Latin America and the Caribbean combine different elements of these models of care.
These different types of feminist models of care also differ in the way they approach laws and legal restrictions. Abortion hotlines circumvent restrictions by limiting their work to providing

information, which is legal in most contexts and guaranteed by international treaties (Erdman, 2012). The best known accompaniment groups publicly confront restrictive laws (Zurbriggen et al., 2019; Zarco Iturbe et al., 2020) and their work has been instrumental in some of the recent legal changes in the region, such as decriminalization in Mexico and Argentina. Others, living in contexts that pose higher risks for activists' and pregnant people's security, do not confront or circumvent the laws. They limit themselves to providing practical support in a discreet manner that solves practical needs while protecting the security of the people involved (Walsh, 2020). Finally, e-health services and other organizations use the legality of abortion in some territories to support those who live in more restrictive environments, using online platforms, by providing travel support and access to pills and information (Jelinska & Yanow, 2017; Zarco Iturbe & López Uribe, 2020).

2. Conceptual frameworks

The central concepts in this thesis are inequalities in abortion access and quality of abortion care. These two conceptual frameworks represent two sides of the same coin. The health inequalities framework allows examination of the causes of the unequal and unjust distribution of abortion care and to understand the mechanisms that permit unequal distribution of access to safe abortion among groups of population, going beyond the traditional approach that looks at the legal status of abortion as the only determinant of safe abortion access. Using the quality of care framework—a framework largely applied to study service provision in formal healthcare facilities—to examine informal abortion support initiatives allows to make visible the resistance and the feminist organizing that has emerged in unjust contexts to tackle the issue of access to safe (and good) abortion care, as well as the development of feminist health practices.

This chapter explains the conceptual frameworks forming the basis of this work, the understandings underpinning each of the concepts included, the evidence supporting their inclusion in these

frameworks and how our research findings shed light on these concepts, along with a proposed study framework.

2.1 Health Inequalities and the Social Determinants of Abortion Care

We took the framework of social determinants of health inequalities created by the Spanish Commission to Reduce Social Inequalities in Health (Comisión para Reducir las Desigualdades Sociales en Salud en España, 2010) as a point of departure to develop a novel framework to explain inequalities in access to safe abortions in contexts where abortion is restricted by law (Figure 2). A review was also conducted of abortion and other conceptual frameworks with a similar perspective (CSDH, 2008; Artazcoz et. al., 2019; Vásquez-Vera et al., 2021; Coast et.al., 2018).

The term health inequalities refers to unfair, avoidable and systematic differences in the health status of population groups. These differences are socially produced by the unequal distribution of resources and power and are marked by social, economic, geographic and demographic lines (Borrell & Malmusi, 2010). Our framework of social determinants of inequalities in safe abortion access includes structural and intermediate determinants. In this framework, the structural determinants encompass the socioeconomic and political context and the axes of inequality (social class, gender, age, ethnicity and territory). These structures determine the distribution of abortion access through exposure to intermediate determinants. Intermediate determinants include material resources, working and living conditions, and unpaid domestic and care work, among others. Together with structural determinants, intermediate determinants have an impact on psychosocial, biological and behavioral factors and, finally, on the health status of populations and individuals.

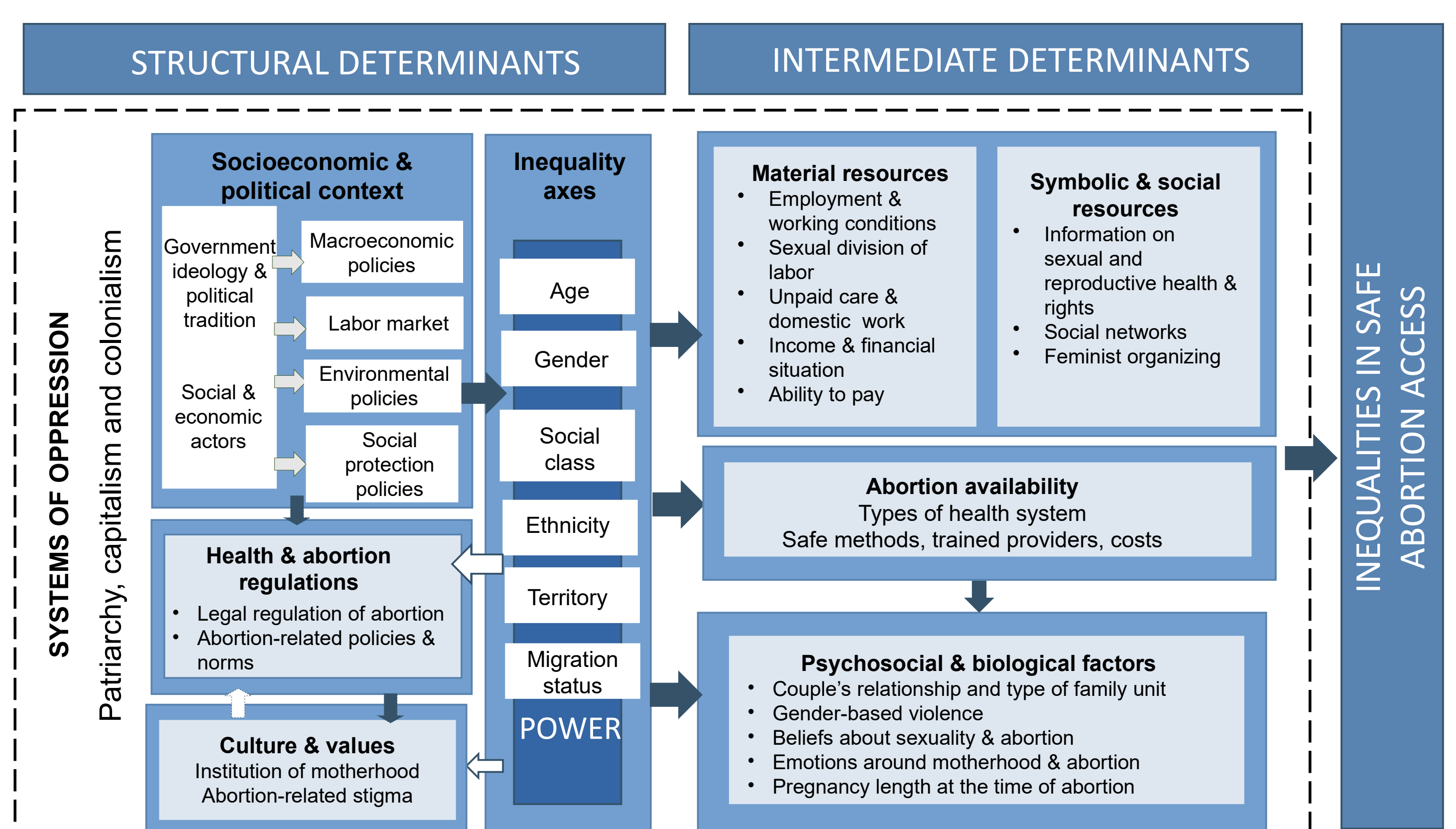

Figure 2. Conceptual framework for the analysis of social determinants of inequalities in safe abortion access. Personal compilation.

2.1.1 Systems of Oppression

Patriarchy, capitalism and colonialism are the systems of oppression that configure the macro-level context in which access to abortion happens. Thus, in this framework, these systems surround all the other determinants of inequalities in abortion access.

In this thesis, **patriarchy** refers to a social system based on male domination and centrality, where "manhood and masculinity are more closely associated with being human and femininity relegated to the marginal position of 'other'" (Johnson, 2004. p. 29). Patriarchy is thus "a system of male domination and female subordination" (Hunnicut, 2009. p. 553) that expresses itself in diverse ways depending on the historical, political and cultural contexts (Hunnicut, 2009).

Gender systems are one of the ways in which social relationships, subjectivities and the distribution of power are organized in a patriarchal world. Gender systems are understood as the social structures that define the differentiated roles, opportunities, expectations and resources based on gender. Gender inequalities are the main characteristic of a patriarchal social system, where people's power, opportunities for self-determination, rights, access to resources, and health status are determined by a gendered, hierarchical and unequal division of the world (Ridgeway and Correll, 2004). The gender system also defines the number of genders and the—also subordinated and othered—place occupied by gender nonconforming people in a society. Here, gender nonconforming is defined as an umbrella term to identify persons who do not align with the gender identity commonly associated with the sex they were assigned at birth. For the case of abortion, it includes trans men (people who were assigned female sex at birth and identify with a masculine gender), gender non-binary people (people who were assigned female sex at birth and do not identify with masculine or feminine genders) and some intersex people (people whose genitalia does not correspond with the binary category of male or female and who can become pregnant).

However, patriarchy is not the only oppression system that configures power and resource distribution in today's societies. **Capitalism**, an economic and political system based on private ownership of property, means of production and wealth, and the accumulation of resources that comes with it, intersects with patriarchy to configure an unequal system based on several hierarchic social categories (Federicci, 2018).

First, capitalism is an oppression system based on social class. Social classes are categories of people that are based on work, income and prestige, and are a product of the social division of labor among those who own the means of production and live from the surplus generated by it, and those who work to subsist.

Second, capitalism is based on a sexual division of labor. Here, the sexual division of labor refers to the division between reproductive and productive work. In capitalism, reproductive labor, or the care and domestic work necessary for the reproduction of life, has been conceptualized as private work and is attributed to women and other feminized subjects. Productive labor, or the work needed to produce commodities, is attributed to men and happens in the public sphere (Federicci, 2018). Sexual division of labor is associated with profound inequalities between the material and symbolic recognition of private and public labor, which includes the neglect of the recognition of reproductive work as labor and, thus, its lack of material recognition in the form of a salary (Federicci, 2018).

Another characteristic of capitalism is that it is based on spoliation and exploitation. The industrial and technological development under the capitalist system is dependent on the human ability to extract as many resources as possible from nature, working classes and non-male subjects. In capitalism, raw material is extracted from nature. Labor is extracted from specific groups of human beings in a context of spoliation of the product of the work (which is appropriated by the owners of the means of production) and exploitation of the labor force. Care and sexual work are extracted particularly from women and other feminized subjects in the form of motherhood and childbearing, paid and unpaid sexual services and emotional support.

The third division of labor characterizing capitalism is the international division of labor, which enables extractivism by expanding capitalism to new territories. The need to extract as much as possible gave rise to the colonial system as we currently know it (Quijano, 2000). **Colonialism** started with the expansion projects of the European nations in the fifteenth century and developed as the establishment of a new global system based on extractivism, spoliation and exploitation that continues developing today.

One of the fundamental ideas that sustains capitalism and its international division of labor is the idea of race. The concept of race was created along with the colonial enterprise and served the purposes of distinguishing the colonizers from the colonized, and naturalizing the global unequal distribution of power and resources. That is, the concept of race enabled the idea that racialized people (the colonized) are naturally inferior to white people (the colonizers), which persists in the still common assumption that people are divided by phenotype characteristics (Quijano, 2000). As a consequence, a fourth division of labor, that is, a racial division of labor and its subsequent racialized distribution of power and wealth also exists in the bases of capitalism as we know it. The racialized division of labor, which in its inception existed only between territories in the world, is now reproduced among peoples in the same countries.

In summary, even though each of the definitions of these oppression systems follows distinct lines of hierarchy and inequality (gender for patriarchy, social class for capitalism and territory/race for colonialism), the fact is that these three systems have been intertwined since their inception. Gendered, classist, colonial and racist oppression compound each other and impact societies as a whole, but also have differentiated effects on individuals and groups of people with different material conditions and identity markers. This means that people and groups occupy a different place in the social hierarchy based on attributes such as their gender, social class, origins, ethnicity and race. These places determine the forms in which social relationships, subjectivities and cultures are (re) produced.

2.1.2 Structural Determinants

At the structural level we have included the socioeconomic and political contexts, health and abortion policy and legislation, culture and values, and the axes of inequality.

- Socioeconomic and political context

The socioeconomic and political context encompasses **governments and political traditions** and **social and economic actors** that together determine **macroeconomic policies**, **job markets**, and **environmental and social protection policies**. While Latin America and the Caribbean is far from being a homogeneous region, all countries in the region share a common history of colonialism, spoliation and authoritarianism. As a result, the region is one of the most unequal in the world. Structural problems such as poverty, economic inequality, job informality, and lack of access to basic services and social protection have also affected the region historically. According to projections for 2020, around 37% of the population in the region lives in poverty or extreme poverty (CEPAL, 2021) and this rate is even higher for women, people living in rural areas, people of indigenous or African descent and single-parent households (CEPAL, 2021). On the other hand, the richest 20% of the population concentrates between 46% and 58% of the total income (CEPAL, 2021). This rampant socioeconomic inequality results in health disparities both inside and among countries in the region (Cardona et al., 2013).

Macroeconomic policies, the labor market, environmental and social protection policies are important determinants of childbearing intention, which in turn affects abortion rates (Sigh et al., 2010). In Latin America and the Caribbean, more than half of pregnancies are unplanned, and it is estimated that one out of three unplanned pregnancies results in unplanned births (Sigh et al., 2010).

Abortion rates and unintended pregnancies ending in abortion also vary according to the country’s income level (Bearak et al., 2020). Abortion rates are higher in middle- and lower-income countries,

unintended pregnancies are higher in countries with lower income, and the proportion of pregnancies ending in abortion is higher in middle- and higher-income countries. These findings suggest that people in low-income countries face more unintended pregnancies and that people in high-income countries generally have better access to sexual and reproductive health care (Bearak et al., 2020), showing a relationship between the level of economic growth in a country, sexual and reproductive health needs and access to abortion care.

Examples of how governments and their **political traditions and ideologies** determine abortion politics are abundant in Latin America and the Caribbean, particularly after the shift toward left wing politics that took place in the region during the first two decades of the 21st century. In their study of abortion politics in this political era, Blofield & Ewig (2017) developed a conceptual model that explains abortion liberalization through key factors in the political context. According to their framework, the following elements are enablers of abortion liberalization: supportive public opinion, secularization, feminist mobilization that is stronger than conservative mobilization (including religious actors), left wing majorities in executive and legislative powers and the type of left wing government, which they categorize as institutionalized partisan left, movement left, populist left and populist machine left (Blofield et. al., 2017).

Uruguay was the first country in South America to decriminalize abortion in 2012, with a bill presented in congress by the leftist Frente Amplio, a coalition of parties that supported the farmer and president José Mujica (Blofield et. al., 2017). The bill was supported by the feminist movement and organizations of health professionals. The reasons that explain the success of Uruguay in changing the law are an institutionalized left wing party in power both in the executive and in the legislature, a secularized society, strong feminist mobilization and strong public opinion in favor of abortion liberalization (Blofield et. al., 2017).

However, Chile, Ecuador and Nicaragua had different outcomes after attempts at abortion liberalization despite having governments

with apparently similar political ideologies. These different outcomes are also explained by a combination of socioeconomic and political factors.

In Chile, therapeutic abortion—the interruption of a pregnancy to protect the pregnant person's health and life—was legal from 1931 to 1989 (Dides et. al., 2015). During an eight-month period under the socialist government of Salvador Allende (1970–1973), health professionals interpreted this clause liberally and openly provided abortion and post-abortion care in public hospitals (Monreal, 1979). This practice changed when dictator Augusto Pinochet seized power, but only at the end of his military dictatorship was abortion formally penalized in all circumstances, including therapeutic abortion (Dides et. al., 2015). In 2006, Michelle Bachelet, a physician, was elected president. Representing Concertación de Partidos por la Democacia, a coalition of leftist and centrist parties that governed Chile in the first years of its return to democracy (Alfaro Monsalve et. Atl., 2015), Bachelet was the first woman in South America to be elected president. During the first presidential period of Michelle Bachelet, the debate on the social status of women and their sexual and reproductive health and rights gained momentum, but it was only during her second presidential period that Bachelet publicly supported the decriminalization of abortion. In 2017, with Bachelet still in the presidency, both Congress and Senate passed a bill that decriminalized abortion when performed by health professionals on three grounds: to save the life of a pregnant person, for fatal fetal anomalies, and in cases of rape (Huneeus et al., 2020). A key factor in the successful legal reform was the support of some members of the Christian Democratic Party, which voted in favor of the bill despite their confessional program because it only decriminalized abortion under limited grounds, linked to humanitarian reasons (Blofield et. al., 2017).

At the time of writing this thesis, the Chilean congress has approved a new bill that would decriminalize abortion on demand until the 14th week of pregnancy. Two features of the current political context seem important in this abortion liberalization enterprise and its result. First, the regained people's power that led to the creation of a Constituent Assembly that will write a new constitution, after

the 2019 social protests. Second, the fact that a conservative right wing government is still in power despite the generalized social discontent. It remains to be seen how this political context will influence the possibility of decriminalizing abortion until week 14th, thus advancing in the realization of the right to abortion among a majority of Chilean women.

In Ecuador, a country with a highly restrictive abortion law that only allowed abortion to protect the health and life of the pregnant person and in cases of rape in "mentally unfit" women, the debate about abortion decriminalization was blocked during the ten years of government of Rafael Correa, a leftist economist who was elected president in 2007. In 2008, during the inaugural act of the Assembly that would reform the Ecuadorian constitution, Correa threatened to resign the presidency if the new constitution included any changes related to abortion. Correa's threat ended in a new constitution that guarantees the protection of life from the moment of conception (Castello, 2013). In 2013, several female members of his party, Alianza País, supported by feminist organizations, presented a bill to extend abortion decriminalization in cases of rape to all women. The congresswomen who supported the bill were accused of treason by Correa and the Ethics Committee of the party decided to temporarily suspend these congresswomen from the party, arguing that they were working for an independent agenda that was opposed to the party's position (Blofield et. al., 2017). In 2021, four years after the end of Correa's era, the Constitutional Court declared the penal code articles criminalizing abortion in cases of rape unconstitutional, after a demand presented by feminist organizations and women's rights groups. This virtual cancellation of the debate around abortion during the left wing era in Ecuador, can be explained by the type of leftist government represented by Correa: a non-institutionalized party that concentrates most power under the charismatic figure of one leader, which makes the charismatic leader's personal stances a central element of the political debate (Blofield et. al., 2017).

Similarly, the current president of Nicaragua, former Sandinista militant Daniel Ortega, has supported for 15 years the total abortion ban that was passed in the country under a rightwing government in

2006, days before his election. While historically the Frente Sandinista por la Liberación Nacional was a revolutionary party that supported popular demands and women's rights, in the last decades it became what Blofield and Ewig (2017) call a "populist machine left". That is, a party with a personalistic leadership, clientelist strategies and high concentration of power, and where the party's former socialist ideology has been replaced by a fluid ideology linked to Ortega's personal beliefs. In this context, and after receiving the support of Catholic and Evangelic leaders during one of his campaigns for presidency, Ortega publicly announced his opposition to abortion rights and adopted a religious rhetoric. Despite the mobilization of feminist organizations and networks, the few proposals to review the total abortion ban have been unsuccessful since 2006 (Blofield et al., 2017).

Nevertheless, other countries in the region had seen similar trends under right wing governments. In recent years, Brazilian women have been confronted by the tightening of barriers to access legal abortion services under the extreme conservative government of Jair Bolsonaro. While there have not been any legal changes to abortion regulation, discourses against feminism, abortion and "gender ideology" have permeated Brazilian public spheres and are starting to see their way through public agendas and policies(De Aguiar et al., 2019). Moreover, fear of criminalization and political retaliation, and attempts to further restrict sexual and reproductive rights, continue to mark the Brazilian political context under Bolsonaro's government.

In the Dominican Republic a total ban on abortion was passed in 2009 and has persisted since, despite several attempts to decriminalize abortion on three grounds, with the support of several presidents and the feminist movement. The constitutional tribunal and both Congress and Senate have blocked every attempt to liberalize abortion. Conservative movements and religious leaders overpowering feminist mobilization seem to be the key to explain the persistence of the total ban (Sandoval-Mantilla et. al., 2018).

In Honduras, abortion was completely banned in 1985 and has remained banned since then. While women's rights organizations

and the feminist movement have made several unsuccessful attempts to reform the penal code, the backlash against women's reproductive rights—which includes the penalization of emergency contraception in 2009 populist machine left—continues to be sustained by a right wing government that rose to power after a coup in 2009 (García et.al., 2019).

- Health and abortion policy and legislation

Health and abortion policy and legislation are another important group of structural determinants of inequalities in abortion access. This group includes the **legal regulation of abortion** and **policies and norms** that are not strictly about abortion but relate directly or indirectly with its practice.

Despite being a medical procedure, abortion has been regulated in the penal codes in many countries around the world, including in Latin America and the Caribbean, where abortion regulation varies from country to country (Ishola et al., 2021). The Dominican Republic, Honduras, Nicaragua, El Salvador, Haiti and Suriname ban abortion altogether. Uruguay, Cuba, Argentina and several states of Mexico[2] generally allow abortion, but establish some restrictions to its practice. The remaining countries—the majority of the countries in the region—generally prohibit abortion, but have authorized some exceptions to abortion bans (also known as causales) including when the pregnancy endangers the health or life of the pregnant person, when it is result of a rape, when fetal abnormalities are present, and for some socioeconomic reasons (Guttmacher, 2018). Outside the causales, abortion is generally punishable with prison for both abortion seekers and providers and, in some cases, for people who support them (Berro Pizzarossa & Skuster, 2021).

2 While I was writing this thesis, the Constitutional Tribunal of Mexico declared the unconstitutionality of abortion penalization. This means that the state level laws will now have to change to accommodate this national legal precedent. However, it is still too soon to know how and when this decision will impact abortion access in states that currently have restrictive abortion laws.

Broad evidence shows that people seek abortions even when prohibited by law (Bearak et al. 2020), and the advent of self-managed medication abortion has proved that safe abortion access is possible even in legally restrictive settings (Gomperts et al., 2008; Gerdts & Hudaya, 2016; Zubriggen et al., 2019). However, access to safe abortion services is still determined by the legal regulation of abortion: laws that criminalize or restrict abortion make access to safe services harder. In addition to determining whether or not abortion is a lawful practice, laws and policies often include clauses that restrict abortion access for some specific groups of people, or that criminalize self-managed abortion, making it more challenging for people to have a safe abortion outside the formal health system.

Abortion provision is also regulated in norms that establish who can perform an abortion and in which facilities, whether reporting is mandatory in cases of rape, pregnancy length limits, and mandatory "reflection" periods that pregnant people must endure before being able to legally access an abortion, etc. While these requirements are established in the penal code or in abortion laws in some countries, in others they are included in secondary or apparently unrelated norms, such as medical guidelines, health system models, lists of prohibited drugs, among others (Berer, 2017). In practice, these norms determine the availability of providers and safe methods. Other norms that affect abortion provision, access to services and choice of safe methods are those that regulate importation of medicines for personal use, patient's right to privacy and confidentiality, health professional's right to conscientious objection, and censorship of online information, among others.

An important example of how an apparently unrelated norm impacts abortion access is the regulation of the distribution and use of misoprostol. While misoprostol is available through pharmacies in most countries in Latin America and the Caribbean—which facilitates access to a relatively safe abortion method—at least in 17 countries of the region a prescription is required for its purchase. Uruguay, Chile and Brazil have further restricted misoprostol distribution by limiting it to designated health facilities (Casas & Vivaldi, 2014; Berro Pizarroza & Stuker, 2021; Assis, 2020). These

regulations affect access to safe abortion by making abortion medication harder to obtain, limiting options to clandestine surgical abortions, and forcing pregnant people to take legal and health risks when buying abortion medication from unknown vendors on the parallel market.

The case of Uruguay is a good example of how health and abortion policies and legislation can restrict abortion access even when created with the opposite aim. As discussed above, in Uruguay, a new abortion law was implemented in 2012 to permit abortion on demand until the 12th week of pregnancy, in cases of rape until the 14th week, and without time limits when the pregnancy endangers the health of the pregnant person. However, the law also established that for abortions to be non-punishable in these cases, the pregnant person must comply with a complicated procedure consisting of a series of medical consultations, receiving an authorization and information from a board of three health professionals, and a mandatory waiting period of five days (Berro Pizarroza & Stuker, 2021). Additionally, according to the law, abortions must be performed during an in-person consultation with a doctor (Ishola et. al., 2021; Berro Pizarroza & Stuker, 2021). In 2013, the Ministry of Health updated its medicines list and determined that misoprostol could only be distributed in hospitals (Berro Pizarroza & Stuker, 2021). Although abortion is generally legal in Uruguay, the way it is regulated implies barriers for people who cannot access the formal health system, such as irregular migrants, people seeking the abortion later in pregnancy or those who want or need to self-manage using misoprostol.

- Culture and values

Culture and values are also an important piece of the puzzle of inequalities in abortion access, because they determine individual and societal opinions and sentiments about abortion. One of the ways in which culture and values are related to beliefs and perceptions around abortion is through the **institution of motherhood**. Following Adrianne Rich (1986), this thesis distinguishes between motherhood as an experience and

motherhood as an institution. The experience of motherhood refers to the lived experience of supporting a child during their development. While this duty has been historically ascribed to the female giving birth to the child, it can also be performed by other people. On the other hand, here, the institution of motherhood is defined as a social, symbolic and ideological system grounded in the idea that a woman's ultimate fulfillment is to be a mother, and that all women (and gender nonconforming people who can conceive) should be mothers. This social mandate of mothering gives rise to the idea of the existence of two kinds of women, one that is capable and willing to comply with her feminine duty, and is thus symbolized as fertile, nurturing and pure, and another that is unable or unwilling to fulfill her duty, and is thus depicted as evil, barren and impure. The institution of motherhood is functional to the sexual division of labor in which mothering is classified as a feminine role (Rich, 1986).

The institution of motherhood is also associated with psychosocial and biological factors that determine abortion access. Social expectations for women and gender nonconforming people are defined in relation to the institution of motherhood. Women's expectations, desires and ambitions around fertility, family, work and personal fulfillment, as well as their perceptions and emotions around motherhood are also, at least partly, determined in relation with the idea of motherhood as fulfillment. By refusing to comply with the patriarchal mandate to procreate, people who have abortions challenge the institution of motherhood and the values that come with it, which are often embedded in the legal systems that make abortion a crime (Rich, 1986).

Challenging social and legal norms is often associated with stigma, and this is also true for the case of abortion (Norris et al., 2011). **Abortion-related stigma** is another salient feature of the hegemonic cultural beliefs configuring the context in which abortions take place in Latin American and the Caribbean (DePiñeres et al., 2017; Zamberlin et al., 2012, Zurbriggen et al., 2019).

Abortion-related stigma refers to the social ascription of negative attributes to people who have abortions and their partners and providers (Norris et al., 2011). It is expressed as fear of social judgment, self-judgment, silence and shame among people who have abortions, and those related to abortion in other ways. For people who have abortions, stigma comes from the social belief that they fall short of the ideals of womanhood, which include mandatory motherhood as an institution (Kumar et al., 2009) and other strong social institutions such as religion and family (McMurtrie, 2012; Biggs et al., 2019; Blofield et. al., 2017). Research in the region has shown how abortion-related stigma acts as a barrier to safe abortion access, and also makes abortion trajectories and experiences more difficult and demanding (DePiñeres et al., 2017; Zamberlin et al., 2012; Hanschmidt et al., 2016; Rossier et al., 2021, McMurtrie, 2012). In addition, stigma acts as a deterrent to the availability of abortion services, because it creates an unsupportive environment for health professionals who could provide abortion services. For abortion providers, the stigma comes from the belief that abortion is dirty and unhealthy, which is also reproduced in anti-choice strategies that attribute personhood to the fetus and use stigma as a powerful political tool (Norris et al., 2011). Research in the region has found that abortion-related stigma is often reproduced in medical education and healthcare institutions (Cevallos, 2011, Biggs et al., 2019). As a result, prospective abortion providers in highly stigmatizing contexts often worry about being viewed negatively by their peers and clients (Biggs et al., 2019). Abortion providers have also reported feeling isolated and discriminated against (Hanschmidt et al., 2016).

Through the institution of motherhood and abortion-related stigma, culture and values are also associated with abortion and health regulations. In the issue of abortion, regulations are plagued with stigmatizing views about abortion and women, which is apparent in the mandatory waiting periods before accessing an abortion and the regulations that place power over the decision around abortion in the hands of health professionals rather than in those of pregnant people. Simultaneously, stigmatizing views about abortion are often anchored in the fact that abortion is considered a crime (Norris et al., 2011). In fact, while abortion-related stigma can survive

abortion law liberalization (Cárdenas et al., 2018; DePiñeres et al., 2017), it is often compounded by legal restrictions.

- Axes of inequality

Axes of inequality determine the distribution of power and operate transversely on all social determinants of health (Borrell and Malmusi, 2010). These axes can also be understood as the lines that divide the groups among which there is an unequal distribution of symbolic and material resources. Thus, they both affect and are affected by the socioeconomic and political context and, through intermediate determinants, impact social inequalities in safe abortion access.

In Latin America and the Caribbean, it is well known that persons suffering the most from the consequences of unsafe abortions are women belonging to marginalized groups of society. However, inequality also impacts societies as a whole and determines abortion incidence, access and trajectories in a deeply contextual way.

Regarding **age**, young and impoverished women are at higher risk of dying from unsafe abortions (Organización Mundial de la Salud, 2012) and they are more likely to be criminalized for an abortion (García et al., 2019; Cruz Sánchez, 2011, Zaragocin et al., 2018, Citizen's Coalition, 2014). Depending on the regulatory context, girls and young women who have not yet reached the age of majority may also encounter additional barriers to access pre- and post-abortion services, such as medical consultations, ultrasound scans and emergency care, as well as greater difficulties in accessing legal abortion services when permitted by law. In their review of the regional evidence on pregnancy and abortion among girls aged 15 years or younger, Escobar et al. (2019) found that the lack of clarity on processes and protocols for the provision of abortion services to girls and adolescents may act as a barrier to access. They also found added legal barriers, including norms that require parental consent or the authorization of a judge when parents are not involved in the abortion process (Escobar et al., 2019).

There is also evidence that educational level and socioeconomic position (both related to **social class**) are associated with differences in abortion incidence, decision-making, access and trajectories. For instance, a study conducted in Mexico City (Becker et al., 2011) found that education level was associated with barriers to accessing abortion services. They found that less educated women had greater difficulties in getting a medical appointment, arranging transportation and getting time off work for the abortion procedure (Becker et al., 2011). A national abortion survey in Brazil found that the incidence of abortion varies by socioeconomic position, with low-income women having a higher abortion incidence (Diniz et al., 2017). In contrast, an analysis of a representative sample of young women in Chile found that women with higher socioeconomic status have a higher abortion incidence (Huneeus et al., 2020). In Buenos Aires, Argentina, Petracci et al. (2012) found that abortion decision-making and trajectories differ according to socioeconomic background. While impoverished women carried their first pregnancy to term and aborted the second one, middle-class women first had abortions and then had children.

Research on the links between abortion, race and **ethnicity** in the region are generally scarce. However, a few studies in the region show that the incidence of abortion varies according to race: in Brazil abortion is more frequent among black, brown and indigenous women (Diniz et al., 2017), while in Cuba the incidence is higher among white women (Cabezas-García et al., 1998). Additionally, as described above, research on criminalization and unsafe abortion shows that a higher incidence of abortion, unsafe abortion and criminalization are more common among impoverished and rural women. In Latin America and the Caribbean, most racialized populations, particularly from African and Indigenous descent are poor and live in rural areas (CEPAL, 2021).

Territory is another important driver of health inequalities. Exposure to health risks, the prevalence of health conditions and access to healthcare facilities are unequally distributed among countries in Latin America and the Caribbean and among territories

in the same countries (Cardona et al., 2013). In the case of abortion, research shows that abortion incidence and trajectories also vary by territories. For example, in Brazil, abortion is more frequent in the less developed regions (Domingues et al., 2020). In Honduras, Ecuador, Mexico and El Salvador, researchers have found that women from rural areas are more likely to face criminal charges after an abortion (García et al., 2019; Zaracocin et al., 2018; Cruz Sánchez, 2011, Citizen's Coalition, 2014).

Migration status affects abortion access, experiences and trajectories in two important ways. On the one hand, having migrated, and particularly being an undocumented migrant, can pose particular barriers to accessing health services in general. In the case of abortion, these services include, pre- and post-abortion services as well as legal abortions when they are available. For instance, in the case of Uruguay, the law establishes that, to access legal abortion services, a person must be a legal resident of the country for at least one year. This, added to the harsh restrictions on misoprostol distribution, leaves recent and undocumented migrants with virtually no options to access a legal abortion (Stifani et al., 2018). One the other hand, having migrated often means a decrease in the amount of individual social capital. Social capital, in the form of social relationships that facilitate access to knowledge, contacts and information, is a critical tool for accessing safe abortion services, as will be described in the next section. Thus, the difference between seeking an abortion while being a regular resident of a country or a recent migrant, can translate into accessing a safe and supported abortion or an unsafe one in isolation.

Finally, abortion has been traditionally seen as a “women’s issue”, making everything about abortion gendered. Thus, legal regulations, social and cultural institutions and beliefs, psychosocial and behavioral factors, are all based on patriarchal views about women. Additionally, particular difficulties arise for **gender** nonconforming people who become pregnant.

Although data on gender nonconforming people’s experiences with abortion are scarce, it is well established that their experiences with

healthcare often include discrimination based on gender identity, limited provider knowledge, delay and denial of services and added economic difficulties in accessing care (Moseson et al., 2021). Compounded by abortion being a strongly gendered issue, traditionally associated with female gender identities, it is likely that these barriers also affect gender nonconforming people seeking abortion information and services. A study conducted in the United States showed that gender nonconforming people often prefer medication abortion over surgical abortion because of the added need for privacy during the procedure (Moseson et al., 2021).

2.1.3 Intermediate determinants

Access to safe abortion is determined by social structures through a set of intermediate drivers. At the intermediate level, we have included material resources, symbolic and social resources, abortion availability, and psychosocial, behavioral and biological factors.

- Material resources

Material resources include **employment and working conditions**, the **burden of unpaid care and domestic work**, **income and financial situation** and, through them, the **ability to pay** for abortion services.

As described above, access to material resources is determined by structural elements such as macroeconomic policies and the sexual division of labor. In turn, the availability of material resources often impacts the decision to have an abortion. For example, women cite being unemployed, wanting to keep a job, having financial problems or having to take care of their children or other dependents as reasons for an abortion (Wollum et al., 2021). Moreover, in contexts where employment conditions are marked by insecurity, informality, scarcity and domination (CEPAL, 2021; Borgeaud-Garciandía, 2014), it is likely that women decide to terminate a pregnancy in order to keep a job, as described by a study in the Kancheepuram district of India (Anandhi, 2007).

Material resources are also associated with access to abortion in a variety of ways. Pregnant people need to take time off work and domestic responsibilities to seek information, find a service, attend medical appointments or have a self-managed abortion. They also need money to pay for the abortion, and many also need to pay for transportation and accommodation if they need to travel to access the service and pay for childcare and other dependent people's care (Coast et al., 2021).
The ability to pay for abortion and abortion-related services will ultimately determine access to safe abortion methods. This means that inequalities in income, financial situation, autonomy over financial decisions, the burden of unpaid care and domestic work and fund raising ability, translate into inequalities in safe abortion access.

- Symbolic and social resources

Material resources are not the only kind of resources that mediate safe abortion access. Symbolic and social resources are also important determinants of abortion access and can sometimes even replace the need for material resources to access abortion services.

Following Bourdieu's conceptualization of social capital, that is, the "resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance or recognition" (Bourdieu 1986, p. 248), we understand social resources as the result of participating in social relationships and networks that can provide information, emotional and financial support, accompaniment and, ultimately, access to safe abortion methods.

In our framework, social capital is understood as both an individual and collective feature. Individual social capital includes social resources such as information on sexual and reproductive health and rights, which can facilitate or pose barriers to accessing abortion services and information. Collective social capital includes social networks and feminist organizing. This means that on top of being a relevant social actor in the context of abortion, as described above,

feminist organizations and the ability of feminists to collectively organize are important sources of social capital for some women, and are also a source of abortion information and services.

Additionally, in a context where sexual education and **information on sexual and reproductive health and rights** are limited and often of poor quality (Kostrzewa, 2008; Córdova Pozo et al., 2015), people access information via informal channels, including the internet, peers and social networks, pharmacists and national and international organizations (Berro Pizarrosa & Nandagiri, 2021). Information facilitates decision-making and access to abortion services (Zamberlin et al., 2012). As most information about abortion on the internet is untrustworthy or biased (Han et al., 2020), people depend on the information they can access through acquaintances, friends and organizations to identify reliable information on the internet. The connections forged in educational institutions can also be important sources of relationships and information. For instance, a previous study in Chile found that university students accessed abortion medication, information and support through students and feminist organizations and other networks of young people (Palma-Manríquez et al., 2018).

Simultaneously, individuals and collectives that spread misinformation, campaign against abortion rights and disseminate stigmatizing views on abortion (widely called the anti-rights movement, but not limited to organized efforts to impose barriers to abortion) can limit safe abortion access (Berro Pizarrosa & Nandagiri, 2021). Thus, the concept of **social networks** as defined in the conceptual framework in this thesis pinpoints two ways in which social capital can influence abortion access. On the one hand, social capital is beneficial for abortion seekers who are involved in **feminist activism**, for those who have acquaintances in the feminist movement and for those who are related to networks of health professionals. On the other hand, social capital can have a negative impact among people belonging to conservative social networks (i.e. anti-rights activists, very religious families), because it strengthens stigma, making the decision on abortion harder to make and share with others and services more difficult to access.

- Abortion availability

The availability of safe methods refers to the existence of facilities, providers, equipment and supplies needed to provide safe abortion. Abortion availability determines the monetary costs of accessing services, the time it will take to find those services and, consequently, the pregnancy length at the time of the abortion (Zurbriggen et al., 2019; Coast et al., 2021).

The characteristics of a **health system** also have implications on abortion access. Important factors that also impact who can access safe abortion services are whether the health system is private, public or mixed and to what extent, whether informal care practices exist and are legitimate, and whether or not public funding or insurance coverage for abortion-related services exists (Coast et al., 2021). For example, if pregnancy tests, ultrasound scans and post-abortion care are expensive or inaccessible, access to safe abortion methods is more difficult and it is more likely that people will have abortions later in pregnancy. This increases the risk of medical complications and can make safe methods, such as misoprostol, not so safe anymore (Coast et al., 2021, Zurbriggen et al., 2019).

Additionally, as described above, the socioeconomic and political context, policies and legislation, stigma and collective social resources such the existence of feminist organizing and committed health professionals determines the availability of **safe abortion services and methods**. For instance, government and political tradition can impact health professionals' willingness to provide abortions, by increasing the fear of criminal charges stigmatization (Barrios et al., 2018; Kumar et al., 2009). Norms that allow for extended rights to conscientious objection also decrease the availability of abortion providers (Montero & Villarruel, 2018). Feminist organizations willing to support abortion access have improved abortion availability in the region (Zurbriggen et al., 2019; Walsh, 2020; Drovetta, 2015).

- Psychosocial and biological factors

The implications of an unwanted or unplanned pregnancy differ among women, depending on their personal circumstances as well as on their expectations and emotions regarding motherhood, relationships, family and abortion. Moreover, psychosocial factors intersect with material, symbolic and social conditions to determine abortion trajectories (Coast et al., 2018).

Regarding the **type of couple's relationship and family unit**, in a study in Argentina women mentioned the couple not working anymore, being in a new relationship or in one that is carried out clandestinely because of social norms, as reasons to have an abortion (Petracci et al., 2012). In the process of deciding what to do with an unplanned pregnancy, people often take into account the kind of support they can expect from their partner and other members of the family unit, both to interrupt a pregnancy or to carry it to term (Petracci et al., 2012). In a review of studies in Latin America, Zamberlin et al. found that the support of partners, female relatives and close friends can help with gathering the money to pay for the abortion, can make abortion experiences easier, and can also facilitate childcare during the abortion process (Zamberlin et al., 2012).

Experiences of **gender-based violence** also impact abortion trajectories and decision-making. Women mention being in an abusive relationship or the pregnancy being the result of rape as reasons for its interruption (Wollum et al., 2021; Petracci et al., 2012; Coast et al., 2018; Zurbriggen et al., 2019).

Beliefs about sexuality and abortion, which are closely linked with the patriarchal system and the culture and values related to it, can also be important drivers of unwanted pregnancies and influence abortion decision-making, trajectories and experiences. For example, patriarchal beliefs and cultural norms that assign women the sole responsibility for contraception may be the reason for unwanted pregnancies (Zurbriggen et al., 2019). Women who are ashamed about extramarital sex may choose to terminate a pregnancy in order to keep the sexual relationship that resulted in the pregnancy a secret. Women who believe abortion is not morally right may take longer to make a decision and seek abortion services

(Zurbriggen et al., 2019), or may choose to have the abortion alone for fear of disclosing the pregnancy in an unsupportive environment (Zamberlin et al., 2012).

Emotions and expectations around motherhood and abortion are also linked to patriarchal cultural institutions, such as the institution of motherhood (Rich, 1986), and impact the way women deal with an unwanted pregnancy, including the abortion experience. Conflicting beliefs and emotions around abortion often arise from the internalization of the expectations established in the institution of motherhood and the ideals of womanhood (Rich, 1986; Kumar et al., 2009). When women have conflicting beliefs and emotions, or live in a context that does not support the decision to terminate a pregnancy, the decision-making process becomes more challenging and may take longer, making it more likely that the abortion will happen later in pregnancy (Zurbriggen et al., 2019). In contrast, women who have a clear idea of the conditions in which they want to have children, or a perception of high self-efficacy, are able find services faster, making it easier for them to have an early abortion (Zurbriggen et al., 2019). Stigma is also related to psychosocial factors: the more stigma someone experiences the more likely it is for them to have adverse emotional outcomes after the abortion (Norris et al., 2011; Zamberlin et al., 2012).

Finally, **pregnancy length** is a biological factor that is closely linked to the possibility of accessing safe abortion services. At the beginning of the pregnancy, and particularly in the first 12 weeks, it is easier to find safer abortion methods, including self-managing a medication abortion. However, the longer the pregnancy, the harder and more expensive it is to access a safe method. In the second trimester of pregnancy, complications are more common and safe abortion options depend more on the availability of trained providers and appropriate facilities and equipment. Women who have abortions in the second trimester describe a wide range of factors that trigger delays in confirming the pregnancy, which in turn makes the decision and the process of seeking and accessing services harder (Zurbriggen et al., 2019).

For instance, physiological factors such as bleeding during the first weeks of the pregnancy—that may be mistaken as menstruation—or having a history of irregular menstrual cycles, can cause delays in suspecting and confirming the pregnancy. Psychosocial factors such as the ones mentioned above (moral conflicts, relationship instability and gender-based violence) are other reasons for seeking abortions in the second trimester (Zurbriggen et al., 2019). In addition, economic difficulties, challenges in finding information, stigma and criminalization are also drivers of delays (Coast et al., 2021; Zurbriggen et al., 2019). As a result, the behavioral factor of the timing of the decision to abort and the biological factor of the pregnancy length at the moment of the abortion are both linked to other intermediate and structural determinants such as the ability to pay for abortion services, the availability of safe abortion methods, stigma and secrecy, legal restrictions and access to social support.

2.2 Quality of Abortion Care

This thesis was started using the World Health Organization framework on Quality of Care (WHO, 2006). This framework was developed as a tool to understand and improve quality of care in a wide array of health services and improve health systems design and planning. The framework includes six dimensions of quality of care: effectiveness, efficiency, accessibility, acceptability/patient-centeredness, equity and security (Figure 3).

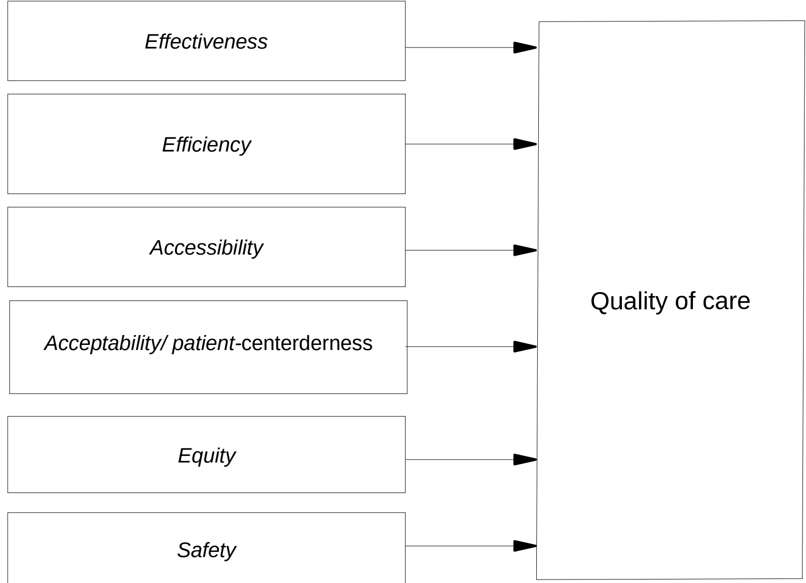

Figure 3: Conceptual Framework of Quality of Care. Based on WHO. Quality of Care (2006).

After the start of data collection, it became apparent that this conceptual framework was not the best choice for the study of quality of care in the work of feminist organizations providing abortion support. Several factors made us arrive to this conclusion.

In the WHO framework, **effectiveness** is defined as the capacity to offer evidence-based health care that results in an improvement in the health status of individuals and communities, based on the need for care (WHO, 2006). However, on approaching feminist abortion support initiatives, it became evident that they were not thinking about their work as health care provision but as political projects aiming to facilitate women's and gender nonconforming people's autonomy (Zurbriggen et al., 2019; Larrea & Palència et al., 2021). Thus, the health outcomes traditionally used as indicators of the effectiveness of an abortion service, such as successfully ending the pregnancy and having a complete abortion, are not good indicators of the quality of the support these feminists provide. Instead, the

focus when assessing this kind of service should also be on whether or not they are enabling the user's autonomy.

The WHO defines **efficiency** as avoiding waste of resources. However, this definition has been extensively discussed and the general agreement now is that while efficiency is an important indicator of a system's performance it is not necessarily a good indicator of quality of care (Busse et al., 2019). Moreover, in the case of feminist initiatives, the relationship with resources differs from that of formal health systems. While in formal services the relationship between resource expenditure and health outcomes is important, in these initiatives, activists are opposed to thinking about material resources in these terms. Thus, the efficiency of the feminist abortion support work studied herein could be evaluated by assessing the relationship between the resources they spend and the steps forward in achieving their political goal, which is women and gender nonconforming people accessing good quality abortion services, either through feminist support services or in formal health facilities, which would imply a change in social and legal norms.

Accessibility is defined as the delivery of care that is timely, geographically reasonable and provided in an environment in which resources are appropriate to medical need (WHO, 2006). While the direct actions organized by these feminist activists aim to provide support that is timely, their geographical scope and the quantity and quality of their resources (in relation to need) are not necessarily the best indicator of accessibility to their initiatives. While activist projects supporting self-managed abortion often do not cover large geographical areas and have limited resources, they have found alternative ways to deal with issues of accessibility. For instance, they deal with continuity of care by building networks of activists, providers and health professionals where they can refer people in need of medical care (Burton et al., 2016).

Acceptability and patient-centered care are defined as the delivery of health care that takes into consideration the preferences and aspirations of users and their cultures and communities (WHO, 2006). While feminist activists strive to provide care that is centered in the needs of the people they support, they are critical of the idea

that an acceptable service should adapt to the culture and preferences of the pregnant person. In contrast, most of their initiatives have the political aim of contributing to changing heteropatriarchal cultures and values.

According to the WHO framework, **equity** entails delivering services that do not vary in quality according to personal characteristics such as gender, race, ethnicity, geographic location or socioeconomic status. However, feminist initiatives show how the idea of equity as providing service that does not vary in quality because of the personal characteristics of users is not the only possible way to define equity. In contrast, feminists have designed models of care that are directed to people who can become pregnant (cis-women, and some gender nonconforming people) and that are tailored to personal needs that are often related to personal characteristics and contexts. Additionally, activists in the initiatives studied herein think about equity in terms of social and reproductive justice (Ross, 2017), which implies acknowledging the different needs of people with diverse material conditions and identity markers, and aiming to take these structural differences into account when providing support.

Finally, in the WHO framework **safety** is understood as providing a service that minimizes risk and harm to users. While feminist activists supporting self-managed abortion do aim to diminish risk and harm, their definitions of the harms and risks that should be reduced by an abortion support initiative include a number of social and legal risks and harms that are not usually part of the definition of safety in medical services, which are generally focused on health outcomes.

By grounding their work on feminist ethics, activists have developed new definitions of dimensions of quality of care, including novel elements that—while central in the conceptualization of health from a feminist perspective—have not been included in mainstream approaches to quality of care. This is particularly true regarding the dimensions of patient-centeredness, safety and autonomy.

Once the research for this thesis had revealed these findings, conceptual frameworks were sought that focus on the quality of sexual and reproductive health services. This was because the history of the concept of sexual and reproductive health is closely linked to feminist theories and the work done by feminist scholars to ensure that women are able to access health services and are treated with dignity and respect when doing so (Ross, 2017).

We first looked into frameworks that explain quality of abortion care and found that while there is a general agreement that evaluating and improving abortion care quality is relevant, there is no standard definition of it (Darney et al., 2018). In a recent systematic review, Dennis et al. (2017) found that only a few indicators of quality of abortion care are commonly used across different approaches. Among them, the most cited indicators measure the availability of trained providers, the service's accessibility, whether women are treated with dignity and respect and supported in their decisions, whether appropriate referrals are provided and the rates of complications and mortality due to abortion (Dennis et al., 2017). While some of these commonly used indicators could be applied to the feminist abortion care analyzed here, not all indicators were applicable. More specifically, the focus on facilities, professional training of providers and the measurement of mortality and facility-based treatment for complications did not apply to the work of feminist activists. Thus, in the next part of this section, we discuss conceptual frameworks that would be more appropriate to assess these dimensions of quality of care in feminist initiatives and highlight the conceptual contributions that arise from our study on quality of care.

2.2.1 Patient-centeredness

Many reproductive health frameworks include patient-centeredness as a dimension of quality of care. Patient-centeredness in reproductive health care has been defined as "Providing reproductive health care that is respectful of and responsive to individual women and their families' preferences, needs and values, and ensuring that their values guide all clinical decisions"

(Sudhinaraset et al., 2017. P. 3). In developing a conceptual framework based on this definition, Sudhinaraset et al. propose eight domains of quality of reproductive care: dignity, autonomy, privacy/confidentiality, communication, social support, supportive care, trust, and health facility environment.

In this framework, dignity is defined as receiving care in a respectful and caring setting. Autonomy refers to providers respecting women's views on their own treatment and supporting women and their companions to make informed choices. Privacy/confidentiality refers to the provision of care in a setting that allows for the protection of medical records and of privileged communication between patients and providers. Communication refers to health professionals providing clear explanations on women's health conditions and the options for treatment. Social support is understood as the extent to which women can be accompanied by a person of their choice while receiving care. Supportive care is defined as providing care that is timely, compassionate, caring, and responsive to women's needs. Trust refers to women feeling they are receiving complete and truthful information about their condition and treatment, and whether they have confidence in the provider's competence. Finally, the health facility environment refers to the structural and material conditions of the facility where care is being provided, including appropriate equipment and resources, hygiene and whether the staff feels respected, valued and supported. The framework also takes into account cultural and social determinants of health, healthcare seeking behaviors and provision of care, as shown in Figure 4.

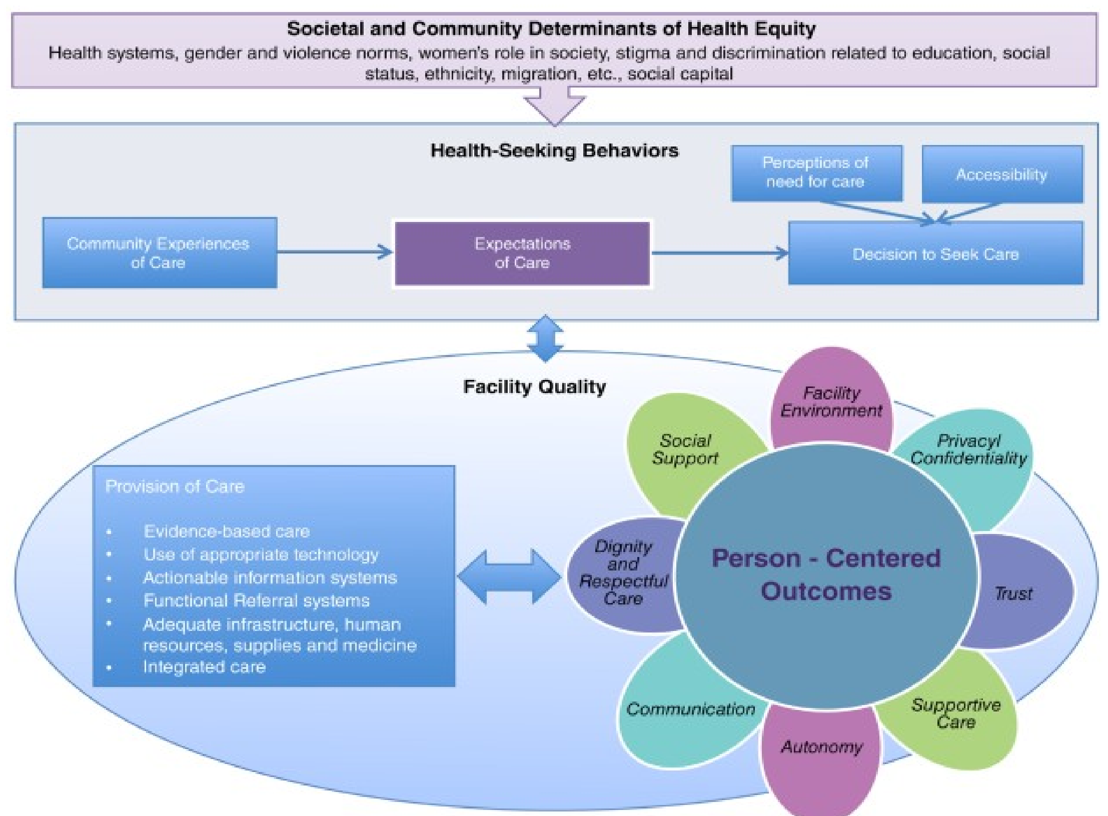

Figure 4. Person-Centered Care Framework for Reproductive Equity. Source: Reproduced from Sudhinaraset, et al., 2017.

2.2.2 Safety

Safety in abortion care has traditionally been measured as the rates of post-abortion complications and mortality. Until very recently, estimates of the proportions of safe and unsafe abortions were almost solely based on the legal status of abortion (Ganatra et al., 2017). This changed with the advent of medication abortion, which provided a safer alternative that does not depend on healthcare facilities and medical professionals. However, since abortion is a socially controversial issue and abortion provision is determined by a combination of structural and intermediate factors that include but are not limited to the legal regulation of abortion, other important determinants such as gender systems and abortion-related stigma should also be taken into account. Thus, abortion safety should be understood as an issue that encompasses social, legal and health factors. Based on the results of the present work, Figure 5 shows the definition of safety as a dimension of quality of abortion care that is used in this thesis.

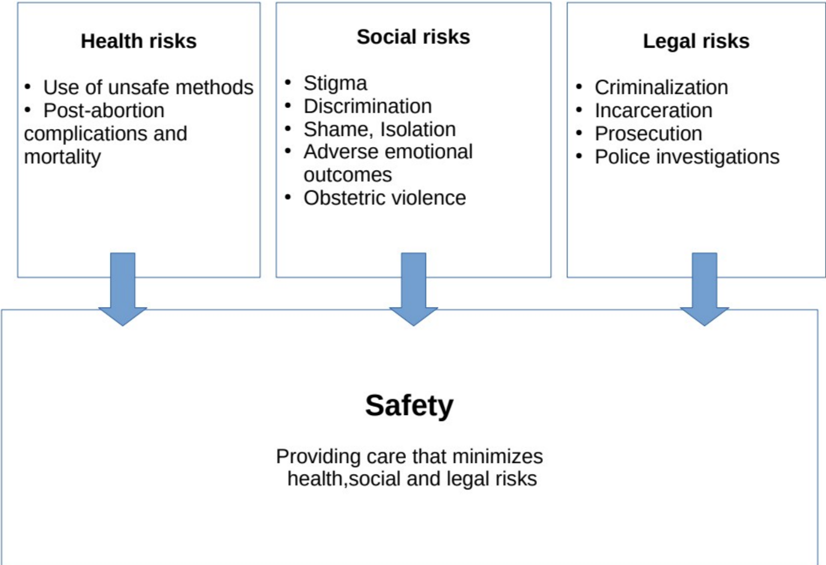

Figure 5. Safety as a Dimension of Quality of Abortion Care. Source: personal compilation.

As with every medical procedure, abortion poses some risks to health. With medication abortion, serious complications are rare and the most common complications include infection, incomplete abortion, hemorrhage, and a continuing pregnancy. All these complications are treatable with appropriate healthcare (Hamoda et al., 2003; Niinimäki et al., 2011; Fjerstad et al., 2009; Shannon et al., 2004). This means that in assessing safety in a self-managed abortion, one important indicator should be whether or not the care provider can enable users to access post-abortion care in case it is needed. This can be done in a number of ways, including providing information on how to access public or private services, establishing networks with health professionals or creating referral networks.

Social risks in abortion care include those related to stigma, such as discrimination, shame and isolation, and adverse emotional outcomes (Kumar et al., 2009; Norris, 2011). It also includes risks related to the regulation of the distribution of abortion medicines, such as the risk of being scammed when trying to buy mifepristone and misoprostol in the parallel market (DePiñeres et al., 2017) and being subject of obstetric violence, including denial and delay of legal services, verbal, physical and sexual abuse, and failure to meet standards of care (Larrea & Assis et al., 2021). The main legal risk when having an abortion in a legally restricted setting is being criminalized. Examples of criminalization during an abortion procedure include people being investigated while receiving care at the hospital, incarcerations and other legal penalties such as community work (García et al., 2019; Zaragocin et al., 2018).

We thus propose that safety in abortion care should be defined as providing care that minimizes health, social and legal risks and harms. In doing so, some dimensions of quality of care are fundamental. For example, ensuring confidentiality and privacy in abortion provision would help to diminish social stigmatization, discrimination and shame. It would also decrease the risk of being criminalized. Permitting the provision of high-quality and accessible abortion medicines in the formal market would reduce the risk of being scammed. The availability of trained providers, equipment and facilities when relevant as well as of evidence-based

information in both formal and informal healthcare systems, would diminish the health risks related to unsafe abortion.

3. Justification

A few years after the inception of the first feminist organizations supporting self-managed abortion in the first decade of the 2000s, a handful of researchers started analyzing data on their outcomes. Specifically, research performed with the data of Women on Web, a feminist telemedicine service founded in 2004 to provide abortion to people in restricted settings, was the first evidence of the safety, efficiency and acceptability of medication abortion provided through telemedicine by feminist activists (Gomperts et. al, 2008; Gomperts et. al., 2012).

Other researchers also conceptualized the independent use of abortion pills as a harm-reduction strategy that could be applied to increase access to abortion in a variety of settings. Building from previous experiences on harm-reduction strategies applied by activists on HIV and drug use, scholars hypothesized that the provision of information on medication abortion and the support of self-managed abortion would reduce the harms created by stigma, criminalization and lack of access to medication (Erdman, 2012; Hyman et al., 2013). In Latin America, the abortion harm-reduction strategy had already been proved successful in Uruguay, where it was credited with an important role in the implementation of abortion services following legalization in 2012 (Stifani et al., 2018). In 2018, Grossman et al. published an analysis of the outcomes of a harm-reduction initiative implemented in a clinical setting in Peru. They concluded that using misoprostol with the information provided through this harm-reduction model was safe and effective (Grossman et. al., 2018).

However, while closely linked to a feminist view of abortion care, and often conducted by feminist activists themselves, most of the studies performed with a public health perspective did not pay enough attention to the organizing efforts that allowed the creation of feminist models of care, as well as the fundamental link between

feminist activism, the availability of information on medication abortion, and safe abortion provision in restrictive settings (Braine, 2020).

In recent years, a new line of research into the quality of the care provided by feminist initiatives produced a new, more positive, approach to self-managed abortion. For example, in 2016 Gerts and Hudaya published an article describing the characteristics of the users of an abortion hotline in Indonesia. They concluded that abortion hotlines should be evaluated for the quality of their care, and not only for the harm they reduce (Gerdts & Hudaya, 2016). In 2020, Baum et al. published an article assessing the experiences of feminist helplines users in Poland, Brazil and Nigeria. These authors found that, in contrast to the stigmatizing care users had received in formal health services, stories of being supported by feminists showed high-quality and person-centered care (Appendix IV).

While the framework of quality of care is still anchored in the public health field, this perspective enabled researchers to highlight the particularities of feminist abortion care and its potential to improve access and quality. By doing so, researchers increased the visibility of the contributions of feminist care to mainstream sexual and reproductive health care, even when it was not always mentioned explicitly.

Conversely, feminist abortion support initiatives have been studied by social scientists and legal scholars as expressions of feminist organizing. However, these studies have been much less visible in advocacy and dissemination efforts, possibly because their results are not as straightforward as producing evidence-based medicine (Braine, 2020). In this line of research, feminism takes a central role in explaining how self-managed support initiatives came to be, how they function and what they can contribute to the society. In Argentina, there has been prolific production of research on feminism and self-managed abortion. For instance, in 2013 Mines Cuenya et al., founders of the Argentinian abortion hotline Más información, menos riesgos (More information, less risk), published an article discussing the relationship between their experience as

feminist, lesbian and trans-gender activists supporting abortion access, and the development of a demedicalizing, autonomous and empowering discourse around bodily autonomy and abortion. They also problematize essentialist views on gender identity and heterosexuality in abortion support and activism (Mines Cuenya et al., 2013). Socorristas en Red, a national network of feminist organizations providing abortion accompaniment, has been the subject of several studies and publications. These publications include research and reflections on the history of the use of misoprostol in Argentina, including the models of care developed by feminists and militant health professionals in the public health system (Fernández Vázquez & Szwarc, 2018); a description of the alliances between the Socorristas and actors in the public health system (Grosso & Zurbriggen, 2016); a reflection paper on the development process of Socorristas en Red (Grosso et al., 2013), and a self-published book in which Socorristas narrate their experiences of accompanying second trimester abortion, and analyze women's experiences of their accompaniment (Zubriggen et al., 2019).

While the analysis of these feminist initiatives has not been as prolific in other countries in the region, other publications include a pioneer study describing the models of care of hotlines in Argentina, Chile, Ecuador, Peru and Venezuela (Drovetta, 2015), a qualitative study of feminist abortion accompaniment in southern Mexico, Guatemala, Honduras and El Salvador (Walsh, 2020); an examination of how clandestine abortion is practiced in Chile, which underscores the centrality of a feminist hotline (Casas & Vivaldi, 2014), and an analysis of several feminist abortion support initiatives as autonomous health movements (Braine, 2020).

One of the characteristics shared by these investigations is that they are generally carried out by activists or allied researchers who study a feminist practice that they either support or are involved with. Thus, research on feminist support for self-managed abortion is an example of how activist-research can be useful to build knowledge about a healthcare practice with roots in a social movement. While the amount of publications and research projects focusing on self-managed abortion has grown exponentially in the last few years,

there are still some research gaps that need to be filled. These are described below.

First, from a public health and epidemiological perspective, there is a lack of analysis on how structural inequalities are (re)produced in feminist initiatives, on who are the people accessing and using feminist abortion support and how their material conditions and identity markers impact the experiences and outcomes of self-managed abortion. The present work aimed to fill this gap by using the health inequalities framework to analyze abortion trajectories, experiences, outcomes and evaluations of quality of abortion care.

Second, from a methodological perspective, there has been a clear discipline divide in the kind of methods used to approach self-managed abortion. While most public health informed research has been quantitative, most social sciences research has been qualitative. By combining quantitative and qualitative methods to approach different aspects of feminist support for self-managed abortion, we aimed to contribute to the creation of "hard evidence" on the existing inequalities and feminist resistance to them. We also aimed to contribute to the understanding of the nuances of personal experiences, perceptions, trajectories and meanings attributed to them, while situating these experiences in the context of unequal and harmful policies and distribution of power and resources. The multidisciplinary and mixed methods approach adopted herein, also allowed the present work to contribute to the visibilization of feminism and feminist organizing and its importance for the advance of medical technologies, abortion provision and its quality.

Finally, the issue of how feminist activists providing support for self-managed abortion approach quality of care has been understudied. By using the quality of care framework to approach activists' perspectives about their own work as well as user perceptions of the care they received, this work aimed to contribute to filling this research gap.

4. Objectives

General objective

The aim in this thesis was to understand social inequalities and quality of care in feminist initiatives supporting self-managed abortion in legally restrictive settings of Latin America and the Caribbean.

Specific objectives

The specific objectives were the following:

1. To describe the socioeconomic characteristics of women and gender nonconforming people who access self-managed abortion support provided by feminist initiatives in the region and to analyze social inequalities in access.
2. To analyze the relationship between users' socioeconomic characteristics and feminist abortion support utilization and outcomes.
3. To determine how feminist activists are conceptualizing quality of abortion care and identify the strategies they have developed to provide high-quality care.
4. To examine how users experience health inequalities and quality of care in feminist abortion support initiatives.

5. Hypotheses

Based on our literature review and previous experience with the subject, the following hypotheses were formulated:

1. Women and gender nonconforming people with diverse socioeconomic characteristics request feminist abortion support. However, the access to these initiatives, as well as their utilization and outcomes, are determined by social and economic factors, which results in social inequalities.
2. From a clinical perspective, the outcomes of medication abortion provided through informal feminist initiatives are similar

to those of the same type of abortion provided in formal health facilities.

3. Feminist activists running abortion support initiatives have conceptualized quality of abortion care from their own perspective, and have developed strategies for its achievement.

4. Women and gender nonconforming people who have had abortions with the support of feminist activists consider the initiatives that supported them to be safe and of good quality. However, their trajectories and experiences vary according to their socioeconomic characteristics and their identity markers.

6. Thesis structure

This thesis is organized in four chapters. Chapter 1 contains background information, the conceptual frameworks used to approach quality of abortion care and inequalities in abortion access, a research justification statement, the study aims and a description of the thesis structure.

Chapter 2 consists of a compilation of articles resulting from the thesis studies. In the first article, soon to be submitted to *Cadernos de Saúde Pública*, we analyzed social inequalities in utilization of a feminist telehealth abortion service in Brazil. The study showed that age, social class, race and region inequalities exist both in access (i.e. requesting the service) and in utilization (i.e. receiving the abortion pills through the service) of this feminist abortion service. An ecologic analysis revealed a strong correlation between service utilization on the one hand, and the percentage of racialized women, the adjusted net school attendance rate and the household income *per capita* on the other.

In the second article, published in *Gaceta Sanitaria*, we assessed self-reported complications and treatment after a medication abortion provided by Women on Web (WoW) in 16 countries of Latin America and the Caribbean. The study shows that while the rates of complications and post-abortion treatment are similar to those of formal abortion provision, socioeconomic deprivation, measured as reports of having had difficulties in donating to WoW

and as having donated less than required, increased the risk of complications (particularly the risk of incomplete abortion) and the risk of receiving a surgical post-abortion intervention.

In the third article, published in Healthcare for Women International, we conducted a qualitative study with activists from eight organizations operating in 17 Latin American and Caribbean countries to understand their perspectives and strategies around quality of abortion care. That study shows that feminist activists have developed models of abortion care that are mostly in line with general definitions of quality of healthcare. However, by applying feminist ethics to health care practice, activists contribute new elements to the understanding of quality of abortion care. They underscore autonomy in reproductive and health care choices, a horizontal perspective for interpersonal relations in healthcare, the potential of new communication and medical technologies to improve efficiency, accessibility and equity and a broader perspective on safety that accounts for legal and social circumstances.

In the fourth article, published in Sexual and Reproductive Health Matters, we conducted a qualitative study with users of Women Help Women (WHW) service that lived in Chile. The article shows that this feminist service is perceived as good, trustworthy, fast and affordable and that users value confidentiality and privacy; the quantity and quality of information; having direct, personalized and timely communication with service staff; and being treated with respect and feeling safe, cared for and supported in their decisions. However, stigma and expectations surrounding motherhood and abortion also determine users' experiences and trajectories, and the dominant feeling in women's narratives was fear. Our analysis underscores how, while good quality abortion care can be provided despite legally restrictive conditions, stigma and the fear of criminalization still determine women's trajectories and experiences of abortion, which makes more structural solutions, such as public funding for abortion care, abortion destigmatization and decriminalization, indispensable.

In Chapter 3, I return to the results of these publications to discuss them in the context of existing research and highlight our contributions to the study field. This chapter also includes reflections on the implications of our results and recommendations for future research and public policy.

Finally, Chapter 4 consists on a series of conclusions that emerged from our research results. The appendix section contains other peer-reviewed publications that I authored during my PhD program. While these publications were not strictly part of my PhD work, the process of producing them contributed new insights about my study subject and some of the results of these articles are also included in the discussion, recommendations and conclusions sections.

CHAPTER 2

ARTICLES

This thesis includes the following articles:

1. Larrea S, Palència L, Assis M, Borrell C. Social inequalities in utilization of a feminist telehealth abortion service in Brazil: a multilevel analysis. [Forthcoming]

2. Larrea S, Palència L, Perez G. Aborto farmacológico dispensado a través de un servicio de telemedicina a mujeres de América Latina: complicaciones y su tratamiento. Gac Sanit. 2015;29(3):198-204

3. Larrea S, Palència L, Borrell C. Medical abortion provision and quality of care: What can be learned from feminist activists? Health Care Women Int. 2021:1-20

4. Larrea S, Hidalgo C, Jacques-Aviñó C, Borrell C. "No one should be alone in living this process": trajectories, experiences and user ' s perceptions about quality of abortion care in a telehealth service in Chile. Sex Reprod Heal M. 2022;29(3):1-13

1. Larrea S, Palència L, Assis M, Borrell C. Social inequalities in utilization of a feminist telehealth abortion service in Brazil: a multilevel analysis. [Forthcoming]

Social inequalities in utilization of a feminist telehealth abortion service in Brazil: a multilevel analysis

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Abstract

Background: In Brazil, abortion services and medication are highly restricted. However, medication abortion is a common method. One of the available sources of abortion pills are international feminist telehealth organizations supporting self-managed abortion. Methods: We conducted a cross-sectional multilevel study to assess how individual and contextual social factors impact utilization of a telehealth service. For the individual-level, we analyzed data from the service records of requesters aged 14-49 years old who contacted the organization during 2019 (n=25,920). Individual-level variables were age, race, education level and pregnancy length. Contextual-level units were Brazilian states, for which we extracted data from the national Demographic Census and Household Surveys. Contextual-level variables where household income *per* capita, adjusted net school attendance rate, percentage of racialized women and income Gini Index. We fitted five multilevel Poisson Mixed-effects models with robust variance, to estimate prevalence ratios (PR) of service utilization. Utilization was defined as receiving the abortion pills through the service. The null model included all the individual-level variables and in Models 1-5 we added one contextual variable in each model. Results: Only 8.2% of requesters got abortion pills through the service. Service utilization was higher among women who were older, white, with higher levels of education and 5-8-weeks pregnant. Independently of this, service utilization was higher in states with higher incomes, higher percentage of educated women and lower percentage of racialized women and in certain regions. Conclusion: While feminist online abortion initiatives provide a life-saving service for some people in highly restrictive contexts, they are incapable of overcoming common social inequalities in its utilization, both at individual and contextual levels.

Key words: Self-managed abortion, misoprostol, mifepristone, social inequalities, abortion access, multilevel analysis

Introduction

Along with other countries in Latin America and the Caribbean, Brazil has a long legacy of colonialism and persistent socioeconomic inequalities[1]. However, during the last couple of decades, the country has seen a sustained decline in economic and health inequalities[2,3]. The decrease in inequalities has been attributed to the establishment of intersectoral policies, labor formalization, increasing in education access and redistributive policies[1,3]. These welfare policies, established after the country's redemocratization, also include the creation of the SUS (*Sistema Único de Saúde*), a unified health system based on the principles of universality, equity, integrality and social participation[4]. As a result, most of the population now has access to institutional delivery and modern contraceptive methods, some of the key indicators of access to reproductive health[4]. However, abortion care remains highly restricted, thus not following a similar pattern, mainly because of its legal regulation.

In Brazil, abortion is criminalized, except in cases of rape, when the pregnancy poses a risk to the life of a pregnant person[5] and when the fetus is anencephalic[6]. Thus, abortion seekers often fall out of the very narrow legal grounds for abortion or find various barriers to access legal services[7,8]. Many of those who cannot access legal services resort to the use of misoprostol. Misoprostol is an analog of prostaglandin that was introduced in the Brazilian market to treat gastric ulcers in 1986. Soon after, Brazilian women discovered its abortifacient effect and started using it to self-induce abortions[9]. Following the discovery of women, Brazilian researchers documented the use of misoprostol to induce abortions[9] and health institutions around the world followed suit. Currently misoprostol is recognized as a safe method to induce abortions with limited health professional's involvement[10] and its use –alone or in combination with mifepristone- is the method of choice in a wide variety of contexts globally, including settings where abortion services are offered legally[11].

Nearly 50% of clandestine abortions in Brazil are done using pills, mainly misoprostol[12]. While this change in abortion methods contributed to a decrease of abortion-related morbidity and mortality[13],

misoprostol still features in the national list of substances and drugs subjected to special control[14]. People cannot access abortion pills in pharmacies, thus procuring them through vendors in the parallel market[15] and international online organizations[16], and risk being criminalized in the process[15, 17]. Feminist organizations facilitating access to medication abortion have operated in Brazil since 2004[16,18]. Based online, these initiatives provide emotional and practical support for abortion self-management. They operate from territories where abortion is legal and deliver mifepristone and misoprostol by mail. A donation of the equivalent of 70-90 Euros is requested from the service users who can donate.

Despite severe legal restrictions, abortion is a common procedure in Brazil. It is estimated that 1 in every 5 women will have at least one abortion by the time they turn 40[12]. While women with diverse socioeconomic positions have abortions, barriers to safe abortion methods disproportionately affect population groups that have been historically marginalized and impoverished[13]. The use of private abortion clinics is more common among women who are white, have higher education levels and income[15], and those who can afford it, travel abroad seeking abortion care[19]. However, abortion incidence is higher among black, brown, and indigenous women and those with lower educational levels[12, 13]. Racialized women, women with low formal education and income levels, single women and women with children are also more likely to have unsafe abortions, to need hospitalization after a self-managed abortion, face more barriers to access post-abortion care and have higher odds of being criminalized[8, 13, 20].

Additionally, regional inequalities exist both in socioeconomic and reproductive health indicators. The North and Northeast regions have a higher proportion of racialized women, particularly black and brown, and their population has generally lower educational levels and lower income[21]. Economic data shows that high development rates remain concentrated in the South, Southeast and Central-West, which translates into lower formal education, higher rates of unemployment and lower *per capita* income in the North and Northeast[22]. Contraceptive use is higher among women in the South, Southeast and Central-West regions[23] and abortion incidence is

higher among women living in the North and Northeast regions[12]. Regional inequality is a problem long acknowledged by political economists in Brazi[24, 25,] and its origin is attributed to the historical social formation of the regions which, in turn, determines the relative population composition of each region, which has been reproduced throughout the centuries[25].

Social and racial inequalities in abortion access and safety have been studied in Brazil at the individual-level[8, 12, 13]. Multilevel analyses have been used to examine adolescent fertility and reproductive behaviors. These analyses indicate that state-level income inequalities, coverage of reproductive health services, maternal mortality rates and regions are associated with adolescent fertility[26-28]. To the best of our knowledge, there are no studies assessing the combined effect of individual and contextual variables on abortion access. Additionally, little is known about the relationship between structural inequalities and utilization of informal initiatives that use the Internet to increase access to safe abortion. During the last few years, and particularly with the advent of COVID-19, Internet-based abortion provision has been continuously growing both in Brazil and around the world[29,30]. With this study, our purpose was to contribute to the understanding of inequalities in abortion access in Brazil by assessing how individual and contextual social factors impact utilization of an online feminist service supporting self-managed abortion.

Methods

Study design and population and information sources

We conducted a cross-sectional multilevel study. Individual-level units were women aged between 14 and 49 years while contextual-level units were Brazilian states. For the individual-level, we used data from the records of a feminist telehealth service. Study participants were living in Brazil, requested the service between January 1st and December 31st 2019, were less than 9 weeks pregnant and between 14 and 49 years old. Upon service request, requesters fill out an online survey containing questions to identify eligibility for medication abortion according to the latest WHO

guidelines available[10]. They are also asked for personal contact information, shipping address and socio-demographic data (age, educational level and race) and a donation of the equivalent of 75 Euro, which can be done via credit card or international bank transfer. People who cannot donate but has answered an automatic email about the donation are still offered the pills. During the study period, around 6% of those who accessed the pills through the service did not donate. A package containing one pill of 200 mg of mifepristone and 8 pills of 200 mcg of misoprostol is shipped to people who fulfill the service requirements. Instructions on how to use the pills as well as detailed information about the abortion process are provided via email in the requester's language. During the study period, 25,920 people requested a medical abortion from the service and 2,121 received the abortion pills.

For the contextual level, we used state-level data from the 2010 Demographic Census and the Annual Continuous National Survey of Households of 2015, 2019 and 2020, conducted by the Brazilian Institute of Geography and Statistics (IBGE).

Variables

Outcome variable

- Service utilization

Defined as having received a package with abortion pills as recorded by the service staff among all those who requested the service (yes/no).

Independent variables

<u>Individual-level</u>

- Age

We calculated age from the date of birth and categorized it as follows for descriptive purposes: 14-19, 20-24, 25-29, 30-34, 35-39

and 40-49 years-old. For the multilevel analysis we used the original continuous variable without the categories.

- Race

Requesters were asked "among the following alternatives, do you recognize or identify yourself as color or race: white, black, brown, yellow, indigenous?" For the descriptive statistics, we maintained the original responses as categories. For the multilevel analysis, we categorized responses as white and racialized, the latter including brown, black, yellow and indigenous women.

- Higher educational level accessed

Requesters are asked "what is the highest level of education you have attained?" and given the following options: Incomplete/complete primary (elementary) education, Incomplete/complete secondary education (high school), incomplete/complete tertiary (technical) education, incomplete/complete university education, incomplete/complete post-graduate education, incomplete/complete doctorate. We categorized responses as basic education (up to complete elementary education), secondary education (up to complete secondary education) and university or more (incomplete tertiary education or more).

- Pregnancy length

Requesters are asked their pregnancy length in weeks and can choose a number of weeks between 4 and ≥ 9 weeks. For those who are 9 weeks or more, an automatic message informing that the service is for people who are less than 9 weeks pregnant appears, and the consultation stops. We categorized pregnancy length as follows: 4 weeks, 5-6 weeks, 7-8 weeks.

<u>Contextual variables</u>

- Adjusted net school attendance rate

It is the percentage of women 18-24 years old who attend school at the appropriate level for their age group, among the total number of women in the same age group. For this indicator we used data from

the Annual Continuous National Survey of Households-2nd quarter 2019.

- Percentage of racialized women

We defined racialized women as women who self-identify as indigenous, black, brown or yellow. We calculated the percentage of racialized women among the total population of women in each state. We used data from the 2010 Demographic Census on percentages of population by sex, race and state.

- Gini

The Gini index measures the extent to which the distribution of income deviates from an equal distribution, where 0 represents perfect equality and 1 indicates perfect inequality. We used the Gini index of monthly income distribution of persons aged 15 years and over for the year 2015. Data was collected within the National Survey of Households 2015.

- Region

We used the IBGE classification of regions (North, Northeast, Southeast, South, Central-West).

- Household income *per capita*

It is the ratio between the total earnings (in Brazilian Reais, R$) and the total number of residents of a household. Work, pensions and other income are considered in the calculation. The source of the data was the Annual Continuous National Survey of Households – 2020. For the multilevel analysis, we divided the variable by 1,000 so that coefficients were associated to a 1,000 R$ increase in household income *per capita.* At the moment of writing this article, 1,000 R$ are equivalent to 161€.

Analysis

Individual-level analysis

We described the distribution of our sample according to the categories of our dependent and independent variables. We also compared people who requested the service but did not use the

service (i.e. filled in the online survey but did not receive the pills) with those who used the service (i.e. received a package with pills), according to their socio-demographic characteristics using a Pearson's X^2 test.

Ecological analysis

We first described all the contextual variables for states and regions. To see if requests were homogeneously distributed among states, we calculated the rate of requests per 100,000 women at reproductive age by dividing the number of requests in each state by the number of women at reproductive age in the same state. We also calculated the percentage of service utilization in each state, which is the proportion of requesters from a given state that accessed the pills through the service among requesters from the same state that requested the service. We then mapped quintiles of all our contextual continuous variables and calculated the correlations and significance levels among all the continuous variables at the contextual level. We also performed ANOVA tests (or Kruskal–Wallis tests when the hypothesis of equal variances was not fulfilled) to examine the correlation between our categorical variable regions and the contextual continuous variables.

Multilevel analysis

We fitted five multilevel Poisson Mixed-effects models with robust variance, with individual data in level 1 and state data in level 2, to estimate prevalence ratios (PR) of service utilization with 95% confidence intervals (IC) and variance of random effects. In Model 0 we included all the individual-level variables (race, educational level, age, pregnancy length). In Models 1-5 we included all the individual-level variables and one contextual variable in each model: region in Model 1, household income *per capita* in Model 2, adjusted net school attendance rate in Model 3, percentage of racialized women in Model 4 and income Gini index in Model 5. In each of these models we calculated the percentage of variance explained by the inclusion of the contextual variable in the model by comparing the variance with that of Model 0.

We used STATA 14 to run our analyses and R to plot the maps.

Ethical issues

Upon acceptance of the terms and conditions of the service, requesters consent to the use of their anonymized data for research purposes. We followed the principles of the Declaration of Helsinki on Human Research and the study was approved by the Drug Research Ethical Committee CEIm -Parc de Salut MAR, Barcelona (Code: 2018/8145/I).

Results

Individual-level results

Our study population included 25,920 requesters who fulfilled the inclusion criteria. Table 1 presents descriptive data on the individual-level variables as well as the results of our bivariate analysis on service utilization. Most requesters were between 20 and 24 years old (34.9 %), self-identified as white (48.3 %), had access to secondary or university education (46.5 %) and were 6 weeks pregnant or less (75.3 %).

2,121 requesters (8.2%) used the service (i.e. accessed abortion pills through the service) during the study period. There was a clear utilization gradient based on age: 11.9% of people in the 40-49 category received the pills through the service, but only 4.4% of people 14-19 years old did. The proportion of white women who used the service almost triples that of indigenous women who did, and is 3 percentage points higher that the proportion of brown, black and yellow women who used the service. Women with university education received the pills 4 times more than their peers with basic education. People who are between 5- and 8-weeks pregnant received the pills at double the rate than those who were earlier in pregnancy. The association between service use and all individual-level variables was statistically significant.

Table 1: Socio-demographic characteristics of study participants, service utilization and p value of the association between socio-demographic characteristics and service utilization

	Total	Utilization		
	Requested the service N (%)	Yes (received the pills) N (%)	No (did not receive the pills) N(%)	p
	25,920 (100.00)	2,121 (8.18)	23,799 (91.82)	
Variable				
Age (years)				0.001
14-19	6,436 (24.83)	285 (4.43)	6,151 (95.57)	
20-24	9,051 (34.92)	724 (8.00)	8,327 (92.00)	
25-29	5,075 (19.58)	524 (10.33)	4,551 (89.67)	
30-34	2,999 (11.57)	330 (11.00)	2,669 (89.00)	
35-39	1,735 (6.69)	184 (10.61)	1,551 (89.39)	
40-49	624 (2.4)	74 (11.86)	550 (88.14)	
Race				0.001
White	12510 (48.26)	1,232 (9.85)	11,278 (90.15)	
Brown	9262 (35.73)	621 (6.70)	8,641 (93.30)	
Black	3276 (12.64)	216 (6.59)	3,060 (93.41)	
Yellow	673 (2.6)	45 (6.69)	628 (93.31)	
Indigenous	199 (0.77)	7(3.52)	192 (96.48)	
Higher educational level accessed				0.001
Basic education	2453 (9.46)	76 (3.10)	2,377 (96.90)	
Secondary education	11427 (44.09)	567 (4.96)	10,860 (95.04)	
University or more	12040 (46.45)	1,478 (12.28)	10,562 (87.72)	
Pregnancy length				0.001
4 weeks	9135 (35.24)	466 (5.10)	8,669 (94.90)	
5-6 weeks	10381 (40.05)	1,067 (10.28)	9,314 (89.72)	
7-8 weeks	6404 (24.71)	588 (9.18)	5816 (90.82)	

Context-level results

The distribution of context level variables by state and region is presented in Table 2. Brazil has 27 states that are organized in 5 regions. The state's population size varies widely: the state with the smallest population is Roraima, which has 631,181 inhabitants and 181,783 women at reproductive age. São Paulo, the largest state in the country, has more than 46 million inhabitants and more than 12 million women at reproductive age.

Other regional characteristics also differ widely. For example, the North and Northeast regions have the highest proportions of racialized women (76% and 70% respectively), the lowest school attendance rates (23.2% and 23.7% respectively) and the states with the lowest income *per capita* (676R$ for Maranhão, 796 R$ for Alagoas and 852R$ for Amazonas). The Central-West region has the highest school attendance rate (37.7%), and the highest income inequality (Gini index: 0.498). The South region has the lowest proportion of racialized women (20.8%) and the lowest income inequality in the country (Gini index 0.450).

A selection of variables in Table 2 are mapped in Figure 1, which shows the geographic distribution of requests, percentage of service utilization, household income *per capita* and income Gini index by state. The first three maps show the same pattern: the number of requests, the percentage of service utilization and the household income *per capita* are higher in the states of the South, Southeast and Central-West regions and lower in the North and Northeast regions. The maps of education level and percentage of racialized women (not shown) follow the same pattern. The map of the Gini index highlights the slight differences in income inequality by regions, which follow a different pattern than the other maps. Generally, inequality is the highest in Central-Western and Northeastern states and the lowest in the Southern states.

Table 2: Context-level variables by region and state

Region and State	Population[1]	Women at reproductive age (14-49 years)[2]	Adjusted net school attendance rate[3]	Percentage of racialized women[4]	Household income *per capita* (R$)[5]	Gini index[6]	Number of requests per 100,000 women at reproductive age	Utilization (% of requesters that received the pills through the service)
Brazil	**211,755,692**	**58,720,495**	**29.7**	**51.5**	**1,380**	**0.491**	**44.3**	**8.17**
North Region	**18,672,591**	**5,411,780**	**23.2**	**76.0**	**-**	**0.473**	**20.6**	**3.49**
Rondônia	1,796,460	519,713	30.6	64.3	1,169	0.452	25.4	3.79
Acre	894,470	258,680	27.8	75.9	917	0.5	15.5	0
Amazonas	4,207,714	1,206,738	24.3	77.9	852	0.476	19.5	3.4
Roraima	631,181	181,783	26.8	78.0	983	0.5	41.8	7.89
Pará	8,690,745	2,532,687	18.4	77.6	883	0.465	17.2	2.98
Amapá	861,773	257,008	34.5	75.0	893	0.457	27.2	0
Tocantins	1,590,248	455,171	27.2	75.1	1,060	0.504	28.1	5.47
Northeast	**57,374,243**	**16,531,575**	**22.7**	**70.0**	**-**	**0.484**	**21.6**	**5.57**
Maranhão	7,114,598	2,067,949	20.2	77.4	676	0.506	13.0	2.6
Piauí	3,281,480	943,623	28.1	75.2	859	0.505	20.7	2.56
Ceará	9,187,103	2,647,793	25.8	67.3	1,028	0.453	22.8	6.12
Rio Grande do Norte	3,534,165	1,002,710	26.2	58.0	1,077	0.503	18.2	7.96
Paraíba	4,039,277	1,147,349	25.1	59.3	892	0.51	22.2	7.06
Pernambuco	9,616,621	2,752,837	23.1	62.5	897	0.492	26.0	6.98

Alagoas	3,351,543	988,690	17.1	68.2	796	0.438	21.6	7.48
Sergipe	2,318,822	685,381	22	71.6	1,028	0.46	20.7	5.63
Bahia	14,930,634	4,295,243	20.6	77.6	965	0.481	23.2	4.41
Southeast	**89,012,240**	**24,099,986**	**32.5**	**44.0**	**-**	**0.477**	**59.6**	**9.13**
Minas Gerais	21,292,666	5,777,126	29.7	54.1	1,314	0.478	50.7	8.81
Espírito Santo	4,064,052	1,110,013	29.2	57.1	1,347	0.471	43.5	7.45
Rio de Janeiro	17,366,189	4,661,660	33	51.6	1,723	0.454	59.0	10
São Paulo	46,289,333	12,551,187	34	35.2	1,814	0.47	65.3	9.05
South	**30,192,315**	**7,992,461**	**36.8**	**20.8**	**-**	**0.45**	**53.1**	**8.93**
Paraná	11,516,840	3,099,169	37.1	28.9	1,508	0.459	51.6	8.76
Santa Catarina	7,252,502	1,951,305	40.2	15.4	1,632	0.419	59.4	8.19
Rio Grande do Sul	11,422,973	2,941,987	34.2	16.2	1,759	0.487	50.4	9.7
Central-West	**16,504,303**	**4,684,693**	**37.3**	**57.5**	**-**	**0.498**	**47.9**	**7.76**
Mato Grosso do Sul	2,809,394	764,065	31.4	52.0	1,488	0.479	45.3	8.38
Mato Grosso	3,526,220	977,797	32.4	62.2	1,401	0.445	43.2	6.4
Goiás	7,113,540	2,010,623	38	57.6	1,258	0.436	39.8	5.25
Distrito Federal	3,055,149	932,208	45.4	57.1	2,475	0.555	72.3	11.28

Sources: (1) IBGE, Population estimations 2020. (2) IBGE, Population projections 2018. (3) IBGE, National Survey of Households-2nd quarter 2019. (4)IBGE, Demographic Census, 2010. (5) National Survey of Households-2020. (6) National Survey of Households-2015

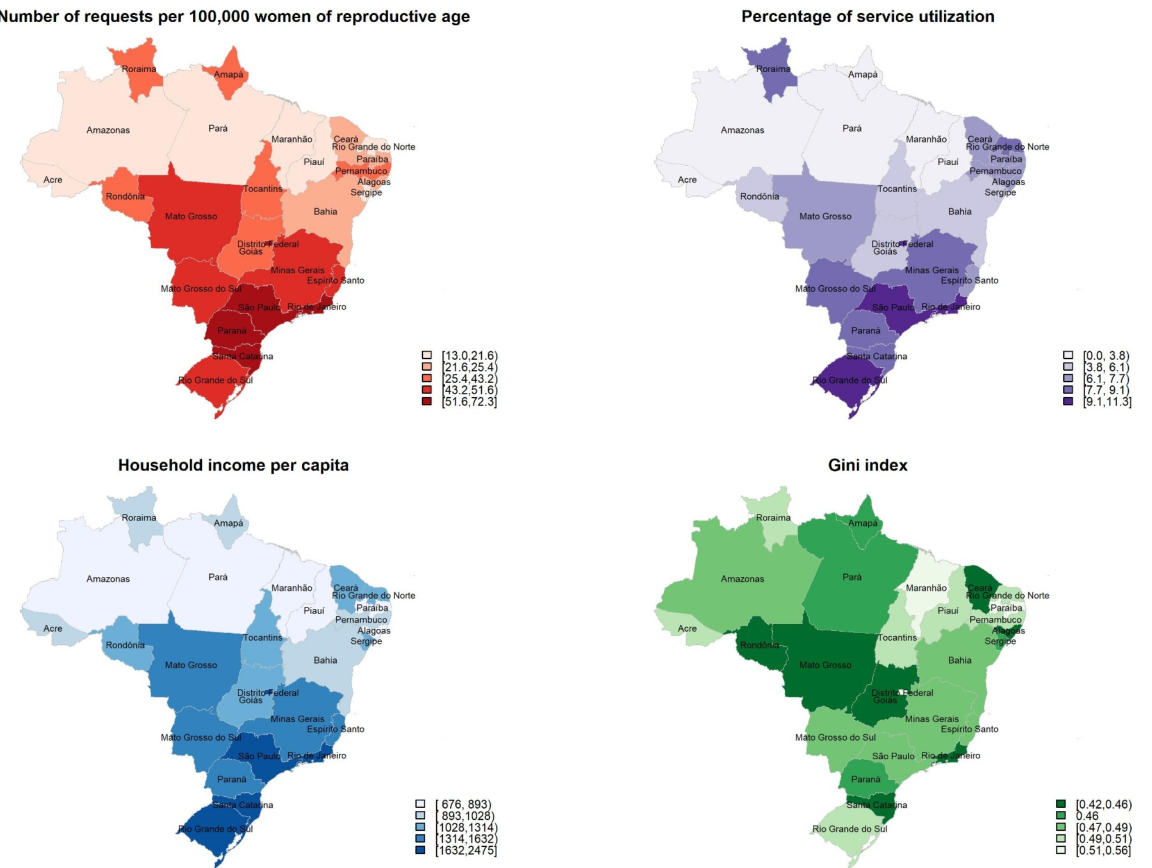

Figure 1: Number of requests per 100,000 women at reproductive age, percentage of service utilization, household income per capita and Gini index according to Brazilian states.

The relationship between contextual variables is shown in Table 3. There is a positive and statistically significant correlation between utilization and household income *per capita* (r=0.727) and adjusted net school attendance rate (r=0.409) and. This means that the probability of using the service is higher in states with higher income *per capita* and with higher school attendance rates. We also found an inverse correlation (r=-0.659) between utilization and the percentage of racialized women, meaning that the probability of accessing the pills through the service is lower in states with higher proportions of racialized women. There is also a statistically significant relationship between utilization and region, meaning that there is a higher probability of service utilization in the South, Southeast and Central-West regions. Utilization is not statistically significantly correlated with the Gini index.

We also found positive correlations between the school attendance rate and income and region, meaning that school attendance rate is higher in states with higher income and in some regions. There was a negative association between the proportion of racialized women and school attendance rate and income *per capita*, meaning that in states where the proportion of racialized women is higher, school attendance rate and income *per capita* are lower.

The rate of requests follows the same exact relationship with the other variables as the percentage of utilization of the service (results not shown).

Multilevel results

Table 4 shows the results for our multilevel models. The null model indicates a positive association between utilization and the individual-level variables of race, higher educational level accessed and age. This means that the probability of service utilization is 21% higher for white women than for racialized women; 2.7 times higher for women who accessed university education and 69% higher for those who attended secondary education than for women with basic education; and increases 1% for the increase of each year of age.

Table 3: Correlations and their p-values between variables of the contextual level

	Utilization	Adjusted net school attendance rate	Percentage of racialized women	Household income per capita	Gini Index
Utilization	1				
Adjusted net school attendance rate	0.4095 *0.0339*	1			
Percentage of racialized women	-0.659 *0.0002*	-0.6283 *0.0004*	1		
Household income *per capita*	0.7273 *<0,0001*	0.8177 *<0,0001*	-0.6877 *0.0001*	1	
Gini Index	0.0586 *0.7716*	-0.0298 *0.8828*	0.2702 *0.1728*	0.0784 *0.6974*	1
Region*	*0.0018*	*0.0001*	< 0.0001	*0.0007*	*0.5949*

*Region is a categorical value so the p-value is the one for the ANOVA test with the other variables

For pregnancy length the association is positive, meaning that when compared with those who are 4 weeks pregnant, people between the 5th and the 8th week of pregnancy use the service 86-87 % more.

Results for Model 1 show a positive association between service utilization and region, meaning that when compared with the North region, the probability of using the service is 53% higher in the

Northeast, 100% higher in the Central-West, 121% higher in the South and 143% higher in the Southeast region. Region accounts for 93.4% of the state-level variance in utilization. Model 2 indicates that utilization increases 59% (95% CI 27%-100%) for each increase of 1000 R$ in household income *per capita*, and 95.1% of the variance in state-level utilization is attributed to income on its own.

Model 3 indicates that utilization is also positively associated with the adjusted net school attendance rate, meaning that the probability of using the service increases 2% (95% CI 0.1%-4.0%) for each percentage point increase in school attendance. Independently, school attendance rate accounts for 57.7% of the state-level variance in utilization. Models 4 indicates a negative association between utilization and percentage of racialized women, meaning that the probability of using the service decreased 1% for each point increase in percentage of racialized women. Model 5 did not indicate a statistically significant association between utilization and income inequality.

Discussion

We found evidence of individual and contextual inequalities in utilization of the telehealth abortion service we analyzed. The prevalence of service utilization was higher among women who were older, white, with higher levels of education and between 5 and 8 weeks pregnant. Independently of this, service utilization was higher in states with higher incomes, higher percentage of educated women and lower percentage of racialized women and in the regions with highest levels of these same indicators (South, Southeast and Central-West). Income inequality was not associated with utilization.

Our individual-level analysis showed that women of all age groups, races and education levels resorted to the telehealth service when seeking for an abortion, which is in line with previous studies showing that Internet is an important source of information and abortion access in Brazil[18, 31]. However, women from richer regions, with higher education levels and with lower percentage of racialized

Table 4: Prevalence ratios (PR) of service utilization with 95% confidence intervals and residual variance for multilevel logistic regressions

	Model 0	Model 1	Model 2	Model 3	Model 4	Model 5
	PR (IC 95%)	PR (IC 95%)	PR (IC 95%)	PR (IC 95%)	PR (IC 95%)	PR (IC 95%)
Race						
Racialized	1	1	1	1	1	1
White	1.21 (1.16-1.27)	1.20 (1.14-1.25)	1.21 (1.16-1.27)	1.20 (1.15-1.26)	1.20 (1.14-1.26)	1.21 (1.15-1.27)
Higher educational level accessed						
Basic education	1	1	1	1	1	1
Secondary education	1.69 (1.34-2.12)	1.69 (1.34-2.12)	1.69 (1.34-2.12)	1.69 (1.34-2.12)	1.69 (1.34-2.13)	1.69 (1.34-2.12)
University or more	3.73 (3.05-4.57)	3.75 (3.06-4.70)	3.72 (3.04-4.54)	3.73 (3.05-4.56)	3.74 (3.05-4.58)	3.73 (3.05-4.57)
Age	1.01 (1.01-1.02)	1.01 (1.01-1.02)	1.01 (1.01-1.02)	1.01 (1.01-1.02)	1.01 (1.01-1.02)	1.01 (1.01-1.02)
Pregnancy length						
4 weeks	1	1	1	1	1	1
5-6 weeks	1.87 (1.70-2.05)	1.87 (1.70-2.06)	1.87 (1.70-2.05)	1.87 (1.70-2.05)	1.87 (1.70-2.05)	1.87 (1.70-2.05)
7-8 weeks	1.86 (1.65-2.09)	1.86 (1.65-2.09)	1.86 (1.65-2.09)	1.86 (1.65-2.09)	1.86 (1.65-2.09)	1.86 (1.65-2.09)
Region						
North		1				

Northeast		1.53 (1.06-2.22)				
Southeast		2.43 (1.76-3.35)				
South		2.21 (1.58-3.09)				
Central-West		2.00 (1.30-3.07)				
Household income per capita (1000 Reais)			1.59 (1.27-2.00)			
Adjusted net school attendance rate				1.02 (1.00-1.04)		
% of racialized women					0.992 (0.98-0.99)	
Gini Index (2015)						0.052 (0.00-4.29)
Variance	0.232	0.015	0.011	0.098	0.072	0.237
% variance reduction with respect to model 0		93.4	95.1	57.7	68.8	-2.2

women were more likely to request the service, which contrasts with the higher abortion incidence in the North and Northeast regions[12]. Inequalities in Internet access could explain this difference: while Brazil generally has good Internet access (more than 7 out of 10 Brazilians have some kind of Internet connection), the coverage and quality of the Internet vary widely across the country. Most of the North and Northeast regions depend on satellite connections, or mobile 3G and 4G. Purchasing power also determines high quality Internet access, as 99% of households with higher socioeconomic status are connected to the Internet while only 43% of households of lower socioeconomic status have access[32]. Additionally, only a small proportion of requesters (8.2%) actually used the service, defined here as obtaining the abortion pills through it. This also indicates a general poor access to the pills.

As mentioned above, the prevalence of service utilization was higher among women who were older, white, between 5 and 8 weeks pregnant and those with higher levels of education. The same pattern of individual-level inequalities we found in our analysis has also been found in previous studies examining abortion incidence[12] and public services utilization in Brazil[8].

Ability to pay could explain individual-level inequalities. For example, at the moment of this analysis, the donation requested by the service is equivalent to 50% of a monthly minimum salary in Brazil, which makes it hard to afford for most women. Although the feminist organization running this service is committed to serve those who cannot donate, the percentage of people who use the service without donating is small (6%). One possible explanation for this fact is that people who cannot donate do not follow up on the communication after requesting the service, which could be interpreted as the amount of the requested donation or the requirement of an international payment method acting as symbolic barriers for service utilization. A study in Kenya found that some payment methods can act as barriers and trigger delays in service utilization[33].

Similarly, in line with previous studies, we found that older women accessed the service at higher rates than their younger peers. Being younger can be a barrier to abortion access in several ways. For ex-

ample, in a review of the regional evidence on pregnancy and abortion among girls 15 years old or younger, authors found that girls and young women face particular barriers to access legal abortion services, such as the lack of clarity on protocols for the provision of abortion services to underage women, as well as norms that require parental consent or judicial authorization when parents do not consent or are not involved in the process[34]. Regarding this specific service, younger women may not have information about its existence, they may lack access to private devices to connect to the Internet and contact the service, they may also face more difficulties to gather the money for the requested donation and to find a way to transfer it internationally. In any case, young women who do not get abortion support will have to get the abortion by other means and may be at higher risk of being criminalized, as research in the region has shown[35,36].

Race and educational level are also important determinants of utilization of this abortion service. In Brazil, abortion incidence is higher among racialized women and women with lower socioeconomic status[12], but they face more barriers to access safe abortion methods and post-abortion care[8]. Our results show that this pattern still stands for those who resort to this feminist service, thus revealing that structural inequality operates both in formal and informal settings.

Utilization of the service was also associated with pregnancy length, with women who are between 5 and 8 weeks pregnant having a higher prevalence of service utilization. The fact that women who are very early in their pregnancies use this service at lower rates could be explained because some people may request the service before confirming the pregnancy, because a high proportion (between 11% and 30%) of early pregnancies end in a natural miscarriage[37] or because being early in the pregnancy translates into having more time to find local solutions. However, those who are 9 weeks pregnant or more and thus do not fulfill the service requirements are likely to face more difficulties accessing a safe abortion elsewhere, which could cause further delays in accessing the abortion, or even mean they will have to carry the pregnancy to term, as has been demonstrated by other studies in the region[38, 39].

Our context-level analysis showed that the probability of using the service increases when income and school attendance are higher at the state-level, and is lower in states with higher proportions of racialized women. However, some of these variables are also correlated among them, confirming the compounded nature of inequality and exclusion shown by previous research that demonstrates that under-served communities are also often racialized, with lower income and access to formal education[24, 40].

The results of our multi-level analysis showed that while service utilization is associated with individual characteristics, most of its state-level variability is explained by contextual variables such as region and state income *per capita*, which account for more than 90% of the variance in state-level utilization. Thus, our results indicate that social inequalities in abortion access are not a unique feature of this service, not only a result of its users' individual characteristics, but they also reflect the context in which Brazilian people seek abortion services. While an important promise of medication abortion provision is to dismantle geographic barriers in abortion access[41], we showed that inequalities based on age, race, income, and formal education, can be reproduced even in a remote, Internet-based service.

The evidence of inequalities in the utilization of this abortion service highlights, first, the relevance of working to improve equity in access to feminist abortion support. And, second, the pressing need to consider the local context in structuring services so that feminist models of care can fulfill their aim of confronting contextual and individual inequalities in abortion access, instead of reproducing them. Other feminist initiatives have implemented specific strategies to tackle social inequalities in access to their support[42]. For example, some feminist organizations use phones, rather than Internet, to provide abortion information[43], which amplifies access to disadvantaged population groups. Others organize in-person meetings with large groups of women, so that all the necessary information as well as the medication can be delivered in one single opportunity[38]. While not all feminist local initiatives in the region request a payment or donation in exchange for their support, those who do are

able to establish an amount that is better suited for the specific context they work in, making the service affordable for at least most people in their own territories. Other activists have established alliances with health professionals to secure the people they support will have access to the public health system if needed[44].

More research is needed to understand how social inequalities in access to remote abortion services operate in different contexts, including settings with liberal abortion regulations and with less social inequalities. In terms of services and policies, our results suggest that remote Internet-based initiatives that support abortion access are not sufficient to reach the most marginalized social groups in a very unequal context, which underscores the need for local and in-person provision of abortion services or for remote alternatives that are specifically tailored to local contexts. These services would only be enable by abortion decriminalization and provision of public abortion care, which are thus necessary to secure equity in safe abortion access.

Strengths and Limitations

To our knowledge, this is the first multilevel analysis seeking to explain social inequalities in informal abortion services in Brazil. Thus, our study contributes with fresh data on the relationship between contexts, individual characteristics and inequality in safe abortion services utilization. This is the study's major strength. While our study is not representative of the Brazilian population, it provides an overview of inequalities in informal access to safe abortion, and the size of our population was large enough to arrive to sound conclusions.

However, it is worth noting that our population was not representative of Brazilian population but only of women who requested the service, thus existing a selection bias as shown in the results. Also, interpretations regarding the analysis of the pregnancy length in our study should be cautious. Because we found a high percentage of missing cases in the data on last menstrual period, we used limited data coming from a self-assessment of pregnancy length in number

of weeks, which due to the characteristics of the service, might reflect an information bias.

Conclusion

Our study shows that while feminist telehealth abortion services, such as the one we analyzed, secure safe abortion access for some people in highly restrictive contexts, they are incapable of overcoming common social inequalities in safe abortion access. Individual-level inequalities in service utilization are associated to age, education level and race. Contextual-level inequalities are associated to region, income *per capita*, percentage of racialized women and schooling. Thus, our findings suggest that decriminalization and local provision of public abortion care are necessary to secure equity in safe abortion access.

2. Larrea S, Palència L, Perez G. Aborto farmacológico dispensado a través de un servicio de telemedicina a mujeres de América Latina: complicaciones y su tratamiento. Gac Sanit. 2015;29(3):198-204.

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Original

Aborto farmacológico dispensado a través de un servicio de telemedicina a mujeres de América Latina: complicaciones y su tratamiento

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RESUMEN

Objetivo: Analizar las complicaciones y los tratamientos declarados después de un aborto farmacológico con mifepristona y misoprostol dispensado a través de un servicio de telemedicina a mujeres que viven en América Latina.
Métodos: Estudio observacional basado en el registro de consultas médicas de un servicio de telemedicina. Participaron 872 mujeres que usaron el servicio entre 2010 y 2011. Variables dependientes: total de complicaciones, hemorragia, aborto incompleto, total de tratamientos, evacuación quirúrgica y antibióticos. Variables independientes: edad, zona de residencia, privación socioeconómica, tener hijos/as, embarazos y abortos previos, y semana gestacional. Se ajustaron modelos de Poisson con estimación de la varianza robusta para estimar razones de incidencia (RI) y sus intervalos de confianza del 95% (IC95%).
Resultados: El 14,6% de las participantes declaró complicaciones (6,2% hemorragia y 6,8% aborto incompleto). El 19,0% tuvo tratamiento postaborto (10,9% evacuación quirúrgica y 9,3% antibióticos). La privación socioeconómica aumentó en un 64% el riesgo de complicaciones (IC95%: 15%-132%), y dentro de estas un 82% el de aborto incompleto (IC95%: 8%-206%) y un 62% el riesgo de intervención quirúrgica (IC95%: 7%-144%). Los embarazos previos aumentaron el riesgo de hemorragia (RI = 2,29; IC95%: 1,33-3,95%). Las mujeres con un embarazo de 12 semanas o más tuvieron un riesgo 2,45 veces mayor de tener tratamiento médico y 2,94 veces mayor de tomar antibióticos, comparado con embarazos de 7 semanas o menos.
Conclusión: El aborto farmacológico proveído por telemedicina puede ser una opción segura y efectiva para la interrupción voluntaria del embarazo en contextos donde está legalmente restringido.

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Medical abortion provided by telemedicine to women in Latin America: complications and their treatment

Keywords:
Induced abortion
Misoprostol
Mifepristone
Telemedicine
Complications

ABSTRACT

Objective: To analyze reported complications and their treatment after a medical abortion with mifepristone and misoprostol provided by a telemedicine service to women living in Latin America.
Methods: Observational study based on the registry of consultations in a telemedicine service. A total of 872 women who used the service in 2010 and 2011 participated in the study. The dependent variables were overall complications, hemorrhage, incomplete abortion, overall treatments, surgical evacuation, and antibiotics. Independent variables were age, area of residence, socioeconomic deprivation, previous children, pregnancies and abortions, and week of pregnancy. We fitted Poisson regression models with robust variance to estimate incidence ratios and 95% confidence intervals (95%CI).
Results: Complications were reported by 14.6% of the participants: 6.2% reported hemorrhage and 6.8% incomplete abortion. Nearly one-fifth (19.0%) received postabortion treatment: 10.9% had a surgical evacuation and 9.3% took antibiotics. Socioeconomic deprivation increased the risk of complications by 64% (95%CI: 15%-132%), and, among these, the risk of incomplete abortion by 82% (95%CI: 8%-206%) and the risk of surgical intervention by 62% (95%CI: 7%-144%). Previous pregnancies increased the risk of complications and, specifically, the risk of hemorrhage by 2.29 times (95%CI: 1.33-3.95%). Women with a

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pregnancy of 12 or more weeks had a 2.45 times higher risk of receiving medical treatment and a 2.94 times higher risk of taking antibiotics compared with women with pregnancies of 7 or less weeks.
Conclusion: Medical abortion provided by telemedicine seems to be a safe and effective alternative in contexts where it is legally restricted.
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Introducción

En Latinoamérica, el aborto está penalizado en la mayoría de los países y de los supuestos. Aun así, se estima que en esta región ocurren cada año aproximadamente 4,4 millones de abortos, y que en torno al 95% son abortos inseguros[1]. Incluso en las condiciones en que el aborto es legal, los servicios de aborto son poco accesibles y la atención postaborto es en general de mala calidad. Algunos de los problemas más comunes en la atención postaborto son los retrasos en el tratamiento, el uso de métodos inapropiados y las actitudes prejuiciosas del personal sanitario[1].

Estudios previos concluyen que el aborto farmacológico proveído por telemedicina constituye una alternativa segura para inducir abortos, sobre todo en lugares donde el acceso a un aborto quirúrgico es difícil[2,3] y en países donde esta práctica es clandestina y se usan métodos riesgosos[4–6].

La incidencia de complicaciones y de tratamientos postaborto farmacológico ha sido estudiada en contextos donde el aborto es legal. Se sabe que las complicaciones más frecuentes son aborto incompleto[7–9], infecciones[7,10–13], hemorragia[7–9] y embarazo que continúa[7–9,14]. Los tratamientos más comunes postaborto farmacológico incluyen la evacuación quirúrgica, el uso de antibióticos y aumentar la dosis de misoprostol[15,16]. La prescripción y el tipo de tratamiento dependen de los criterios diagnósticos, la experiencia del personal sanitario y de los recursos disponibles[2,15,17,18].

A pesar de que el aborto farmacológico es un método habitual en Latinoamérica, la información sobre los riesgos y los resultados del procedimiento practicado fuera de servicios de salud en la región es escasa, y no existen registros oficiales sobre esta práctica[19]. En consecuencia, la relación entre los resultados del aborto farmacológico y la posición socioeconómica de la mujer no se ha analizado en este contexto a pesar de que se sabe que son las mujeres en posición socioeconómica más desfavorecida las que sufren las consecuencias más graves de la clandestinidad del aborto[1,20].

La falta de información fiable sobre el aborto en la región es una importante limitación en el diseño de políticas públicas y de protocolos para reducir la mortalidad y la morbilidad asociadas al aborto inseguro.

Para contribuir a la solución de este problema, el presente estudio analiza las complicaciones y el tratamiento declarados después de un aborto farmacológico con mifepristona y misoprostol dispensado a través de un servicio de telemedicina a mujeres de Latinoamérica en 2010 y 2011. Usamos las variables de aproximación disponibles en el registro del servicio para explorar la relación entre la incidencia de complicaciones y tratamiento, la posición socioeconómica de la mujer y las características del embarazo actual y de los anteriores.

Métodos

Diseño, población de estudio y fuentes de información

Estudio observacional de diseño longitudinal basado en el registro de consultas médicas y cuestionarios de evaluación del servicio de *Women on Web*. Este servicio facilita a las mujeres el acceso al aborto farmacológico con mifepristona y misoprostol cuando no existen servicios seguros de aborto disponibles en sus países.

A través de una página de Internet (www.womenonweb.org), la organización refiere a mujeres con menos de 9 semanas de embarazo a una consulta médica basada en un cuestionario en línea. Las respuestas son revisadas por un/a médico/a y, si no hay contraindicaciones para el aborto farmacológico, las mujeres reciben un paquete con pastillas e instrucciones para inducir un aborto con mifepristona (200 μg por vía oral) y misoprostol (800 μg por vía sublingual o bucal 24 horas después de la mifepristona y 400 μg por la misma vía 4 horas después de la primera dosis de misoprostol). También reciben asesoría por correo electrónico durante y después del procedimiento, y se les aconseja acudir a los servicios médicos locales para confirmar el éxito del aborto y recibir tratamiento si presentan síntomas de complicación. El servicio solicita una donación de 90 euros, pero las mujeres pueden donar una cantidad menor o recibir el servicio gratuitamente si declaran no tener recursos. Esta donación se realiza antes de recibir el servicio (inmediatamente después de la consulta médica, pero antes de que el paquete sea enviado). Una descripción más detallada del servicio puede encontrarse en publicaciones anteriores[4,5,21].

El primer cuestionario contiene 25 preguntas y se administra antes del envío de las pastillas (aproximadamente 2 semanas antes del aborto). Este cuestionario recoge información sobre la situación emocional de la mujer, su lugar de residencia, el método de diagnóstico del embarazo, la semana gestacional, las condiciones de seguridad para la realización del aborto, la historia médica y reproductiva de la mujer, y las razones del embarazo y el aborto. El segundo cuestionario (de evaluación) es enviado por correo electrónico 35 días después de la primera consulta. Si la mujer no contesta el cuestionario, se le envía de nuevo 21 días después de la primera vez. Las preguntas de la evaluación se refieren al momento y el proceso del aborto, la confirmación de su éxito, complicaciones y tratamientos, la satisfacción con el método, las dificultades para hacer la donación y la situación emocional después del aborto. Las mujeres que usan el servicio autorizan por escrito el uso de su información con fines de investigación.

Criterios de inclusión y exclusión

En una primera etapa consideramos a todas las residentes de Latinoamérica que utilizaron el servicio en 2010 y 2011. Posteriormente excluimos a las mujeres que declararon a través de correo electrónico no haber usado las pastillas, o que no mantuvieron contacto después de haber recibido el paquete y que, por tanto, no declararon si las usaron o no (fig. 1). Consideramos pérdidas de seguimiento a las que no contestaron el cuestionario de evaluación después de enviarlo dos veces por correo electrónico, y eliminamos aquellas observaciones en las que hubo una intervención quirúrgica hasta 2 días después de haber tomado las pastillas, sin haber declarado ningún síntoma de complicación. La decisión de excluir a estas mujeres se basa en la evidencia de que el aborto con medicamentos es un procedimiento que tarda varios días en completarse[7], y al producirse una intervención sin síntomas es imposible ver el evento de interés. La muestra final del estudio fue de 872 mujeres.

Variables dependientes

Las complicaciones postaborto declaradas por la mujer fueron clasificadas siguiendo la clasificación de los efectos adversos del

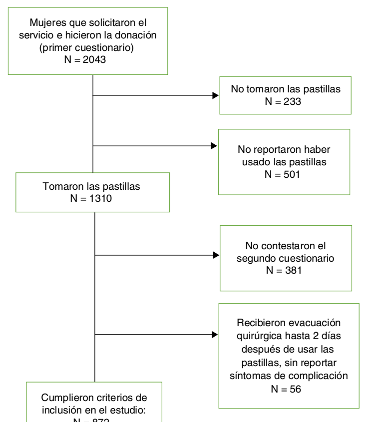

Figura 1. Criterios de inclusión y exclusión de las mujeres que solicitaron el servicio de aborto farmacológico mediante telemedicina en América Latina, 2010-2011.

Royal College of Obstetricians and Gynecologists[17]. Así, las complicaciones estudiadas fueron la infección, el embarazo que continúa, la hemorragia (definida como sangrado que llena más de dos toallas sanitarias en 1 hora durante 2 horas seguidas) y el aborto incompleto (si el aborto no se completó y la mujer recibió tratamiento médico porque presentó síntomas o malestar). Incluimos la variable dicotómica «complicaciones», cuyo valor es «sí» cuando las mujeres declararon haber tenido una o más de las complicaciones descritas. Analizamos las variables «hemorragia» y «aborto incompleto» por ser las complicaciones más frecuentes.

Haber recibido tratamiento se analizó como variable dependiente, cuyo valor fue «sí» cuando las mujeres declararon haber recibido uno o más de los siguientes tratamientos: evacuación quirúrgica, antibióticos, otro (que incluye una dosis extra de misoprostol, transfusión de sangre o fluidos, o tratamientos no especificados). Todas las categorías de tratamiento, excepto «otro», también fueron analizadas con valores «sí» y «no».

Variables independientes

Las variables independientes del estudio fueron la edad (en tres categorías: 15-24 años, 25-34 años y 35 años o más), la zona de residencia (Centro América, Andes, Cono Sur y Brasil), haber tenido embarazos previos (sí o no), haber tenido hijos/as (sí o no) y abortos voluntarios (sí o no), y la semana gestacional cuando usó las pastillas (cuatro categorías: hasta 7 semanas, entre 8 y 9 semanas, entre 10 y 11 semanas, 12 semanas o más).

Debido a que el servicio no recoge datos demográficos de las mujeres, usamos la información sobre la donación realizada como una aproximación a la posición socioeconómica de la mujer. Declarar dificultad para hacer la donación (*¿Tuvo dificultad para realizar la donación?* Sí o no) y hacer una donación reducida (cuyo valor es «sí» cuando la mujer donó menos de 90 euros o no hizo ninguna donación) se consideraron indicadores de privación socioeconómica. La información sobre la cantidad de la donación se recogió del registro del servicio, mientras que la dificultad para hacer la donación fue declarada por las mujeres en el segundo cuestionario.

Análisis estadístico

En primer lugar se realizó un análisis de valores perdidos para comprobar si las mujeres incluidas y excluidas diferían en las variables estudiadas. Calculamos la distribución de las mujeres según las variables dependientes e independientes (análisis univariado). También calculamos las incidencias de las variables dependientes según las categorías de las variables independientes (análisis bivariado), y comprobamos su asociación utilizando la prueba de ji al cuadrado.

Ajustamos modelos de regresión de Poisson con estimación de la varianza robusta[23,24] para estimar riesgos relativos con intervalos de confianza del 95% (IC95%). Incluimos todas las variables independientes que en el análisis bivariado tuvieron $p < 0,2$, para posteriormente excluir todas las no significativas y comprobar una a una su no significación. También ajustamos modelos que incluían todas las variables independientes que tuvieron $p < 0,2$ en el análisis bivariado, y modelos que incluían cada una de las variables independientes. Utilizamos pruebas de razón de verosimilitudes para comprobar la significación estadística de las variables con más de una categoría. El análisis estadístico se realizó con STATA10 para Windows.

Resultados

De las 2043 mujeres que solicitaron el servicio, 1310 declararon haber usado los medicamentos para abortar. De estas, el 29,1% (n = 381) no contestó al segundo cuestionario. Una de ellas declaró haber tenido un choque hipovolémico el día en que tomó el misoprostol. El 4,3% (n = 56) tuvo una evacuación quirúrgica antes del tercer día después de empezar el tratamiento, sin haber presentado síntomas de complicación (fig. 1).

No encontramos diferencias significativas entre las mujeres excluidas e incluidas en el estudio, excepto en la semana gestacional en el momento de la consulta: un mayor porcentaje de mujeres excluidas estaba en la primera y última categorías de semana gestacional (véase la tabla I en la versión *online* de este artículo).

La mayor parte de las mujeres vivían en Brasil (68,9%), hicieron una donación completa (79,0%), no tenían hijos/as (83,9%) ni abortos previos (93,2%), y abortaron antes de la décima semana de embarazo (74,5%). El 14,6% de las mujeres declaró haber tenido complicaciones: el 6,2% hemorragia, el 6,8% aborto incompleto, el 1,5% infección y el 1,4% embarazo que continúa. El 19,0% de las mujeres declaró haber recibido tratamiento médico después del aborto: 10,9% evacuación quirúrgica, 9,3% antibióticos y 3,1% otro tratamiento (tabla 1).

Los resultados del análisis bivariado se presentan en las tablas 2 y 3. Haber hecho una donación reducida se asoció a tener complicaciones (21,7% en las que hicieron donación reducida frente a 12,8% en las que hicieron la donación completa), aborto incompleto (10,6% frente a 5,8%), recibir tratamiento médico (25,6% frente a 17,3%), evacuación quirúrgica (15,6% frente a 9,6%) y tomar antibióticos (13,3% frente a 8,3%).

Haber tenido embarazos previos se asoció a tener complicaciones (18% en las que habían tenido embarazos frente a 11,6% en las que no), como evacuaciones quirúrgicas (13,6% frente a 8,7%) y hemorragia (9,0% frente a 3,4%). Haber tenido hijos/as se asoció a sufrir una hemorragia (10,6% frente a 5,5%). La semana gestacional se asoció a recibir tratamiento (17,8% en embarazos de hasta 7 semanas frente a 43,6% en embarazos de 12 semanas o más) y a tomar antibióticos después del aborto (7,8% frente a 23,1%).

Tabla 1
Descripción de las mujeres incluidas en el estudio que solicitaron el servicio de aborto farmacológico mediante telemedicina en América Latina, 2010-2011

Variables	N = 872	
	n	%
Edad (años)		
15-24	370	42,4
25-34	386	44,3
35 o más	110	12,6
No contesta	6	0,7
Zona de residencia[a]		
Centro América	61	7
Andes	49	5,6
Cono Sur	161	18,5
Brasil	601	68,9
No contesta	0	0
Declaró que fue difícil hacer la donación		
No	466	53,4
Sí	390	44,7
No contesta	16	1,8
Hizo una donación menor de 90 € (donación reducida)		
No	689	79
Sí	180	20,6
No contesta	3	0,3
Antecedentes de hijos/as		
No	732	83,9
Sí	132	15,1
No contesta	8	0,9
Embarazos previos		
No	483	55,4
Sí	377	43,2
No contesta	12	1,4
Abortos previos		
No	813	93,2
Sí	51	5,9
No contesta	8	0,9
Semana gestacional		
7 semanas o menos	333	38,2
Entre 8 y 9 semanas	317	36,4
Entre 10 y 11 semanas	132	15,1
12 semanas o más	39	4,5
No contesta	51	5,9
Complicaciones		
Total de complicaciones	127	14,6
Hemorragia	54	6,2
Aborto incompleto	59	6,8
Infección	13	1,5
Embarazo que continúa	12	1,4
Tratamiento		
Total de tratamientos	166	19,0
Evacuación quirúrgica	95	19,9
Antibióticos	81	9,3
Otro	27	3,1

[a] Centro América: Costa Rica, República Dominicana, El Salvador, Guatemala, Honduras, México, Nicaragua; Andes: Bolivia, Colombia, Ecuador, Perú, Venezuela; Cono Sur: Chile, Argentina, Paraguay, Uruguay.

Los resultados del análisis multivariado (tabla 4) mostraron que, entre las que hicieron una donación reducida, el riesgo de declarar una complicación fue un 64% mayor que entre aquellas que hicieron la donación completa, el riesgo de tener un aborto incompleto fue un 82% mayor y el riesgo de recibir una intervención quirúrgica fue un 62% mayor.

Haber tenido embarazos previos aumentó 1,51 veces el riesgo de complicaciones (IC95%: 1,09-2,10) y 2,29 veces el riesgo de hemorragia (IC95%: 1,33-3,95). Las mujeres con un embarazo de más de 12 semanas tuvieron un riesgo 2,45 veces mayor (IC95%: 1,60-3,75) de recibir tratamiento médico y 2,94 veces mayor de tomar antibióticos (IC95%: 1,49-5,82) con respecto a las mujeres que llevaban menos de 7 semanas de embarazo cuando usaron las pastillas.

Discusión

La incidencia de complicaciones postaborto encontrada en este estudio (14,6%) es similar a la hallada en estudios sobre aborto farmacológico realizado en servicios de salud con supervisión de personal sanitario[2,7–9,14,25] y en estudios previos sobre el mismo servicio[4,5,22].

El tratamiento postaborto, en especial la evacuación quirúrgica (19% y 10,9%, respectivamente), fue más frecuente en nuestro estudio que en otros anteriores[2,14–17]. Esto coincide con lo que ya se había encontrado en el mismo servicio: las mujeres latinoamericanas declaran entre el doble y el triple de evacuaciones quirúrgicas que las mujeres en otras regiones[22], y un alto porcentaje recibe este tratamiento sin presentar síntomas de complicación[5]. La alta incidencia de evacuación quirúrgica se evidenció aun después de haber excluido a las mujeres que habían recibido intervenciones claramente innecesarias (4,3% del total de mujeres que usaron las pastillas). Estudios previos sugieren que la frecuencia de esta intervención refleja las prácticas médicas locales y no necesariamente la presencia de complicaciones o de sus síntomas[5].

Se sabe que cuando las mujeres acuden a un hospital después de un aborto (espontáneo o voluntario) reciben procedimientos inapropiados y dolorosos, y tratos prejuiciosos del personal sanitario[1,26,27]. Debido a los riesgos que implica la evacuación quirúrgica y al consenso que hay acerca de las condiciones en que debe efectuarse[17,18], futuros estudios deberán indagar las razones para la alta incidencia de evacuación quirúrgica postaborto farmacológico en la región y establecer estrategias para evitar intervenciones innecesarias y riesgosas, en especial en las mujeres que realizan el aborto farmacológico fuera del sistema sanitario.

A pesar de las limitaciones en las variables utilizadas en este estudio para aproximarnos a la situación socioeconómica de las mujeres, la incidencia de complicaciones y de tratamiento entre las que hicieron una donación reducida fue aproximadamente el doble que en aquellas que hicieron la donación completa, lo que muestra un claro patrón de desigualdad socioeconómica en los resultados del aborto farmacológico.

Aunque no encontramos análisis previos sobre esta asociación, se sabe que un menor acceso a buenas condiciones de vida, trabajo y alimentación, entre otros, hace que las personas en posición socioeconómica desfavorecida tengan peores resultados en múltiples indicadores de salud[28,29], y es probable que sean estos mismos mecanismos los que provocan la mayor incidencia de complicaciones postaborto en las mujeres con privación socioeconómica. También es probable que la privación socioeconómica impida que las mujeres accedan a servicios de salud de buena calidad, lo que explicaría parcialmente la mayor incidencia de tratamientos postaborto en este grupo de mujeres (pero no de complicaciones).

Igual que en estudios previos, los antecedentes reproductivos de la mujer se asociaron a riesgo de complicaciones y tratamiento[30]. En nuestro estudio, haber tenido embarazos previos se asoció a tener complicaciones (en particular hemorragia) y a recibir una intervención quirúrgica, mientras que haber tenido hijos/as se asoció a riesgo de hemorragia. Las mujeres que tuvieron hijos y embarazos previos son significativamente mayores que las mujeres que no tienen antecedentes reproductivos, y se sabe que las complicaciones aumentan con la edad de las mujeres[9,30], aunque esto no se haya encontrado en el presente estudio.

Tabla 2
Incidencia de complicaciones y tipos de complicaciones: hemorragia y aborto incompleto tras un aborto farmacológico proveído mediante servicio de telemedicina a mujeres de Latinoamérica, 2010-2011

	N = 872					
	Complicaciones		Hemorragia		Aborto incompleto	
	n (%)	p	n (%)	p	n (%)	p
Edad (años)		0,844		0,954		0,848
15-24	55 (14,9)		22 (6,0)		25 (6,8)	
25-34	57 (14,8)		25 (6,5)		27 (7,0)	
35 o más	14 (12,7)		7 (6,4)		6 (5,5)	
Zona donde vive[a]		0,415		0,227		0,322
Centro América	5 (8,2)		2 (3,3)		2 (3,3)	
Andes	7 (14,3)		5 (10,2)		1 (2,0)	
Cono Sur	21 (13,0)		6 (3,7)		13 (8,1)	
Brasil	94 (15,6)		41 (6,8)		43 (7,2)	
Declaró que fue difícil hacer la donación		0,502		0,945		0,875
No	63 (13,5)		28 (6,0)		31 (6,7)	
Sí	59 (15,1)		23 (5,9)		27 (6,9)	
Hizo una donación menor de 90 € (donación reducida)		0,003		0,529		0,024
No	88 (12,8)		41(6,0)		40 (5,8)	
Sí	39 (21,7)		13 (7,2)		19 (10,6)	
Antecedentes de hijos/as		0,294		0,025		0,787
No	102 (13,9)		40 (5,5)		49 (6,7)	
Sí	23 (17,4)		14 (10,6)		8 (6,1)	
Embarazos previos		0,008				0,097
No	56 (11,6)		34 (3,9)	0,002	26 (5,4)	
Sí	68 (18,0)		19 (9,0)		31 (8,2)	
Abortos previos		0,877				0,832
No	118 (14,5)		50 (6,2)	0,628	54 (6,6)	
Sí	7 (13,7)		4 (7,8)		3 (5,9)	
Semana gestacional		0,693				0,418
Hasta 7 semanas	45 (13,5)		21 (6,3)	0,993	20 (6,0)	
Entre 8 y 9 semanas	47 (14,8)		20 (6,3)		20 (6,3)	
Entre 10 y 11 semanas	20 (15,2)		8 (6,1)		10 (7,6)	
12 semanas o más	8 (20,5)		2 (5,1)		5 (12,8)	

[a] Centro América: Costa Rica, República Dominicana, El Salvador, Guatemala, Honduras, México, Nicaragua; Andes: Bolivia, Colombia, Ecuador, Perú, Venezuela; Cono Sur: Chile, Argentina, Paraguay, Uruguay.

Del mismo modo que en otros estudios[7,9,25], encontramos que el riesgo de recibir tratamiento aumenta con la semana gestacional. Se sabe que el aumento de la dosis de misoprostol puede reducir este riesgo en embarazos avanzados[5,30].

Limitaciones

La limitación más importante del estudio es que el servicio de *Women on Web* no recoge información de variables validadas para analizar la posición socioeconómica, los criterios de diagnóstico de las complicaciones y las indicaciones para el tratamiento médico. Esto se debe a que la información recogida por el servicio está destinada a facilitar la atención médica y no a ser analizada para la investigación. En este contexto, la única información disponible fue usada para explorar la posición socioeconómica de las mujeres y su relación con los resultados del aborto. A pesar de los posibles sesgos que implica la utilización de una variable de aproximación para el estudio de los efectos de la posición socioeconómica sobre los resultados del aborto, este primer análisis da cuenta de la existencia de un patrón de desigualdad que deberá ser explorado en profundidad cuando existan fuentes más completas de información sobre el aborto en la región.

Analizamos la información sobre la satisfacción con el método de aborto para asegurarnos de que no arrojaba la misma información que la variable «donación». Alrededor del 98% de las mujeres dijo que estaba satisfecha con el método, el 44,7% declaró haber tenido dificultades para realizar la donación y el 20,6% hizo una donación menor a la solicitada por el servicio o no hizo ninguna (véase la tabla II en la versión *online* de este artículo).

Otra limitación del estudio es que la muestra no es representativa de la población latinoamericana: posiblemente las mujeres que usan el servicio tienen más acceso a Internet, más posibilidades de tener educación y menos privaciones socioeconómicas que otras mujeres de sus países. Sin embargo, los resultados del estudio son relevantes para el diseño y el perfeccionamiento de servicios de aborto basados en telemedicina en contextos con leyes de aborto restrictivas, pues la muestra sí representa a la población que podría acceder a servicios de telemedicina basados en Internet.

El hecho de que el 43,2% de las mujeres declare haber tenido embarazos previos, el 15,1% tener hijos/as y solo el 5,9% haber tenido un aborto, sugiere un sesgo de clasificación en los antecedentes reproductivos. Dado que estas variables se recogen en el primer cuestionario y que no encontramos diferencias significativas en el análisis de estas variables entre mujeres incluidas y excluidas del estudio, parece poco probable que este sesgo de clasificación sea diferencial.

Lo mismo ocurre con el alto porcentaje de pérdida de seguimiento, en el que tampoco encontramos diferencias significativas en la comparación entre mujeres incluidas y excluidas del estudio. La única excepción fue la semana gestacional: hubo más mujeres excluidas en la primera y la última categorías de semana

Tabla 3
Incidencia de tratamiento y tipo de tratamiento: evacuación quirúrgica y uso de antibióticos después del aborto farmacológico proveído mediante servicio de telemedicina a mujeres de Latinoamérica, 2010-2011

	N = 872					
	Tratamiento		Evacuación quirúrgica		Antibióticos	
	n (%)	p	n (%)	p	n (%)	p
Edad (años)		0,396		0,696		0,23
15-24	78 (21,1)		44 (11,9)		41 (11,1)	
25-34	66 (17,1)		39 (10,1)		29 (7,5)	
35 o más	21 (19,1)		11 (10,0)		11 (10,0)	
Zona donde vive[a]		0,493		0,443		0,383
Centro América	8 (13,1)		4 (6,6)		4 (6,6)	
Andes	12 (24,5)		8 (16,3)		3 (,1)	
Cono Sur	33 (19,9)		17 (10,6)		20 (12,4)	
Brasil	114 (19,0)		66 (11,0)		54 (9,0)	
Declaró que fue difícil hacer la donación		0,555		0,888		0,331
No	86 (18,5)		50 (10,7)		40 (5,6)	
Sí	78 (20,0)		43 (11,0)		41 (10,5)	
Hizo una donación menor que 90 € (donación reducida)		0,012		0,022		0,038
No	119 (17,3)		66 (9,6)		57 (8,3)	
Sí	46 (25,6)		28 (15,6)		24 (13,3)	
Antecedentes de hijos/as		0,591		0,137		0,181
No	135 (18,5)		74 (10,1)		71 (9,7)	
Sí	27 (20,5)		19 (14,5)		8 (6,1)	
Embarazos previos		0,165		0,023		0,752
No	83 (17,2)		42 (8,7)		43 (8,9)	
Sí	79 (21,0)		51 (13,6)		36 (9,6)	
Abortos previos		0,832		0,817		0,738
No	153 (18,8)		87 (10,7)		75 (9,2)	
Sí	9 (17,7)		6 (11,8)		4 (7,8)	
Semana gestacional		0,001		0,101		0,037
Menos de 7 semanas	59 (17,8)		37 (11,1)		26 (7,8)	
Entre 8 y 9 semanas	53 (16,7)		31 (9,8)		24 (7,6)	
Entre 10 y 11 semanas	25 (18,9)		23 (10,6)		24 (11,4)	
12 semanas o más	17 (43,6)		9 (23,1)		9 (23,1)	

[a] Centro América: Costa Rica, República Dominicana, El Salvador, Guatemala, Honduras, México, Nicaragua; Andes: Bolivia, Colombia, Ecuador, Perú, Venezuela; Cono Sur: Chile, Argentina, Paraguay, Uruguay.

gestacional, pero no hay ninguna hipótesis que nos haga creer que este grupo podría haber tenido más complicaciones o tratamientos.

Que la incidencia de complicaciones en este servicio sea similar a la de abortos realizados en el sistema sanitario en contextos en los que su práctica es legal, y que las mujeres puedan acceder a tratamiento médico postaborto, nos permite concluir que el aborto farmacológico proveído a través de un servicio de telemedicina puede ser una alternativa segura y efectiva en contextos de ilegalidad.

Debido a las limitaciones propias de la base de datos utilizada para este estudio, otras investigaciones deberán profundizar en el análisis de los efectos de la posición socioeconómica sobre el riesgo de complicaciones y tratamiento, y corroborar el patrón de desigualdad encontrado.

Tabla 4
Asociación de complicaciones y tratamiento después del aborto farmacológico proveído por un servicio de telemedicina a mujeres de Latinoamérica, 2010-2011

	Complicaciones RRa (IC95%)	Hemorragia RRa (IC95%)	Aborto incompleto RRa (IC95%)	Tratamiento RRa (IC95%)	Evacuación quirúrgica RRa (IC95%)	Antibióticos RRa (IC95%)
Donación reducida						
No	1	-	1	-	1	-
Sí	1,64 (1,15-2,32)	-	1,82 (1,08-3,06)	-	1,62 (1,07-2,44)	-
Hijos/as						
No	-	-	-	-	-	-
Sí	-	-	-	-	-	-
Embarazos previos						
No	1	1	-	-	-	-
Sí	1,51 (1,09-2,10)	2,29 (1,33-3,95)	-	-	-	-
Tiempo de embarazo cuando tomó las pastillas						
Menos de 7 semanas	-	-	-	1	-	1
Entre 8 y 9 semanas	-	-	-	0,94 (0,67-1,32)	-	0,97 (0,57-1,65)
Entre 10 y 11 semanas	-	-	-	1,07 (0,70-1,63)	-	1,45 (0,80-2,65)
12 semanas o más	-	-	-	2,45 (1,60-3,75)	-	2,94 (1,49-5,82)

RRa: riesgo relativo ajustado mediante Poisson robusta; IC95%: intervalo de confianza del 95%.

Editora responsable del artículo

M. Felicitas Domínguez-Berjón.

¿Qué se sabe sobre el tema?

El aborto farmacológico es un método seguro, efectivo y aceptable, y puede ser proveído a través de servicios de telemedicina. La investigación sobre los resultados del aborto farmacológico en lugares donde este se encuentra penalizado es escasa, y no existen estudios previos que analicen la relación entre el nivel socioeconómico de la mujer y las complicaciones postaborto en contextos similares.

¿Qué añade el estudio realizado a la literatura?

Este estudio aporta información nueva sobre los resultados del aborto farmacológico proveído a través de telemedicina en América Latina, e incluye una primera exploración sobre la relación entre la posición socioeconómica de la mujer y la incidencia de complicaciones y tratamiento postaborto. Esta información es relevante para el diseño de servicios y estrategias de reducción de riesgos en contextos en que el aborto se practica en la clandestinidad y con métodos inseguros.

Contribuciones de autoría

S. Larrea Izaguirre participó en el diseño del estudio, la recogida, el análisis y la interpretación de los datos, y escribió el primer borrador del artículo. L. Palència y G. Perez participaron en el diseño del estudio, el análisis y la interpretación de datos, y la revisión crítica del artículo. Las tres autoras aprobaron la versión final para su publicación.

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Conflictos de intereses

Las autoras declaran no tener conflictos de intereses. S. Larrea Izaguirre estuvo vinculada laboralmente a *Women on Web* durante la realización de este estudio. G. Perez declara que pertenece al comité editorial de la revista Gaceta Sanitaria, pero no ha participado en el proceso editorial del manuscrito.

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Anexo. Material adicional

Se puede consultar material adicional a este artículo en su versión electrónica disponible en doi:10.1016/j.gaceta.2015.02.003.

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RESEARCH ARTICLE

Medical abortion provision and quality of care: What can be learned from feminist activists?

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ABSTRACT

Little is known about how feminist abortion support initiatives -born in legally restrictive settings- approach quality of care. We conducted one focus group and one semi-structured interview with activists from eight organizations operating in Latin America and the Caribbean to understand their perspectives and strategies around quality of abortion care. Activists underscore the need of evidence-based information, trained providers and accessibility for people with diverse needs and resources. Grounded on feminism, they also highlight autonomy, dignity, horizontality and a new definition of safety. If applied in formal health systems, these strategies could improve quality of abortion care in other contexts.

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For more than three decades, abortion has been the subject of heated social and political discussions in Latin America and the Caribbean (LAC), where the most restrictive abortion laws in the world persist. In a region where 97% of women of reproductive age live in countries that restrict abortion, it is estimated that 6.5 million induced abortions are performed each year (Guttmacher, 2018). Restrictive laws force abortion seekers to face the risks of unsafe clandestine abortions, stigma and criminalization when they decide to terminate a pregnancy. In this context, the practices of self-managing medication abortions and of providing feminist abortion care and support have spread quickly. In this qualitative study, we explored how feminist activists providing support for self-managed abortion in legally restrictive settings of LAC approach quality of care. We highlight participant's unique contributions to the definition and practice of good quality abortion care and pose that many of their feminist strategies could be applied in formal health systems and less restrictive contexts, which would improve quality of abortion care broadly.

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Self-managed abortion

It was in Brazil during the 90's that researchers started documenting the already common practice of self-managing abortions using misoprostol, an analogue of prostaglandin that was registered to treat gastric ulcers (Ministerio da Saúde, 2009). Little is known about how women found the abortifacient effect of these pills and started sharing the discovery with others (De Zordo, 2016). However, it became popular knowledge in LAC very quickly and hundreds of thousands of pregnant people (cis women, trans men and gender non conforming people) living in countries where abortion is legally restricted have used medication to self-manage their abortions since then (Hyman et al., 2013; Moseson, Bullard, et al., 2020; Zamberlin et al., 2012). We now know that the use of misoprostol alone and its combination with mifepristone to induce an abortion outside the formal healthcare system is safe, effective and acceptable (Gerdts et al., 2018; Gomperts et al., 2008; Hyman et al., 2013; Moseson, Herold, et al., 2020; Moseson, Bullard, et al., 2020; Wainwright et al., 2016; Zurbriggen et al., 2018). In fact, the combination of mifepristone and misoprostol is widely used in countries where abortion is legally available (Popinchalk & Sedgh, 2019) and is included in the World Health Organization (WHO) list of essential medicines (WHO, 2019).

The widespread use of medication abortion outside the formal health system drastically changed the landscape of abortion and the pervasive effects of the legal restrictions. Self-managed abortion provided a safe alternative to pregnant people who wanted to interrupt their pregnancy and would otherwise access unsafe and invasive methods. As a consequence, the incidence and severity of post-abortion complications decreased (Hyman et al., 2013; Winikoff & Sheldon, 2012). This transformation also challenged the dominant ideas that clandestine abortions are always unsafe and that safe abortions should always be provided by health professionals. Several decades after women started using misoprostol to self-manage their abortions, professional associations and international organizations produced guidelines on misoprostol obstetric uses (FLASOG, 2005; WHO, 2012). These guidelines contained detailed, evidence-based information on how to use misoprostol to interrupt a pregnancy. While the guidelines were initially directed at health professionals, feminist activists and other actors appropriated them and used them to support self-managed abortions (Drovetta, 2015; Mines Cuenya et al., 2013). Much more recently, the WHO came to terms with the fact that medication abortions that occur outside the formal healthcare system and/or are provided by non-specialized personnel are safer than other clandestine practices (Ganatra et al., 2017; Sedgh et al., 2016).

The relatively easy access to abortion pills, the availability of information on how to use them and the legitimacy of the information sources such as the WHO and FLASOG provided feminist activists an unprecedented opportunity to organize political direct action against the heteropatriarchal system (Mines Cuenya et al., 2013). Before the advent of abortion pills, feminist activists in legally restrictive settings had organized surgical abortion services, such as the ones in Italy in the 60's (Zaccaria, 1996) and in USA in the 70's (Bart, 1987). However, abortion pills enabled activists to support abortion access without having to perform the abortion themselves or depend on physicians anymore. They also enabled pregnant people to hide that they had voluntarily interrupted their pregnancy if they needed to approach the formal health system, which help them avoid criminalization and obstetric violence in settings where they can be prosecuted and stigmatized for choosing to have an abortion (Assis et al., 2020; Steele & Chiarotti, 2004; Zaragocin et al., 2018).

Feminist organizing and models of care

In the early 2000s, several feminist groups around the world started organizing to support women who were self-managing medication abortions outside the formal healthcare system and the legal indications. Currently, at least 30 of such organizations provide medication abortion access and/or information in legally restricted settings worldwide (https://womenhelp.org/en/page/regional-resources). Two fundamental feminist principles informed the creation of these models of care. First, the idea that women and pregnant people are capable of managing their own abortions. Second, the certainty that other women – activists and non-medical professionals- can provide the evidence-based information and support people need to end their pregnancies safely and autonomously. Feminism also informs the way they organize, how they relate to the state and the laws and to the people they support (Drovetta, 2015; Mines Cuenya et al., 2013; Walsh, 2020; Zurbriggen et al., 2018).

From this basic set of ideas, feminist organizations have developed different models of care that provide evidence-based information on how to safely use and access abortion medication, what to expect during and after the process, how to identify complications and need of medical attention, how to confirm that the abortion took place and confront criminalizing contexts, as well as emotional support and referrals to other services when needed. Simultaneously, these groups campaign for abortion rights and emphasize the positive aspects of abortion, fighting stigma and struggling for decriminalization.

Activists use diverse means and methodologies to do this work. Safe abortion hotlines generally operate publicly and provide telephonic

information on how to access misoprostol locally and how to use it following the latest WHO recommendations (WHO, 2018). Their work is grounded on the human rights to information and to benefit from scientific progress (Drovetta, 2015; Mines Cuenya et al., 2013). On the other side, accompaniment groups are organizations or networks of activists that facilitate access to medicines and provide information and company either in-person or remotely. While some accompaniment groups are very public and visible (Zurbriggen et al., 2018), others work underground and are contacted through mutual support networks (Walsh, 2020). Finally, telehealth services are international Internet-based organizations that provide access to medication abortion. They generally operate from territories with liberal abortion laws and deliver medications by mail to people in restrictive settings. Most of these services also provide information and support during the abortion process, in the language of the people who needs it, through email and/or instant messaging systems (Jelinska & Yanow, 2017). Some organizations combine different elements of these models of care.

Abortion regulation

Generally, abortion in LAC is harshly penalized. The Dominican Republic, Honduras, Nicaragua, El Salvador, Haiti and Suriname ban abortion altogether. Other countries have established exceptions to abortion bans that make it not punishable when performed by medical professionals in different combinations of grounds, including to save the life or protect the physical health of a pregnant person, for fetal anomaly, in cases of rape, among others (Guttmacher, 2018). However, access to abortion in the exceptional cases when it is not punishable is limited (IPPF/RHO, 2007). While misoprostol is accessible through pharmacies in most of the region, at least in 17 countries a prescription is required to buy it (Távara Orozco & Chávez Alvarado, 2013). Chile and Brazil have further restricted misoprostol use and distribution by limiting it to designated health facilities (Assis, 2020; Casas & Vivaldi, 2014).

Quality of care

Quality of care is an important aspect of healthcare because it is associated with service utilization and results. Generally, better quality services achieve better coverage and outcomes. Although evidence regarding quality of abortion care is limited, common approaches are grounded on the principles that improving quality will result in a decrease in abortion related morbidity and mortality, increased use of post-abortion contraception and less need for abortion services (Dennis et al., 2017; Hulton et al., 2000).

But more importantly, quality of care is essential because people deserve to have the highest attainable standard of health.

In spite of the general agreement that evaluating and improving abortion care quality is relevant, there is no standard definition for quality of abortion care (Darney et al., 2018). In a recent systematic review, Dennis et al. (2017) found that only a few indicators of quality of abortion care are commonly used across different approaches. Among those, the most cited indicators measure the availability of trained providers, the service's accessibility, whether women are treated with dignity and respect and supported in their decisions, if appropriate referrals are provided and the rates of complications and mortality due to unsafe abortion. Another review, focused on women's experiences, found that abortion services around the world generally fail to provide person-centered abortion care (Altshuler & Whaley, 2018). In our study, we used WHO working definition of quality of care (WHO, 2006) because it is comprehensive and can be applied to diverse healthcare services and because feminist abortion initiatives have traditionally used WHO guidelines to structure their models of care. WHO definition of quality of care includes six dimensions: effectiveness, efficiency, accessibility, acceptability/patient-centeredness, equity and safety (Figure 1).

Feminist abortion support initiatives have often been seen as a "less unsafe" or provisional solution for people living in countries where abortion access is restricted by law or other structural determinants, such as weak public health systems or lack of abortion services. We claim that the conceptualization of these models as provisional and second choice solutions has hindered the potentialities of feminist abortion care practices to be incorporated in formal systems and routine medical care. Rooted on feminist epistemology, in this study our purpose is to shed light over a feminist practice that could potentially improve abortion care. Thus, our aim was to understand feminist activists' perspectives and strategies around quality of care in abortion support initiatives operating in LAC.

Methods

We conducted a qualitative study that included one focus group and one semi-structured personal interview. Apart from this, our data analysis was informed by documentation review, informal conversations with feminist activists and one of the authors participation in the self-managed abortion support movement.

Materials and participants

For the focus group, we selected a convenience sample out of a group of activists that participated in a Global Hotlines Meeting in Indonesia

WHO working definition of Quality of Care

- Effective, delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need
- Efficient, delivering health care in a manner which maximizes resource use and avoids waste
- Accessible, delivering health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need
- Acceptable/patient-centered, delivering health care which takes into account the preferences and aspirations of individual service users and the cultures of their communities
- Equitable, delivering health care which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status
- Safe, delivering health care which minimizes risks and harm to service users

Source: World Health Organization. Quality of Care. 2006

Figure 1. WHO working definition of Quality of Care

in October 2018. We invited members of hotlines, accompaniment groups and telehealth services that work in legally restrictive settings and covered a variety of contexts in the region. Eleven activists were invited to the focus group and nine attended. One of the participants withdrew her consent after having participated in the focus group because she was not able to discuss her discourse with other members of her collective and felt she was representing them. All her interventions were deleted from the transcripts before the analysis. Due to language barriers (the focus group was run in Spanish), a member of a telehealth service was not able to participate in the focus group, so we conducted a personal interview with another member of the telehealth organization, also in Spanish, in the Netherlands in July 2019.

Five of the participants were members of hotlines, two were members of organizations that sustain a hotline and also do accompaniment work and one was member of a telehealth service. Local organizations (hotlines

and accompaniment groups) operate in seven countries of the region: Dominican Republic, Mexico, Venezuela, Ecuador, Chile, Colombia and Peru. The telehealth service works across the region providing support in 17 countries. Following a semi-structured focus group guide, participants were asked how they define quality of abortion care and their perspectives and strategies regarding the six dimensions of quality of care as defined by the WHO. Both the focus group and the interview were conducted by the first author in a private place. The interview lasted one hour and the focus group 2.5 h. Participants did not receive any compensation.

Data analysis

The focus group and the interview were conducted, transcribed verbatim and analyzed in Spanish. We conducted a codebook thematic analysis (Braun et al., 2019) using a hybrid approach that combined inductive and deductive processes. First, one of the authors used conceptual framework driven codes, taking as a reference the WHO dimensions of Quality of Care, to organize the transcripts, and created new codes for data that didn't fit into the initial framework. Then, the three authors reviewed the transcripts searching for data-driven codes. Next, one of the authors collapsed the codes into categories, and categories into the final study themes: providing comprehensive information and establishing horizontal relationships, WHO and quality of care, feminist ethics, effectiveness, efficiency, accessibility, acceptability, equity and security (the last six being the dimensions of the WHO). Differences in coding were discussed in an iterative process until all authors agreed on the structure and interpretation of the findings. Finally, we extracted quotes from the transcripts to illustrate the themes. Simultaneously, we reviewed public documents from participant's organizations, including websites, blogs, dissemination material and social media and wrote memos on issues related to quality of care. During the analysis process, we reviewed memos and linked our notes with participants' responses in the focus group. This process informed the interpretation of the conversations in the focus group and the interview, by allowing us to understand participant's interventions in the broader context of the public statements from the organizations and previous conversations we have had with them.

Strengths and limitations

In this study, we did not aim to have a representative sample of the feminist activists that support self-managed abortion in LAC, but rather to reveal the voices of some of the activists that have played a key role in developing feminist abortion care models. While we are aware that our sample is small,

it was sufficient to answer our study question and to delineate a first set of themes that highlight what can be learned from feminist activists providing abortion support in legally restrictive settings. Our selection of data collection techniques allowed us to conduct deep conversations around specific dimensions of quality of abortion care, and to interpret them in the light of strategies and practices reflected on the documentation we reviewed and the informal conversations we held with activists in the movement. These data, along with our own feminist approaches and our closeness to the abortion support movement guided our analysis and interpretation and allowed us to better understand what was expressed in the focus group and the interview.

Ethical issues

Participants provided written informed consent to participate in the study and for the conversations to be audio recorded. The study was approved by the Drug Research Ethical Committee CEIM -Parc de Salut MAR, Barcelona.

Results

Providing comprehensive information and establishing horizontal relationships

When asked about what is good quality abortion care, activists described the information they provide and the kind of relationship they establish with the people they support. For these activists, good care entails providing updated, evidence-based and comprehensive information that covers all the different aspects pregnant people need to be aware of, so they know what to expect during the abortion. Members of their teams receive intensive training on evidence-based guidelines about medication abortion and constant updating of knowledge. For them, good information also includes all the options available in the person's context and appropriate for their personal circumstances, as well as dignified answers to all their questions. Activists also agreed that building horizontal relationships –that is, questioning the traditional power imbalance between providers and abortion seekers– is core to good abortion care. According to one activist, this works "to eliminate all the barriers between both people in order to understand the woman's situation." (Focus group, participant from Peru) The way information is provided is also important. Active listening, unconditional support and non-judgmental care were described as elements of the kind of communication they want to achieve.

Feminist ethics

Activists mentioned how feminist values define their models of care. The aim of enabling pregnant people's autonomous decisions was a recurrent subject throughout our conversations. Participants also agreed that they want to enable abortion processes that become transforming experiences, both on individual and cultural levels.

Feminism also defines how these activists identify themselves and the care they provide. About half of participants saw their work as feminist political projects or accompaniment work, as opposed to service provision. Thus, most of them do not identify as abortion providers, but as activists doing direct action. For many, their identity as feminists activists is in direct opposition to the clientelist perspective of health services, with which they do not align.

Most of these feminist organizations prioritize creating spaces that are for women only. From their perspective, this allows them to create safe spaces and "That it is an abortion between women, in a context of trust, security, comfort" (Focus group, participant from Chile). They also agreed that sometimes this contradicts women's preferences and discourses, for example the preference of having their male partners present in the accompaniment process.

WHO and quality of care

When asked about the WHO framework of quality of care, participants first referred to the WHO abortion guidelines they use as a source of information. They agreed that these guidelines have been a fundamental tool to increase the safety of people having abortions and activists supporting them, as it allows avoiding criminalization while decreasing risks of complications. As one participant expressed: "It has that double line of safety that is super valuable" (Focus group, participant from Dominican Republic).

Simultaneously, participants were critical about the WHO approach to quality of care. They all agreed on the idea that the WHO definition of quality of care does not take into account women's autonomy: "The concepts of health as defined by the WHO are not thought of in a feminist way, neither [they think about] the body nor the autonomy of women […] it is not oriented nor it is anchored in what is our real bet, which is autonomy, women's autonomy" (Focus group, participant from Chile).

Participants also criticized the neoliberal background of the WHO approach, apparent in the organization's definition of efficiency as avoiding waste of resources, that contrasted with the activist's perspective of using all available resources to provide high-quality care and not thinking

in monetary terms. For them, the neoliberal background was also evident in the lack of a mention of justice in WHO definitions of equity and accessibility. They also mentioned the importance of accounting for emotional support as a fundamental part of good abortion care, which is absent in WHO definition that is not specific for abortion. Two participants also mentioned that WHO definitions do not take into account ancestral knowledge. Participants also highlighted that the WHO definitions of quality of care are thought for formal health systems and may not be the best approach to think about quality in feminist abortion initiatives.

Perspectives and strategies around quality of care

Effectiveness

Activists critiqued the idea that effectiveness should be measured in terms of a concrete health outcome (i.e. a complete abortion). Instead, they proposed measuring effectiveness in relation to the objectives for which the initiatives were created, which they described as "enabling autonomous decisions," in contrast with providing abortion services. As one of the participants expressed: "For us, the objective is to guarantee all the necessary information so that the decision on whether or not to have an abortion, how, and under what conditions, can be taken autonomously" (Focus group, participant from Venezuela). Participants exemplified that they would consider their work effective in cases where, after receiving information or accompaniment, women decide to continue with the pregnancy, to have a surgical abortion or to take abortion medication differently than what was explained to them. One participant also talked about the difficulties of measuring effectiveness in terms of abortion provision, as in hotlines it is difficult to monitor and evaluate what happens after information is provided.

Efficiency

Participants highlighted that medication abortion is efficient per definition because it reduces the need and use of resources such as healthcare facilities, professional health workers and anesthesia. They also stated that medication abortion is efficient in terms of reducing the expenses associated with the treatment of unsafe abortion consequences, thus saving social and public resources.

In terms of their own feminist abortion support initiatives, they think of efficiency as linked to the concept of time in several ways. One has to do with timing to provide support, as a participant expressed: "I believe that care must not take too long to be provided, and that when it is

provided, it must extend as much as needed" (Focus group, participant from Peru). Since most of these organizations' work is sustained by volunteer labor, time is their most valuable resource, and they all agreed they are open to spend all the time needed with each person they support. They acknowledged that the way they provide abortion information may take longer than a "normal medical consultation" and they see this as another indicator of the quality of their care. Simultaneously, time is linked to efficiency and quality of care in the sense that "abortion care is always urgent."

One of the participants, from the international telehealth service, stated that another way in which they see efficiency is by trying to use their limited resources to increase their reach and support a greater number of people. Another participant mentioned that providing information about medication abortion is also efficient because it has a "snowball" effect, meaning that information provided via hotlines or in person conversations is multiplied by women sharing it with others, which maximizes the use of resources. (Focus group, participant from Ecuador).

Accessibility

Participants shared multiple reflections about barriers to access and described contextualized strategies to overcome them. For these activists, access to abortion pills is central to accessibility. They coincided that regardless of the barriers in each specific context, abortion pills are always more accessible and affordable than surgical abortions.

As these activists described, the price and availability of misoprostol varies widely across LAC. For example, in countries like the Dominican Republic and Mexico misoprostol is available through pharmacies and is relatively cheap compared with other countries in the region, but the precarious economic situation of most women makes it inaccessible. As one participant stated: "You can buy the drug in any pharmacy without a prescription and without any problem, but even so, the majority of women in Mexico cannot afford the drug no matter how cheap it is, right?" (Focus group, participant from Mexico). On the other hand, Chilean regulations on distribution make it impossible to buy misoprostol through pharmacies, which increases its price in the parallel market and makes it harder to get even for people who can afford it.

In addition to misoprostol price and distribution regulations, participants mentioned a number of structural barriers that may prevent people from getting support from their own organizations. Access to telephone and internet, which is unequally distributed in the region, and particularly difficult for people living in rural areas, indigenous people and other marginalized populations, was the most mentioned barrier. As one

participant expressed: "There are places where, for example, there are no telephone networks, so women are totally disconnected, […] places where information does not arrive, and no matter how hard you try to reach those places, it is complex" (Focus group, participant from Colombia). Participants also mentioned economic precariousness and geographic distance, that can complicate the option of traveling to receive support or get the pills. Language might also act as a structural barrier: In some cases information is not available in the native language of people requesting it (e.g. migrants and some indigenous people), information may not be suitable for people with some disabilities, or the language used by the organizations may not be inclusive of some gender identities, specifically trans men and non-binary people.

Participants also mentioned other barriers: National customs may obstruct the possibility of receiving pills sent from abroad; violent or controlling relationships may hinder women from making autonomous decisions and from arranging the logistics for the abortion; stigma and social criminalization of abortion can restrict access to accurate information and may also discourage some people from searching for options when they face an unwanted pregnancy.

Based on their deep understanding of their own contexts and the barriers to access their support and the medication, activists are constantly creating strategies to make their initiatives more accessible. For example, they incorporate translations and support in more languages, use diverse means to provide information (such as phone, in person and online), create written and visual materials and produce subtitled videos. They also work to make their language more inclusive for people with less education, migrants, trans men and non-binary people. Finally, many of them support the creation of new initiatives, focusing on marginalized and rural areas, smaller cities and other countries. Activists also talked about their limited resources and how it is impossible for them to reach all people in need of abortion in their own contexts. Several activists agreed that their models of care are created so women reach them instead of trying to reach more women.

Acceptability

Women's needs and preferences were mentioned along the focus group, even when talking about other aspects of quality. In the words of one participant: "Precisely all the questions and approaches that have come up so far are about how best to provide information that is convenient for her and that is useful to her and that is in accordance with her criteria. Of all the discussions that have come up, this [acceptability] is like the basis that lies underneath it all" (Focus group, participant from the Dominican Republic)

Participants stated that centering the support in the person who needs it means providing information that is adapted to their context, that women think is useful and that enables them to conduct the abortion in their own terms. In doing so, dialogue and listening are key, because they open the possibility of tailoring information to different contexts and personal needs. Regarding context differences, one activist highlighted that acceptability has different meanings in diverse contexts, separating what she believes would be the ideal situation (multiple abortion methods available for free to whomever needs them) from what acceptable abortion care actually is in a restrictive setting and with limited resources, that she described as "the person using the service feeling that it was a safe choice and that it was […] most in line with their well-being, […] that they feel like… informed, supported, that they can control the circumstances surrounding the procedure as much as they can" (Interview, participant from the international telehealth service).

Activists were also critical of the concept of acceptability defined as adapting the service to women's culture and preferences. Understanding that the idea of culture includes patriarchal cultural norms in which abortion stigma and criminalization are grounded, they recognize that the feminist abortion care they provide sometimes implies "clashing with the women we work with and who we serve" (Focus group, participant from Venezuela).

Equity

For most participants, equity was tightly linked with accessibility. They seemed more comfortable discussing accessibility related strategies and perceptions (regarding social class, ethnic and geographical differences in access and their work to overcome them, as described above) than to talk about equity as an element of good quality abortion care. Regarding WHO definition of equity, "delivering care which does not vary in quality because of personal characteristics," most activists agreed they do make differences in terms of sex, as their support is directed to pregnant people and they do not provide information to male companions of pregnant women. One activist also mentioned the lack of reference to justice in this definition as an indicator of the difference between what they do and what WHO aims to achieve in terms of equity. Two activists mentioned providing support to gender non-conforming pregnant people as an equity element they are working to improve.

Safety

Activists approach to safety was wider than the one commonly used in formal health services. They talked about medical complications, violence,

stigma, criminalization and scams. Regarding risks of medical complications, activists agreed that providing evidence-based, detailed and comprehensive information as well as referrals when possible and appropriate is essential to protect women's safety. Participants also expressed that the information they provide allows women to avoid the risks of having a clandestine surgical abortion, which they perceived as much riskier than a medication abortion.

When talking about violence and stigma they stated that their models of care allow women to have abortions without medical care, which protects them from the harmful practices they may encounter in the formal health system, as one of the activists explained: "[hospitals can be] locations of obstetric violence, of criminalization, of stigma and stigmatizing behaviors and even of extortion from medical personnel… I mean, it is not always true that […] formal health systems are safe places, so it may be that your safety is better served by not going to health services, unless it is medically necessary" (Interview, participant from International telehealth service). Acknowledging that in some cases people they support need medical attention, activists have created strategies to assure access to formal health services while preventing obstetric violence and legal consequences. One of the participants described these strategies as "indirect actions that are oriented toward diminishing the levels of violence that women face" (Focus group, participant from Chile) such as referring to networks of trusted health professionals and informing women about their rights as patients in healthcare facilities.

Another risk activists aim to diminish is associated with scams when trying to get abortion pills in the parallel market. To tackle this issue, some organizations work with networks that distribute reliable pills and others publish lists of scammers where seekers can verify the vendor before buying the pills. Safety was also described in terms of "creating a safe space for women," where women feel confident, supported and cared for.

Participants also agreed that the perception of safety is important. For them, "that those who contact us feel safe" (Focus group, participant from Dominican Republic) is a key indicator of safety. Finally, confidentiality and privacy were understood as components of safety and some activists mentioned the difficulties of protecting women's privacy when providing information through means that are inherently insecure, such as whatsapp or email.

Discussion

Our study was a first approximation to feminist activists' perspectives on quality of abortion care and our results include a variety of concrete strategies to provide high quality abortion care. Thus, our findings contribute to the body of research that aims to develop standardized indicators

and inform policies and health system improvements in this field (Dennis et al., 2017).

In the definition proposed by participants in our study, good quality abortion care entails evidence-based information, trained providers (either medical providers or lay health professionals and activists), as well as timely, respectful, dignified and non-judgmental support that is accessible for people with different needs and resources. The elements highlighted by participants in our study fit under the dimensions of effectiveness, patient-centredness/acceptability, accessibility and equity as defined by the WHO (2006) and other international institutions aiming to improve quality of healthcare services (Busse et al., 2019).

Simultaneously, the perspectives and strategies analyzed in this study reflect the legally restrictive contexts where they emerged and the feminist ethics in which they are grounded. The abortion support initiatives described here were developed as a political response to contexts that deny and criminalize reproductive choice. Activists have created models of care tailored to their contexts, aiming to meet a concrete need in a region where 1 out of 3 pregnancies ends in abortion (Guttmacher, 2018) and where formal abortion services are inaccessible for most. Feminist ethics shape these activists' work and distinguish it from abortion care provided in formal health systems, while enabling them to contribute with new conceptual and practical elements in some of the dimensions of quality of abortion care. Autonomy is one of such elements, as it was outlined as central to different dimensions of quality care. Autonomy has been included in quality of care frameworks that are specific for sexual and reproductive health (Dennis et al., 2017; Hulton et al., 2000; Sudhinaraset et al., 2017), but is absent in more general approaches to quality and healthcare (Busse et al., 2019; WHO, 2006). The feminist perspective of our participants contributes to current knowledge by adding a radical vision of autonomy where the hierarchic relations between abortion seekers and providers are questioned, and the power over all decisions during the abortion process remains with the pregnant person.

Regarding efficiency, activists highlighted that support for self-managed medication abortions is efficient in the sense that it helps saving social and individual resources related to the costs of surgical abortions as well as of the treatment of post-abortion complications, which is supported by previous studies (Hyman et al., 2013; Zamberlin et al., 2012). Activists identified several individual and structural barriers for abortion support accessibility, including misoprostol affordability, local regulations for its distribution, access to communication technologies, geographic distance, language, disabilities, custom regulations, violent personal relationships and abortion stigma and criminalization. Previous studies have found similar barriers limiting access to abortion services both in Latin America

(Zamberlin et al., 2012) and in less restrictive contexts (Doran & Nancarrow, 2015). Activists also described strategies to ensure that abortion care is acceptable, which are based on establishing dialogue and listening in the communication with pregnant people. All these specific elements of abortion care quality could be used to build indicators of quality of care. While some apply to legally restricted settings only, others could be useful in more liberal contexts.

Regarding safety, while activists are committed to deliver care that minimizes risk and harm (WHO, 2006), they take a broader approach to the kind of risks and harms that abortion care should tackle. Instead of focusing in health outcomes, as formal health services do, they also aim at minimizing legal and social risks. Notably, one of the strategies that activists have developed to improve the safety of the people they support is to help them avoid approaching formal health systems unless it is strictly necessary for medical reasons. This strategy is based on their empirical knowledge, supported by extensive research, that in their contexts formal health system abortion-related care often lacks quality (Guttmacher, 2018) and can be a locus of obstetric violence that too often becomes a path for criminalization (Steele & Chiarotti, 2004; Zaragocin et al., 2018). While their models are not built to provide emergency care, activists tackle the issue of continuity of care as an aspect of quality by establishing networks of trusted health professionals and institutions where they can refer people in need.

Based on our data we believe that many of the strategies developed by these feminist activists have the potential to improve abortion care in formal health systems and less restrictive contexts. Our results show how a person-centered perspective can be incorporated to healthcare and our participants described concrete strategies to do so. For instance, formal health systems could improve how they use the idea of "dialogue and listening" to build providers' skills to establish rapport with patients. Self-administered medication abortion could be included within the options that pregnant people are offered in formal health systems in liberal contexts and support and information could be offered as a harm reduction practice in restrictive contexts. Remote care that uses widely available technology (such as cellphones), diverse informational means, translations to multiple languages and inclusive language could also help improve abortion services accessibility and equity in contexts with a variety of legal regulations of abortion. Taking into account that abortion is a controversial issue in many different contexts, and that social controversy may impact services accessibility, equity and safety, referral systems in abortion care should include good quality post-abortion and obstetric emergency services as well as other resources that may be needed depending social and legal circumstances. For example,

emotional, social and legal support might also be needed in places where abortion is legal but remains stigmatized or where self-managed abortion remains criminalized.

Finally, in order to improve quality, further research is needed to understand women and pregnant people's experiences and perceptions on quality of abortion care in different contexts, including formal health facilities, self-managed abortion support initiatives and post-abortion care in other legally restricted contexts. We also need to further understand the impact and potentialities of establishing horizontal relationships in healthcare and the precise impacts of abortion criminalization over the quality of abortion-related services in legally restricted contexts.

Conclusion

Feminist abortion support initiatives have developed strategies to achieve good quality abortion care that are mostly in line with common definitions of quality of care used across health issues and for formal health systems. Furthermore, by applying feminist ethics into healthcare practice, activists contribute with new elements to the understanding of quality of abortion care. They underscore autonomy in reproductive and healthcare choices, a horizontal perspective for interpersonal relations in healthcare, the potential of new communication and medical technologies to improve efficiency, accessibility and equity and a broader perspective on safety that accounts for legal and social circumstances.

Author contributions

All authors contributed to the conceptualization of the study, the design of the methodology and the data analysis. SL collected and curated the data and drafted the original manuscript. All authors reviewed and edited the manuscript.

- Effective, delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need
- Efficient, delivering health care in a manner which maximizes resource use and avoids waste
- Accessible, delivering health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need
- Acceptable/patient-centered, delivering health care which takes into account the preferences and aspirations of individual service users and the cultures of their communities

- Equitable, delivering health care which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status
- Safe, delivering health care which minimizes risks and harm to service users
- Source: World Health Organization. Quality of Care. 2006

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RESEARCH ARTICLE

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"*No one should be alone in living this process*": trajectories, experiences and user's perceptions about quality of abortion care in a telehealth service in Chile

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Abstract: *Self-managed abortion is a common self-care practice that enables pregnant people to exercise their rights to health, bodily autonomy and to benefit from the advances of science even when living in contexts that do not guarantee these rights. In this interpretative qualitative study, we aimed to understand women's abortion trajectories, experiences with self-managed abortion and assessments of the quality of care provided by Women Help Women (WHW, an international activist non-profit organisation working on abortion access). Grounded in feminist epistemology and health inequalities approaches, we conducted eleven semi-structured interviews in Santiago, Chile. We found that illegality, stigma and expectations surrounding motherhood and abortion determined women's experiences. Participants perceived the WHW service as good, trustworthy, fast and affordable, and valued confidentiality and privacy; the quantity and quality of information; having direct, personalised and timely communication with service staff; being treated with respect; and feeling safe, cared for and supported in their decisions. Most participants considered self-managed abortion appropriate and acceptable given their circumstances. Fear was the dominant feeling in women's narratives. Some participants mentioned missing instant communication, in-person support and professional care. We conclude that support, information and company are key to improving abortion seekers' experiences and enabling their decisions, particularly in legally restrictive settings. Centring care in pregnant people's needs and autonomy is fundamental to ensure safe, appropriate and accessible self-care interventions in reproductive health. Social and legal changes, such as public funding for abortion, destigmatisation and decriminalisation, are needed to realise people's right to higher standards of healthcare.* DOI: 10.1080/26410397.2021.1948953

Keywords: quality of care, telehealth, abortion, self-managed abortion, misoprostol, mifepristone, qualitative evaluation, feminism

Introduction

Self-managed abortion, the use of pills to interrupt a pregnancy outside the formal health system and without direct medical supervision,[1] is a common self-care practice that enables pregnant people to exercise their rights to health and bodily autonomy and to benefit from the advances of science, even when living in contexts that do not

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guarantee these rights. Seeing this potential, feminist collectives around the world, and particularly in legally restrictive contexts, have organised to provide information and support to those self-managing their abortions. By doing so, these organisations facilitate the rights of populations made vulnerable by unjust laws, neglectful governments and discriminatory societies. To contribute to a better understanding of how supported abortion self-care is evaluated and experienced by people living in legally restrictive settings, in this article we analyse the experiences of Chilean women* who accessed abortion through the Women Help Women (WHW) telehealth service.

The recent history of abortion regulation in Chile speaks of how this issue has been used as a bargaining chip by administrations of diverse political tendencies. Therapeutic abortion – the interruption of a pregnancy to protect the pregnant person's health and life – was legal from 1931 to 1989.[2] During an eight-month period under the socialist government of Salvador Allende (1970–1973), health professionals interpreted this clause liberally and openly provided abortion and post-abortion care in public hospitals.[3] This practice changed when dictator Augusto Pinochet took power, but only at the end of his military dictatorship was abortion formally penalised in all circumstances, including therapeutic abortion.[2] Feminist organisations and social movements advocated for a change in regulation for almost three decades and in 2017, during the second period of Michelle Bachelet's presidency, the change finally arrived. Currently, abortion should be performed by medical professionals on three grounds: to save the life of a pregnant person, for fatal fetal anomalies, and in cases of rape.[4]

However, the long-awaited change in regulations did not improve access substantially. The Chilean Ministry of Health reported that only 700 legal abortions were performed during 2019,[5] meaning that the vast majority of the estimated 72,000–140,000 annual abortions in the country[6] are still performed outside the formal health system and the legal indications. Limited legal grounds, stigma, and a wide definition of health professionals' right to conscientious objection that translates into denial of care,[7,8] explain why the change in the law has failed to improve abortion access for most people with unwanted pregnancies. Socially, abortion is still a contested issue: while around 70% of the population agreed with decriminalisation under limited circumstances as included in the new bill, only a small proportion of Chileans support abortion on demand.[8,9]

Despite the difficulties of studying a clandestine phenomenon, previous research in Chile has shown that elective abortion is most common among women with higher socioeconomic status;[4] that young women and those with internet access are more likely to access safer methods; and that the use of misoprostol to induce abortion increased during the last decades.[10,11] While misoprostol - and more recently mifepristone - are registered for gynaecological uses,[12] distribution is restricted to authorised healthcare facilities. Therefore, most people access misoprostol alone from the parallel market, where prices are high and the authenticity and quality of the medicines are not guaranteed.[10] Local feminist organisations providing accompaniment and hotlines such as *Línea Aborto Libre* (Free Abortion Hotline), *Con las Amigas y en la Casa* (With Friends and at Home) and *Miso pa todas* (Miso for all) Network, as well as telehealth services such as Women Help Women and Women on Web, are also common sources of support, information and, in some cases, abortion pills.[13,14]

Women Help Women (WHW) is an international feminist organisation that facilitates access to medical abortion in restrictive settings. It has operated in Chile since its foundation in 2014. People requesting the service fill in an online survey to confirm their eligibility for medical abortion (being less than eleven weeks pregnant and without contraindications for medical abortion according to WHO guidelines).[15] WHW counsellors provide information through email on the logistics of the service and the process of the medical abortion as well as emotional support. WHW requests a €75 donation that can be made via international bank transfer or credit card but people who cannot donate are still offered the service. 200 mg of mifepristone and two doses of 800mcg of misoprostol each are sent by mail and take one to two weeks to arrive in Chile. WHW recommends taking mifepristone orally

*People with diverse gender identities, including people who do not self-identify as women may need abortion services. While we strive to use language that reflects that need, in this study we interviewed cis-women and use the word women to refer to them.

followed 24 hours later by 800 mcg of buccal misoprostol (the second misoprostol dose is meant to be used only if needed, according to WHO guidelines).[15] Users are informed that the buccal or sublingual use of misoprostol would diminish the risk of criminalisation in case of complications (as opposed to vaginal use where remains of the pills can be found in the vagina days after the procedure, and could be used as evidence that the abortion was induced). A follow-up survey is sent two weeks after the delivery of the package. WHW counsellors are feminist activists trained in medical abortion and two specialised doctors are available to support them and answer medical questions.

Interest in supported self-care interventions, such as the WHW model of care, has grown in recent years, and has been raised further by COVID-19.[16,17] In this context, strategies that were formerly designed and led by activists, such as self-management as an option for abortion care, are being increasingly adopted by formal health systems.[18] While extensive knowledge about the effectiveness, safety and acceptability of the use of abortion pills outside formal healthcare facilities exists,[19,20] research into users' evaluations of the quality of these services is more limited. Evaluations of quality of care are important to inform the design of supported self-care initiatives that aim to facilitate reproductive justice - that is, people's right to have or not to have children and to do both with dignity and support[21] – in a variety of contexts.

To contribute to filling these gaps, our aim in this study was to understand abortion trajectories leading people to use the WHW service in Chile, their experiences with self-managed abortion, how they evaluate WHW's quality of care and how they compare it with gynaecological and obstetric services they have accessed in the past.

Materials and methods

Our interpretative qualitative study was grounded in health inequalities and feminist epistemology approaches. The term "health inequalities" refers to unfair, avoidable and systematic differences in the health status of population groups. They are socially produced by the unequal distribution of resources and power and are marked by social, economic, geographical and demographic lines.[22] By feminist epistemology, we refer to the critical perspective of knowledge production based on three principles. First, that intersectional gender analysis, that is, the analysis of the interaction between gender, race and ethnicity, social class and territories, among other axes of oppression, is fundamental to understanding the world. Second, that the position from which knowledge is produced is important to what and how we know. And third, that the understanding of how the world functions is incomplete without social action to challenge it.[23,24] From these perspectives, our standpoint as feminist activists and scholars, some of us abortion activists and originally from settings were abortion is restricted, informed this study. Having a diverse group of researchers with different relations to the subject of study allowed a balanced analysis.

Sample and data collection

A convenience sample was recruited through the WHW service. An invitation email was sent to people who were living in Santiago and had used the service between November 2018 and April 2019, so that we could offer the option of in-person interviews. Approximately 10% of the invitees responded to our call. The contact information of voluntary participants was sent to the first author, who contacted them by phone to arrange for a telephone or in-person interview (in a private place chosen by the participant).

We used semi-structured interviews to collect data following the rationale of abortion trajectories. That is, "the processes and transitions occurring over time for a pregnancy that ends in abortion".[25] We asked participants about pregnancy confirmation, abortion decision-making and service seeking, experiences with medical abortion, their assessments of the quality of the WHW service, previous experiences with gynaecological services and their recommendations for improvement. We also asked participants to reflect on whether their experience changed their opinions on abortion and for some sociodemographic characteristics (see supplementary data). As the data collection process evolved, we focused on enquiring into issues that emerged in previous interviews, such as the feeling of fear, why they chose the WHW service when other options were available and why they did not contact the WHW service during the abortion.

We conducted seven phone-based and four in-person interviews in Santiago, Chile between May and June 2019. Average duration was 30 min. All interviews were conducted in Spanish, audio

Table 1. Participants' sociodemographic characteristics, number of children and number of previous abortions

Pseudonym*	Age	Is in a relationship	Employment status	Level of education	Number of children	Number of previous abortions
Miriam	25	Yes	Unemployed	University complete	0	0
Fernanda	30	Yes	Employed	Technical education	1	1
Nora	31	Yes	Employed	University complete	0	0
Killa	36	Yes	Unpaid domestic work	University incomplete	4	1**
Cristina	23	Yes	Freelance worker	Technical education	0	0
Antonia	34	No	Employed	University complete	0	0
Iliana	36	Yes	Employed	University complete	0	0
Janet	26	Yes	Employed	University complete	0	0
Carla	23	No	Student + Employed	University incomplete	0	0
Valeria	25	Yes	Employed	University complete	0	0
Manuela	31	No	Employed	University complete	1	Missing data

*In order to protect participants' anonymity, a pseudonym was assigned to each of them.
**For medical reasons.

recorded and transcribed verbatim. Table 1 presents participants' personal characteristics. Age ranged from 23 to 36 years; around half the participants were 30 years or younger. Most participants were in a relationship at the time of the interview, had higher education and were working. Three had children and two had had previous abortions.

Data analysis

Data analysis was conducted by three of the authors. First, one team member read all the interviews for familiarity and selected two interviews that represented different points in the spectrum of responses. Then the three of us coded these interviews separately and met to discuss codes and pre-analytic categories. A first codebook was created as a result of this triangulation. Two members of the team used it to code the next five interviews separately and then discussed interpretation. We then created a second version of the codebook that included categories and one of us used it to code the next four interviews; a second member reviewed the coded transcripts and provided input. Next, we created a table that contained categories, sub-categories, codes and direct quotes exemplifying each subcategory. We also developed a map that summarised categories and relations between them. Finally, we met to discuss the data and agree on the structure of the manuscript. Quotes presented in the manuscript were extracted from the analysis table and are identified with a pseudonym to protect participants' anonymity, and their age.

Ethical issues

The study was approved by the Drug Research Ethical Committee CEIm -Parc de Salut MAR, Barcelona (Code: 2018/8145/I), as a sub-study of a PhD thesis about feminist medical abortion services. We adhered to the Ethical Principles for Human Research defined by the 1964 Declaration

of Helsinki. Participants consented to participate in the study and for the interviews to be audio recorded. They provided written consent for in-person interviews and verbal consent (audio recorded) for telephone ones. All identifiable data were shared through secure channels, stored in encrypted devices and deleted immediately after the interview. Interview recordings and transcripts were identified with an anonymised code.

Results

Trajectories to WHW service: decision-making, disclosure and access to abortion pills

Most participants identified pregnancy symptoms and then confirmed the pregnancy with a urine test or an ultrasound. Several mentioned that they got pregnant while using contraception or explained the reasons why they were not taking precautions. Many of them referred to contraception as their personal duty and felt guilty and irresponsible for getting pregnant unintentionally. Only a few participants thought the abortion decision was theirs to make. Most participants referred to abortion as a "couple's decision", but described different levels of partner involvement: some partners proposed the abortion, others participated in the decision-making process and others just accepted a decision that was made by the woman.

While many interviewees described the decision as easy, fast or "*already made*" (Manuela, 31), because they knew they did not want to parent at all or at that moment, for others it was complex, difficult or took time. For instance, two women mentioned first deciding to keep the pregnancy and then changing their minds. Generally, the moment in life was a decisive factor in the abortion choice. Work, education, economic hardship, a couple's projects and already having children were some of the situations that led them to decide to interrupt the pregnancy. Wishes and feelings around motherhood also played an important role. Some interviewees wanted to be "*more prepared to be a mom*" (Nora, 31) and others wanted to be able to take care of their children.

Most participants handled the pregnancy as a secret and disclosed it only to their partners, though a few talked about it with other family members or friends. Some felt their partner's support was fundamental and others were disappointed about the role they played. Two women mentioned that the pregnancy and the abortion developed into a crisis for the couple, that ended with the relationship. Other participants were forced by the situation to disclose the pregnancy. One had first decided to continue with the pregnancy, so she disclosed it widely and then said she had a miscarriage. Another participant, who needed medical care for an abortion complication, told her religious family she did not know she was pregnant, because she feared their reaction.

Women identified a link between legal restrictions, social punishment and taboos around abortion and mentioned these as reasons to keep both their pregnancy and the abortion a secret. Some, like Manuela (31), shared stories of being judged by their loved ones when disclosing their decision:

"My mom even told me not to do it, that she was never going to forgive me […] it's like if you want to have an abortion you're … I don't know … a bad woman or a devil, so, that's why I wanted to face it alone, because people are still very prejudiced against it".

Others said they did not feel safe approaching the formal health system for information or support.

Most interviewees supported abortion decriminalisation before deciding to abort, only one thought abortion was "*an irresponsible decision"* but changed her mind when she faced an unwanted pregnancy. Most participants also had some previous information about medical abortion. They generally perceived it as a safe procedure that could be managed without medical support. Only a few participants had beliefs that reflected the erroneous information that circulates in the parallel market, for example, that different pills should be used with different administration routes and that women die using abortion medication.

We identified two major ways of seeking for abortion information and services: searching online and asking other women (acquaintances who have had abortions and feminist activists). The time it took them to find WHW by searching online varied; one woman said it was because "*you have to distinguish between what is reliable and what is not, it is not so easy*" (Janet, 26). Finding WHW seemed to be easier for the ones who started by asking other women, particularly those who were part of feminist networks, as one participant explained: "*it's all about friends and support networks*" (Killa, 36).

Most participants considered several services and sources of pills before contacting WHW, including other feminist organisations and vendors in the parallel market. One woman had an unsuccessful abortion attempt with misoprostol she got from the parallel market before contacting WHW, and another requested support from several feminist organisations simultaneously. For the others, WHW was their first choice. Only two mentioned approaching health professionals while seeking abortion care; one of them got a referral to WHW and a local organisation and the other got mistreated by her gynaecologist. Women mentioned fearing to be scammed in the parallel market, receiving contradictory information from online vendors, affordability, and feeling more secure about the authenticity of the pills as the reasons to choose the WHW service.

Abortion experience: information, emotions, time and company

Logistical arrangements for the abortion process included taking time off work, searching for a place to take the pills and finding childcare and company. Most women were accompanied by their partners, others by their female friends, one by her mother and aunt and others were alone. Several participants highlighted the importance of having company during the process and many mentioned feeling lucky because they had more support than other women, as Killa (36) explained:

"I felt more comfortable with the process at home, with my husband accompanying me all the time […] I felt I could handle it. But I think in the same situation, alone, it must be terrible. Because of the pain, because of the discomfort, because of everything. I think that no one should be alone in living this process".

Generally, women followed WHW instructions to take the pills and all of them used misoprostol buccally or sublingually. They described having cramps, bleeding and common side effects such as diarrhoea and chills. While some described the abortion as a "fast", "painless" or "not very intense" process, others said it was "not that positive", or even "traumatic". Some said the pain was "severe but tolerable", but most described the medical abortion as a very painful process. Two participants thought information did not prepare them for the intensity of the pain. Generally, participants said the intense pain lasted between one and four hours, and several mentioned feeling their perception of time was distorted by the intensity of the pain, so they felt that the abortion process "*took forever*" (Cristina, 23). Most participants were able to identify the moment of the expulsion and said pain diminished after that. One of the participants who reported severe pain did not use painkillers because she was afraid it would interfere with the abortion.

Four participants reported complications. One had a haemorrhage a couple of days after the abortion and passed out. She attributed it to the fact she had to take care of her small children too soon after the abortion. Another woman identified a haemorrhage the same day she took misoprostol. Both went to the hospital and, based on WHW information, said they did not know they were pregnant, so were diagnosed for a miscarriage and got treated according to their needs. Both said they were treated well by the staff because they did not mention having induced the abortion. Two other women had intermittent abundant bleeding that lasted more than a month. For both, a complication was ruled out when they sought medical care several weeks after the abortion. Others mentioned fearing they had a complication during the abortion process, because the pain was too strong or the bleeding too abundant, but also being able to recognise this as a normal part of the medical abortion based on the information they had.

Participants described having diverse emotions during the abortion process. Some felt "calmed", "emotionally stable" or "not very affected", and several of them attributed it to knowing what to expect based on the information they got. Others mentioned unpleasant emotions such as sadness, loneliness and guilt or said the process was "*emotionally heavy*" (Antonia, 34). Across the interviews, fear was the most mentioned emotion. Among those who were fearful, criminalisation, social judgment and "something going wrong" during the abortion process (including the pills not working, having long term consequences from the abortion and dying during the process) were most common. Fear of criminalisation and of social judgment often led these women's decisions on how to manage their abortions. For example, one participant stopped her psychiatric treatment because she feared she would be judged by her psychiatrist and others decided not to seek medical care despite having complication signs because they feared being mistreated,

reported at the hospital, or denied care. Janet (26), who was living in a small city at the time of the abortion, stated that "*The place where I live has an institutional conscientious objection. So I imagined that I was going to get there and I was going to be left out, unattended.*" Other fears included not having enough time to wait for the pills to come from abroad, being scammed when using a credit card, getting incorrect pills and doses, not having medical backup in case of a complication, receiving an invasive treatment if they went to the hospital, and regretting the abortion.

Despite the fears, several participants said that being able to choose the place and the company for the abortion was ideal for them. They mentioned comfort, privacy and not having to approach doctors as the reasons for this preference. As Cristina (23) expressed, "*I am grateful that I was able to do this quietly, alone in my home, and not with a doctor.*" On the contrary, others self-managed their abortion because "*it was the only alternative*" (Nora, 31). Some participants would have preferred to be supported by a health professional and one said it was unfair to have to self-manage an abortion as states should support women's reproductive decisions. One participant mentioned she felt good about not having to see anyone during the abortion process only because she feared disclosing the abortion in a context such as Chile.

Participants also described how their beliefs about abortion changed after their experience. Several said they now think abortion medication should be readily available; others felt more motivated to join the struggle for abortion rights and to share their abortion stories and accompany other women with unwanted pregnancies.

Assessing WHW quality of care: abortion normalisation, interpersonal relations, timely communication and pills affordability

All participants considered WHW's service to be of good quality and said they would recommend it. They described it as timely, comfortable, fast, discreet, and efficient. Several participants said they felt safe while contacting WHW. Their reasons included WHW normalising abortion, which made them feel they were approaching "*a legal form of the illegal*" (Fernanda, 30); receiving the pills in their original blister (as pills in the parallel market are often sold unpacked); accessing evidence-based, clear and complete information, which made them trust the service; and knowing they were accessing the method used in countries with liberal abortion laws, as Miriam (25) stated:

"The website and everything, it's as if they were trying to normalise a little, as if they were not judging you, […] since there it is not a crime as it is here, and the vision is different. […] it was as if it was something like … more normal than how it's seen here".

Most participants said WHW exceeded their expectations because they approached it to "buy" the pills and did not expect to receive support and care during the process. One participant said she thought that her contact with WHW would be "*a more clandestine thing, like drug trafficking*" and was surprised she felt comfortable and treated "*like a friend*" (Killa, 36). On the other hand, one participant said she was expecting to be referred to a doctor who would perform the abortion and was given no choice but to self-manage.

Participants described the interpersonal relationship with WHW staff as close, empathic, professional and without judgment. They said WHW staff were welcoming, treated them with care and respect and made them feel they were not alone, as Valeria (25) summarised: "*They are not meddlesome but not indifferent either*". Others said that follow-up emails and questions made them feel cared for and many valued receiving referrals to local services. Most participants described WHW communication as fast or immediate, and only one said she experienced a slight delay in responses. Generally, women said they had good, personalised, direct, and timely communication with WHW and assessed email – the main WHW communication tool – as private, fluid and direct. However, a few women perceived email as distant and interrupted. One of them said she would have liked to have in-person support, as she felt written communication was insufficient. Most participants did not contact WHW during the abortion process because they did not need more information, or because they had support from other feminist organisations, acquaintances who had had abortions and trusted health professionals, with whom they could communicate via instant phone messaging.

The majority of our participants had higher education and personal incomes they could decide how to spend. Thus, when asked about service accessibility, most women felt that accessing the service was easy for them but would be hard

for others in less privileged situations. Several participants mentioned that access to the WHW service is mediated by resources not everyone has, such as contacts, internet access, previous information, and a credit card. Like Killa (36), many expressed that the amount of the donation was "*a lot of Chilean money*", but seemed affordable because the price of the pills in the parallel market can be three or four times the WHW requested donation. Only one participant thought "*anyone could access WHW service*" (Nora, 31).

Several participants mentioned that constant communication with WHW helped them cope with the anxiety they felt while waiting for the package to arrive. Participants were generally satisfied with the delivery, which for most of them took one week, and for others two to three weeks. One of the women who received the package in two weeks said the time for delivery was too long.

Three participants mentioned having technical problems when accessing the website from a cell phone. When asked for recommendations to improve the service, women proposed implementing more immediate and personal communication means, such as instant messaging, phone calls or in-person encounters. Others recommended making the website more visible, focusing attention towards younger women, creating opportunities for collective experience sharing, and providing more information on how to make the decision and disclose it to others. Several participants mentioned the legal situation of abortion in Chile as a justification for the service limitations.

Comparing supported self-care with the formal health system: searching for humane services and non-judgmental care

Previous experiences with sexual and reproductive health services contextualise these women's assessments of WHW quality of care. Compared with formal care they had received in the past, participants mentioned WHW advantages such as staff being "more humane", providing more information and showing actual concern and willingness to help. Several participants highlighted the emotional support, non-judgmental care and rapport, which they perceived as uncommon features in formal health services. As Antonia (34) stated: "*Doctors only care about the medical, not about me as a person*". Two participants thought the comparison did not make sense given the legal restrictions in Chile.

Several participants shared experiences of long waiting times, judgment and mistreatment in the formal health system when trying to access legally available services such as contraception. For example, one said she was on a waiting list for a tubal ligation for so long that she had several kids while waiting. Another explained that in her university the only contraceptive method for which information is available is sexual abstinence and another described being mistreated by a gynaecologist while requesting information about a vasectomy for her partner. Participants also mentioned low quality care when approaching the formal health system with abortion-related needs. Janet's (26) gynaecologist tried to dissuade her from her decision when she mentioned wanting to have an abortion. Valeria (25) had prolonged bleeding and went to the hospital one month after taking the pills. Her gynaecologist – who ruled out a complication – told her that "*her uterus could fall down*" because she waited too long to get medical treatment. While some women normalised the mistreatment in health facilities or justified it because of the legal restrictions, others interpreted the generalised lack of quality in sexual and reproductive health services as the formal health system "*forcing women to be mothers*" (Killa, 36).

Some participants also shared their good experiences with feminist health professionals, and with a "trusted gynaecologist". These experiences included professionals normalising abortion and offering confidentiality about their conversations, providing information and referrals to access abortion outside the health care system and adequately informing about other sexual and reproductive health issues.

Discussion

We found that women's trajectories to the WHW service and their experiences with self-managed abortion were determined by illegality, stigma, expectations around motherhood and abortion, as well as by personal circumstances. In line with previous analysis about self-managed abortion trajectories in the region,[26–28] including previous studies in Chile,[10,11] our results demonstrate that illegality and stigma do not deter women from deciding to interrupt a pregnancy, but make their abortion trajectories and

experiences harder and more demanding. WHW's work in Chile inserts itself into the Latin American feminist tradition of supporting self-care to enable reproductive autonomy and improve abortion access,[29] and has outcomes similar to those of other feminist initiatives in the region.[14,28,30] For example, our results confirm that information, accompaniment and ready access to abortion pills improve self-managed abortion experiences.[10,11,26,30]

By focusing on perceptions about WHW's quality we add fresh data about how its model of care impacts abortion trajectories and experiences in specific ways. This information is relevant for discussions on how self-care could improve access to sexual and reproductive health care in the context of fragmented legal landscapes, growing global inequalities and formal health systems collapsed by the COVID-19 pandemic. Our results show that, despite legal restrictions, several options to access abortion pills are available in Chile and women chose WHW because they perceived it as trustworthy, fast and affordable. Participants considered WHW a good service and valued the quantity and quality of information; having direct, personalised and timely communication with service staff; being treated with respect; and feeling safe, cared for and supported in their decision. Most participants considered self-managed abortion appropriate and acceptable given their circumstances. While the generally positive assessment of self-management as an option of care may be explained by the Chilean restrictive legal environment, WHW's most valued service features are indicative of the elements that every good abortion service should have. Timely information, emotional support, rapport, and respect for women's choices emerged as key elements in abortion care. In contrast, our participant's assessments of gynaecological services provided legally in Chile show how formal care can fall short in some of these important aspects of quality. Similarly, studies conducted in contexts with more liberal abortion laws, where home administration of medical abortion is offered by the formal health system, have found that abortion self-management is sometimes seen as inferior to in-hospital care because of perceived lack of information and follow-up, limited access to health professionals, and insufficient pain management.[31,32] We argue that many of the features of the WHW model of care could be introduced to self-care initiatives led by formal health systems to fulfil the aims of guaranteeing rights and achieving acceptability.

However, our in-depth analysis of the quality of the WHW model also allowed us to understand the limits of what a high-quality service can achieve in a stigmatising and criminalising context. Abortion stigma is a social process by which a negative attribute is ascribed to those associated with abortion (people who have abortions, their partners and providers), grounded on their violation of social expectations.[33] For people who have had abortions, stigma comes from the social belief that they fall short of the ideals of womanhood.[34] In practice, stigma translates into barriers for abortion access, fear, silence and shame.[33,34,36] Abortion stigma is often compounded by criminalisation, but it can also survive liberalisation of abortion laws, as the Uruguayan and Colombian cases show.[35,36] Previous studies have found that fear of being criminalised determines experiences and narratives around abortion in Chile.[10,11] Our findings add that despite accessing a service that normalises abortion, the centrality of stigma and fear persists.

We also found that while most participants valued confidentiality and privacy and felt they had adequate support during the abortion process, many of them identified fears of social judgment and criminalisation as reasons for keeping their abortion secret. As Sheldon has indicated in her analysis of the relation between abortion pills, empowerment and privacy in the Republic of Ireland, secrecy and silence may be functional in perpetuating stigma and for states to continue to neglect their responsibilities for reproductive health.[37] In our interviews we found that women who accessed abortion through WHW's service may be more willing to talk about their abortion experience and join the struggle for abortion decriminalisation. However, at the individual level, the self-protection strategy of silence and secrecy may still endanger women's wellbeing as it makes them fear seeking medical care when needed, as some of our participants mentioned and as Horgan has documented in Northern Ireland.[38]

It is well known that those who suffer the worst consequences of criminalisation and lack of abortion access come from marginalised groups.[10,11,28] Other authors have also established that abortion trajectories and decision-making are differentiated by socioeconomic status.[27] It is thus important to note that most of our interviewees had

university education, access to the internet and support networks. While our participants said that the WHW service was accessible for them, they worried it would not be the case for women with fewer resources. Coinciding with this concern, a previous analysis of a national survey that included a representative sample of women aged 15–29 in Chile, found a socioeconomic gradient on abortion incidence. As compared to young women with low socioeconomic status, those with higher status had almost five times the odds of having induced an abortion, and those with middle status had 1.8 higher odds.[4] The higher presence of relatively privileged women in our study as well as the higher incidence of abortion in this group in the Chilean survey, may be explained by women with more resources being more empowered to act on their reproductive desires,[39] or to disclose their abortion for research purposes, but it could also mean that many women with lower socioeconomic status have no choice but to take unwanted pregnancies to term because they are unable to access abortion services. While the nature of our study did not allow us to assess if access to WHW is determined by socioeconomic status, it does shed light on the qualitative aspects of accessibility. We show that support networks facilitate access, that previous knowledge and access to international payment methods have a mediating effect on access and that the perception of affordability is related to the price of the pills in the parallel market. Further studies aiming to understand the different meanings and expectations around motherhood and abortion and their relation to social class and religion are warranted. Also, further research into service utilisation, that includes those who do not access abortion services, would improve understanding of how structural inequalities operate on abortion access in contexts like Chile, and whether remote support and self-care interventions such as WHW's are sufficient to guarantee the rights of the populations at most risk.

Our study demonstrates that not only support for abortion self-care, but also high-quality abortion care, are possible despite legal restrictions. It also highlights the need for social, political and legal changes to fully realise reproductive justice. From a service perspective, more emphasis on normalising reproductive choices and humanising relationships within health care are key. In-person attention and access to professional and emergency care should also be available for those who want it or need it. In terms of politics, abortion-related regulations should fulfil their aim to protect people's health, rights and well-being; thus total abortion decriminalisation and public funding for abortion are needed in Chile. However, none of this will happen without a profound change in social beliefs about abortion and the role of women and gender non-conforming people in society.

Strengths and limitations

Our study design allowed us to contribute new information on an under-studied and clandestine phenomenon and our results have the potential to improve the quality of abortion services, including supported self-care interventions, in a variety of contexts. Moreover, our qualitative approach enabled us to interview women with diverse trajectories and experiences and to understand their assessments of quality of care in relation to some structural and contextual determinants. However, our study has some limitations. Our sample was small and fairly homogeneous in terms of socioeconomic status and geography, which may have hindered our ability to see a wider array of abortion trajectories. Recruiting users through the service may have limited the possibility of interviewing unsatisfied users and understanding the nuances of satisfaction and acceptability. It is possible that participants identified the interviewer as a member of WHW, which may have influenced responses. Finally, it is possible that our participants were more empowered than other women in the same context to talk about abortion, which would soften the effects of stigma and criminalisation in users' experiences.

Conclusion

Women's trajectories, experiences and assessments of quality of abortion care are determined by the intersection of structural, contextual and individual factors. Support, accompaniment and information are key to improving pregnant people's experiences and enabling their decisions, particularly in legally restrictive settings. Developing models of care centred in pregnant people's needs and autonomy, including complete and evidence-based information, direct and timely communication and good interpersonal relationships, is fundamental to ensure that self-care

interventions in reproductive health are safe and appropriate. However, social and legal changes – such as public funding for abortion, destigmatisation and decriminalisation – are needed to enable the full realisation of people's right to access the highest standard of healthcare.

Contributions

SL designed the study and the data collection tools, CB and LP supervised the design and contributed to it. SL and CH coded the interviews and CJ participated in the analysis. SL drafted the first version of the manuscript and all authors contributed to it.

Disclosure statement

SL was working as a paid staff member at WHW when this study was conducted. Authors declare no other conflict of interest.

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Résumé

L'avortement autogéré est une pratique d'auto-prise en charge qui permet aux personnes enceintes d'exercer leurs droits à la santé, à l'autonomie corporelle ainsi que de bénéficier des progrès de la science, même quand elles vivent dans des contextes qui ne garantissent pas ces droits. Dans cette étude qualitative interprétative, nous souhaitions comprendre les trajectoires d'avortement des femmes*, leur expérience de l'avortement autogéré et les évaluations de la qualité des soins prodigués par Women Help Women (WHW, une organisation militante internationale à but non lucratif travaillant pour l'accès à l'avortement). Nous fondant sur les approches de l'épistémologie féministe et des inégalités de santé, nous avons mené 11 entretiens semi-structurés à Santiago du Chili. Nous avons constaté que l'illégalité, la stigmatisation et les attentes entourant la maternité et l'avortement avaient déterminé l'expérience des femmes. Les participantes ont jugé que les services de WHW étaient bons, dignes de confiance, rapides et d'un coût abordable, et elles ont apprécié la confidentialité et le respect de la vie privée; la quantité et la qualité des informations; le fait d'avoir des communications directes, personnalisées et ponctuelles avec le personnel chargé des services; le traitement respectueux qui leur a été réservé; et le sentiment de sécurité, de prise en charge et de soutien dans leurs décisions. La plupart des participantes considéraient l'avortement autogéré adapté et acceptable compte tenu de leurs circonstances. La peur était le sentiment dominant dans les récits des femmes. Certaines participantes ont mentionné que la communication instantanée, le soutien en personne et les soins professionnels leur avaient manqué. Nous en concluons que l'appui, l'information et l'accompagnement sont essentiels pour améliorer l'expérience des femmes souhaitant avorter et permettre leurs décisions, en particulier dans les environnements juridiquement restrictifs. Il est fondamental de centrer les soins sur les besoins et l'autonomie des personnes enceintes pour garantir des interventions d'auto-prise en charge sûres, appropriées et accessibles dans le domaine de la santé reproductive. Des changements sociaux et juridiques, comme le financement public pour l'avortement, la déstigmatisation et la dépénalisation, sont nécessaire pour réaliser le droit des personnes à des normes plus élevées de soins de santé.

Resumen

La autogestión del aborto permite a las personas embarazadas ejercer sus derechos a la salud, a la autonomía corporal y a beneficiarse del progreso científico aun cuando viven en contextos que no garantizan estos derechos. En este estudio cualitativo interpretativo, nuestro objetivo fue entender las trayectorias de aborto, las experiencias con la autogestión del aborto y las evaluaciones de la calidad de la atención entre usuarias del servicio de Women Help Women (WHW, organización activista internacional sin fines de lucro que trabaja para ampliar el acceso al aborto). Basándonos en los enfoques de la epistemología feminista y las desigualdades en salud, realizamos once entrevistas semiestructuradas en Santiago, Chile. Encontramos que la ilegalidad, el estigma y las expectativas en torno a la maternidad y el aborto determinaban las experiencias de las mujeres. Las participantes valoraron positivamente el servicio y mencionaron características clave para un buen servicio de aborto. La mayoría consideró la autogestión de su aborto como adecuada y aceptable dadas sus circunstancias. A pesar de esto, el miedo fue el sentimiento dominante en las narrativas de estas mujeres. Concluimos que el apoyo, la información y la compañía mejoran las experiencias de quienes buscan un aborto y facilitan sus decisiones, en particular en entornos restrictivos. Centrar la atención en las necesidades y autonomía de las personas embarazadas es fundamental para garantizar intervenciones de autocuidado reproductivo que sean seguras, adecuadas y accesibles.

CHAPTER 3

DISCUSSION

In this thesis, our aim was to understand social inequalities in access and outcomes, and quality of care in feminist initiatives supporting self-managed abortion in legally restrictive settings of Latin America and the Caribbean. To do so, we applied two conceptual frameworks: the framework of social inequalities in abortion access and the framework of quality of care. In this chapter we discuss our results in relation to our conceptual frameworks and to previous research in the field, and provide research and policy recommendations based on what we learned during the process.

In Figure 5, we have highlighted the elements of our conceptual framework that we examined in the studies included in this thesis.

1. Patriarchy and capitalism produce health inequalities and limit quality of abortion care

We assessed the systems of oppression of patriarchy and capitalism in two of our studies. Patriarchy was mentioned and analyzed in our qualitative studies with feminist activists providing self-managed abortion support, and with users of an e-health service in Chile. In both studies, our results confirmed that patriarchal oppression is deeply entrenched in the way abortion is regulated, provided and experienced, as other authors have shown (Cisne et al., 2018; Zurbriggen et al., 2019). Moreover, our results add fresh data on some specific mechanisms through which patriarchal oppression

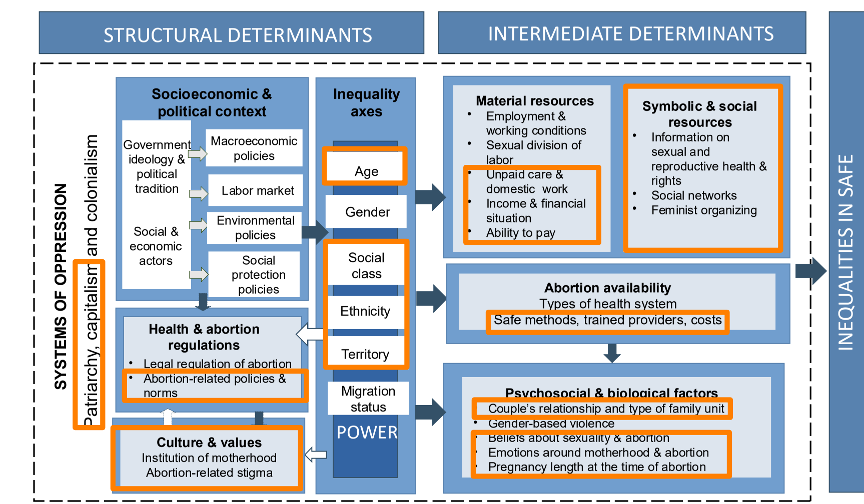

Figure 5. Elements that we studied in the dissertation, highlighted from our conceptual framework for the analysis of the social determinants of inequalities in safe abortion access

operates in abortion processes. For example, in our study with activists we found that one of the most important limitations of mainstream definitions of quality of care is their lack of a reference to autonomy. Autonomy constitutes one of the central demands in anti-patriarchal struggles, because feminist theory poses that it is through the realization of personal, economic and bodily autonomy that women and gender nonconforming people will be able to occupy the role they deserve in society (Magnone Aleman & Viera Cherro, 2015). However, a patriarchal view on women and gender nonconforming people, entrenched in mainstream public health approaches, results in the neglect of autonomy as an indicator of quality of health care. On the contrary, quality of care frameworks built from a feminist perspective to understand sexual and reproductive healthcare, center people's autonomy (Darney et al., 2018; Sudhinaraset et al., 2017).

In addition, we found that feminist activists providing self-managed abortion support, critique and contest the traditional power imbalance between healthcare providers and patients, revealing yet another way in which patriarchal and classist oppression are reproduced in power relationships in medical systems. Other authors have examined how patriarchy operates in health systems, drawing the picture of gendered, classist and racialized norms, unequal and discriminatory treatment, misunderstanding and mismanagement of global health issues such as Zika and COVID-19, and outlining the linkages between patriarchal oppression and abortion and other reproductive health care (Soohoo & Diaz-Tello, 2018; Cevallos, 2011; Nunes & Pimenta 2016; Nandagiri et al., 2020; Briceño Morales et al., 2018). Our study added to this picture by highlighting how the power imbalance between health professionals and health care users results in low quality care and how concrete healthcare conceptualizations, such as the quality of care framework, are also grounded on patriarchal views. Simultaneously, through the analysis of activists' narratives around

quality of care, we showed alternatives for the development of more just healthcare. Thus, our study also reveals concrete ways in which feminist theory and practice can contribute to the development of health sciences, health care and health research by developing alternative models of care and less hierarchical power relationships.

The results of our research with activists were also in line with our findings of the study with users of an e-health service, where participants highlighted that in the region, formal sexual and reproductive healthcare often lacks quality and how the lack of quality is linked with religious and anti-rights personal stances of some healthcare providers. Finally, I also examined the link between patriarchal structures and abortion care in the study I conducted with Assis and Ochoa-Mendoza about abortion-related obstetric violence in Chile, Brazil and Ecuador (Appendix 1). In this study, testimonials of women who approached the formal health system in the process of an abortion revealed that abortion-related obstetric violence is used as a means to punish and control feminized subjects that contradict social and legal mandates regarding abortion and gender, and highlighted the role of modern medical systems in reproducing oppressive structures.

Regarding capitalism, previous analysis have demonstrated that capitalist oppression is fundamentally bad for health. Transnational corporations, commodification and consumerism increase inequalities and negatively impact common health indicators such as life expectancy, malnutrition, mental illnesses, among many others (Flyn, 2021; Prins et al., 2015). Our findings in our studies with telehealth services in Latin America and in Brazil add that the link between capitalist structures, social inequalities and inequalities in health outcomes persist despite activist efforts to design alternatives and counter the current unjust distribution of health, such as when abortion support and access is provided by feminist activists. These findings are important because they highlight the

limitations of small-scale initiatives for better distribution of health, pinpointing the necessity of systemic change to deal with structural inequalities. Following that same line, in our study with women who used WHW service in Chile, we demonstrated that even in legally restrictive environments, abortion access is determined by elements other than legal regulations. This finding suggests that to achieve equity in abortion access, policies and interventions need to go beyond health regulations and also tackle socioeconomic disparities, as researchers focusing in health inequalities have posed for long (CRDSSE, 2012; Borrell & Malmusi, 2010).

2. Restrictive health and abortion regulations add barriers to abortion care

In our research with activists, abortion-related policies and norms were also mentioned as part of the determinants of access to self-managed abortion. In line with previous research in the region (Juárez & González, 2017; Assis & Erdman, 2021), we found that regulations on the distribution of misoprostol impact its accessibility. Based on activists' and users' narratives, we showed that in countries where misoprostol distribution is highly restricted, such as in Chile, the price of the pills in the parallel market is high; while in countries where misoprostol regulation is not particularly restrictive, such as Mexico and the Dominican Republic, the pills can be bought in local pharmacies, which helps maintain the pills affordable and makes them easier to access. Our study adds to current knowledge by showing the compounded effect of regulations and individual socioeconomic status: restrictions to access misoprostol strike particularly those who have less ability to pay for the pills, while people with more economic resources are better suited to navigate restrictive environments to access a safe abortion.

3. Patriarchal culture and values are entrenched in abortion care and produce abortion-related stigma

We approached the way in which culture and values impact inequalities in abortion access in our qualitative studies on activists' and users' perspectives. First, our conversations with feminist activists shed light on the way that the institution of motherhood is entrenched in social and individual beliefs about abortion, and how it affects abortion decisions, the process of seeking for services and the abortion experience. Moreover, we found that activists supporting self-managed abortion center their work in reproductive autonomy because it gives women and gender non-conforming people the option to confront mandatory motherhood.

In contrast with authors posing that scholarly conceptual constructs are often disengaged from the reality of women facing patriarchal violence (Castro & Savage, 2019), in our interviews with women who used an e-health service in Chile, we found that the institution of motherhood is present in women's narratives around their own abortion experiences. While participants in our study did not name their experiences using the concept of institution of motherhood, they reflected on how the idea that bearing children is fundamental for women's personal realization impacted their own choices and experiences, and is in the roots of the legal regulation of abortion, the treatment women get in formal health facilities when seeking for contraception and abortion information, and the possibility to disclose the abortion to others. The difference between our results and Castro and Savage's analysis can be explained in relation to the different levels of success of national feminist movements: while in Chile, where our study was conducted, feminist mobilization around abortion has seen an unprecedented growth in the last few years, in the Dominican Republic –where Castro & Savage's study was conducted-- feminist narratives around abortion still have less social

support. Thus, following Vivaldi (2020) in her analysis of the Chilean feminist movement resistance to the abortion ban, we interpret our findings as an indicator of the success of the Chilean feminist movement in molding narratives around women's lives, and providing individual women with concepts that allow them to make sense of their experiences, name them, and make them visible. Additionally, the generally high educational level of our study participants may also have influenced in the way they make sense of their experience.

We also examined the role that abortion-related stigma plays in abortion access and experiences. Our findings confirmed those of previous studies analyzing stigma in the region (Zamberlin et al., 2012; Casas & Vivaldi, 2014; Palma Manríquez et al., 2018), which show that stigma does not deter pregnant people from having abortions, but make their experiences more difficult and demanding, making it harder for women to access reliable information, to disclose the decision to others and to feel supported during the abortion experience. We also contributed to fill the knowledge gap around abortion-related stigma, by showing that the centrality of stigma and fear of criminalization exists also for those accessing abortions through a feminist service that normalizes its practice. Therefore, our results suggest that normalization in individual abortion care is not sufficient to prevent pregnant people from experiencing the negative effects of stigma. Social decriminalization of abortion or, in other words, its destigmatization on a social level, is necessary to improve women's experiences and ensure equitable access to abortion care.

4. Inequalities by age, social class, territory and race are reproduced in feminist abortion support

We studied the inequality axes of age, social class and territory in both of our quantitative studies with data from e-health services. In our study about social inequalities in utilization of an e-health service in Brazil, we also assessed the role of ethnicity, using the data of self-reported race. While we found that people with diverse social and demographic characteristics approached feminist initiatives when seeking for abortion information and access, our studies also revealed that both utilization of the services and outcomes of the abortion reflected structural social inequalities linked to age, social class, territory and race.

Regarding age, we found that the probability of receiving the pills from an e-health service after having requested it increased with age, but we did not find any significant difference in abortion outcomes. These results are consistent with the commonly held idea that young women face more difficulties to access safe abortion services (Organización Mundial de la Salud, 2012). Our results also suggest that when receiving similar abortion care, young women do not suffer more complications than older women, nor they receive post-abortion treatment at higher rates.

In light of the limited data on socioeconomic position that was available to us, we approached social class using the proxies of education level and socioeconomic deprivation, the latter measured as the declaration of having had difficulties to donate to a feminist service and as having donated less than required. We found a strong association between both proxies of social class and abortion access and outcomes. In our study in Brazil we found that women who had university education had four times more probability of obtaining the pills through the feminist service after having

requested information than women with basic education. In our qualitative study in Chile, we found that most women who agreed to participate in the study had higher education, suggesting that the same pattern found in access to the service in Brazil exists in Chile, but also that women with more formal education might be more likely to discuss their abortion for research purposes. In our study in several countries in Latin America, women with an indicator of socioeconomic deprivation had almost twice the incidence of post-abortion complications and treatment, showing that common patterns of health inequalities are also reproduced in the outcomes of such services, and that self-assessments of economic deprivation work as a good proxy for socioeconomic position.

In our multilevel analysis we found that the context-level variable of education, for which we used the percentage of women aged 18-24 who attend school at the appropriate level for their age group, accounted for more than 50% of the state-level variance in service utilization, defined as having received the abortion pills from the service that they contacted.

In relation to territory as an inequality axis, we had mixed findings. While did not find an association between subregions of Latin America and outcomes of the abortion, we did identify differences in the prevalence of an abortion service requests and utilization according to state in Brazil. In the first place, living in certain (rich) areas was associated with contacting an e-health abortion service. Furthermore, in our multilevel analysis we found that the region women were living in, explained more than 90% of the state variability in service utilization. While regional inequalities in Brazil have been well studied and explained (Bacelar, 2000; Rands, 2011) our results add yet one more example of how socioeconomic inequalities among territories result in health services utilization inequalities and reproductive injustice.

Finally, we were only able to approach ethnicity using data on self-reported race/color, in one of our studies. In our study on utilization of an e-health service in Brazil we found that white women have 50% more probability of accessing the pills through the service than racialized women. Additionally, our multilevel analysis showed that the contextual-level race variable (percentage of racialized women among women of reproductive age by state) explained almost 70% of the variability in the state service utilization. Racial inequalities in abortion access and safety have also been studied in Brazil (Goes et al., 2020; Domingues et al., 2020; Diniz et al., 2017). Our research added that the same racial inequalities found in previous studies are reproduced in one of the feminist initiatives operating in the country.

Others have suggested that medication abortion, particularly remote support for its self-management, may be a solution for economic and territorial inequalities (Vázquez-Quesada et al., 2020), or will at least blurry the traditional lines of health inequalities (Erdman et al., 2020). On the contrary, our results show that utilization of feminist support for self-managed abortion in legally restrictive settings, the outcomes of abortion provided through such initiatives, and the experiences of its users follow the classical patterns of health inequalities.

5. Lack of material resources makes it more difficult to access feminist support for self-managed abortion

Regarding material resources, we explored the issues of unpaid care and domestic work, income and financial situation, and ability to pay. In our qualitative study in Chile, participants stated that having time to take care of the children they already have was one of the elements they took into account when deciding to interrupt the pregnancy, choosing the abortion method and planning for the prac-

ticalities of the abortion process. These findings are in line with a recent systematic review that found evidence that caring for dependents and for the well-being of pre-existing children are named among the reasons women decide to have abortions (Coast et al., 2021). Coast et al. analyzed reasons for interrupting a pregnancy as indicators of the anticipated economic impacts of the abortion. Additionally, in Wollum et al. study (Appendix III) we analyzed the reasons women cited to have an abortion during the outbreak of the Zika pandemic in Brazil, and also found that even in the midst of a pandemic, the most cited reason to have an abortion was taking care of children or not wanting to have children.

Additionally, one participant attributed the post-abortion complications she had to the fact she had to take care of her small children too soon after the abortion. While this perception could not be confirmed because of the nature of the study, we believe our results are telling of the way in which the disproportionate burden of care and domestic work that women bear, impact their health and life choices.

As discussed above, we used inability to pay as a proxi for socioeconomic deprivation and found a strong association with post-abortion complications and treatments. In our study in Chile with e-service users we also explored some qualitative aspects of the ability to pay and found that access to international payment methods impacted access to abortion medications sent from abroad. Similarly, a study in Kenya found that specific payment methods required by providers added barriers to post-abortion care (Mutua et al., 2018). In our study of WoW on abortion outcomes in Latin America, we hypothesized that in the context of the socioeconomic inequalities that exist in Latin America and the Caribbean, having an international credit card or the possibility to make an international bank transfer would be markers of higher socioeconomic status, however,

we did not find any association between the payment methods and the outcomes of the abortion.

Generally, feminist abortion support initiatives are committed to provide access also for people who cannot afford to donate to the services. However, our findings in Brazil suggest that the request for a donation, even if voluntary, may act as a symbolic barrier for people who does not have the ability to pay, as a big proportion of users request the service but do not follow-up on their request and end up not receiving the pills from the service. In fact, only a small proportion of requesters actually access the abortion pills through this e-health service and these women are more likely to have a higher socioeconomic position, which supports previous analysis that anticipated the exacerbation of health inequalities under the implementation of neoliberal policies that turn to technologies and to the market in search for solutions to health inequalities (Rich et al., 2019).

While in our studies we were not able to assess what happens with those who cannot afford to make a donation to a feminist abortion service, the issue of being left out from abortion access has been studied in other contexts. For example, a study in the USA showed that women with lower income faced significant barriers to access abortion care, which resulted in later abortions and, in some cases, inability to interrupt the pregnancy (Doran & Nancarrow, 2015). Similarly, in Colombia, women who were denied a legal abortion faced significant delays and only those who had the support from networks and a good referral system were able to interrupt their pregnancies (DePiñeres et al., 2017).

6. Symbolic and social resources can enhance or limit access to feminist support

We also assessed the way symbolic and social resources affect inequalities in abortion. In our study of women's experiences and trajectories with feminist support for self-managed abortion in Chile we found that, unlike most women in their context, most study participants had higher education. Since our sample was self-selected, we interpret the privileged profile of our participants as an indication that women with more formal education are more willing to talk about their abortions for research purposes. However, the lack of variability in the demographics of our participants also suggests that the service in Chile may be reproducing the same inequality patterns that we found in our study in Brazil, where women with higher education accessed the service almost 4 times more than women with basic education. Thus, in line with previous studies (Zamberlin et al., 2012; Palma Manríquez et al., 2018) our findings suggest that social capital, which includes social relationships and previous knowledge about sexuality and abortion, also facilitates access to feminist support for self-managed abortion.

We also confirmed the important role that partner and family support and advice plays in abortion trajectories and experiences, as has been described in previous studies (Petracci et al., 2012; Zamberlin et al., 2012; Zurbriggen et al., 2019). Our study added that the type of couple's relationship and of family support that women having abortions receive, also impacts access to safe abortion. For instance, we found that women in stable relationships and those with family members and close friends that supported their decision to interrupt the pregnancy found it easier to make the decision, gather the money, be accompanied during the abortion process and felt better about their decision. This findings are also in line with Berro Pizzarossa and Nandagiri's work (2021) when they analyze

the wide array of actors involved in abortion access in legally restrictive settings. We found that being a member of extended social networks --such as the feminist movement or religious groups-- can facilitate or delay access to essential resources such as information, funding and company. For instance, participants of our study who had social connections with feminist activists and organizations, found it easier and faster to contact WHW. On the contrary, women with no links to the feminist movement started their search seeking for abortion information online, and it took them time and efforts to distinguish reliable information and decide to contact a feminist service.

7. Affordability of abortion services is also contextual

Regarding abortion availability we were only able to qualitatively assess the perception of affordability of abortion pills. Reading our results in Chile in the wider context of Latin America and the Caribbean, we concluded that the perception of affordability of the feminist service we analyzed is linked to the high price of the pills in the Chilean parallel market. Due to the hard restrictions on the possession and distribution of misoprostol in Chile, this abortion medication is almost exclusively found in the parallel market, which explains why its price is much higher in Chile than in other countries in the region (Távara Orozco & Chávez Alvarado, 2013). In this context, although the requested donation of the service was seen as a big amount of money for most users, it seemed affordable because it was cheaper than buying the pills somewhere else. Similarly, Zamberlin et al. (2012) found that requirements of prescriptions to access misoprostol encourage the use of informal and more expensive sources of abortion pills. These findings are important because they highlight the role of norms and regulations in creating inequalities in safe abortion access, as other authors have

suggested (Berro Pizzarossa & Nandagiri, 2021; Erdman et al., 2018).

8. Emotions and perceptions impact abortion decision-making

In terms of psychosocial factors, we explored beliefs about sexuality and abortion and emotions around motherhood and abortion our study with users of the WHW service.

In Chile, we found that most women who used the WHW e-health service supported abortion decriminalization before deciding to interrupt their pregnancy, and that having clear values about abortion facilitated their decision-making process. Our participants expressed a variety of emotions around motherhood and abortion, including wanting to take care of the children they already have, or to be more prepared for motherhood as reasons to have the abortion. They also named not wanting to be mothers as an element that facilitated their decision-making process. Our results are in line with previous studies that have integrated psychosocial factors as important features of abortion trajectories (Coast et al., 2018) and with studies finding that having moral doubts around abortion often delays access to services (Zurbriggen et al., 2019).

9. Pregnancy length is associated with abortion access and outcomes

We explored biological factors, namely pregnancy length at the time of the abortion, in our two quantitative studies with telehealth services. In our study in Brazil we found that pregnancy length was associated with service utilization, as women between 5 and 8 weeks pregnant used the e-health service at higher rates than people who where less than 5 weeks or more than 9 weeks pregnant when

they requested the abortion. In our study of WoW outcomes we also found that women who were 12 weeks pregnant or more received post-abortion treatment at higher rates. These results are consistent with previous literature showing that complications and treatment are more common after the 12th week of pregnancy (Niinimäki et al, 2011; Hamoda et al., 2005) and that women who are later in pregnancies face more barriers to access a safe abortion method (Zurbriggen et al., 2019).

Our results highlight the importance of avoiding delays in service utilization and suggest that ready access to abortion should be one of the indicators of the quality of abortion care.

10. Feminist theory and practice contribute to the redefinition of quality of abortion care

Even if this does not appear in the inequalities conceptual framework, another aim of this thesis was to understand how the concept of quality of care is defined and implemented in feminist initiatives supporting self-managed abortion operating in legally restrictive contexts of Latin America and the Caribbean. In our study of WoW service we found that 98% of users were satisfied with the service and that satisfaction was not associated with the ability to make the requested donation. Knowing that satisfaction, being a global ranking of the experience, is different and less detailed than accounts of the abortion experience that refer to specific dimensions of quality of care (Darney et al., 2018), we used qualitative methods to go more in depth in our studies with feminist activists providing support for self-managed abortion and with users of the WHW service in Chile.

In our research with feminist activists, we found that according to activists' perspectives, good quality abortion care entails evidence-

based information, trained providers (either medical providers or lay health professionals and activists), as well as timely, respectful, dignified and non-judgmental support that is accessible for people with different needs and resources. The elements highlighted by participants in our study fit under the dimensions of **effectiveness**, **patient-centredness/acceptability**, **accessibility** and **equity** as defined by the WHO (2006) and other international institutions aiming to improve quality of healthcare services (Busse et al., 2019).

Simultaneously, our study findings reflect the legally restrictive environments in which the models of care we analyzed were created, and the feminist ethics that grounds the work of the activists that created them. As discussed above, the centrality of autonomy and the radical view on hierarchic relations between doctors and patients are two important contributions of feminist activists definitions of the conceptualization and practice of quality of abortion care. While **autonomy** appears as an important element on quality of care frameworks centered on reproductive health and patient's experiences (Sudhinaraset et al, 2017; Altshuler & Whaley, 2018), the idea that abortion care would be better if the relations between providers and users were more horizontal has been less common in health research. However, other examples of **horizontal relationships** in health care exist in harm reduction models and peer-to-peer care.

Harm reduction models were generally developed by users themselves or with meaningful participation of users (Marshall et al., 2015), to diminish risks and harms of stigmatized practices that carry health risks. Examples from other contexts include initiatives to facilitate needles exchange for injectable drug users, access to HIV prevention medicine, testing of recreational drugs, among others (Brunt, 2017; Marshall et al., 2015; Braine, 2020). What these initiatives have in common is that they work to diminish the risks and harms caused by stigma, within relatively restrictive legal regu-

lations, and that they are grounded on social movements organizing that aims to find practical solutions for the lack of support and care from the state (Braine, 2020). In Latin America and the Caribbean, formal health systems have also used the idea that peer-to-peer care could improve accessibility and equity, which has led health systems to incorporate lay healthcare providers in adolescent health, mental health, maternity care and primary healthcare, among other issues (Blanco Pereira et al., 2011; Dahl et al., 2013). In a context where unequal power relations are in the roots of violent and disrespectful care in formal health facilities, as the findings on my study of abortion-related obstetric violence in the region shows (Appendix I), the analysis of the results and implications of building less hierarchic relationships within formal abortion care is relevant and promising.

In our study with activists we also found that they contribute to the conceptualization of **safety** in abortion services by including legal and social elements among the risks that abortion services should aim to minimize. This contribution is also relevant and could be a path to integrate social determinants in healthcare of other stigmatized and criminalized issues.

We also examined quality of abortion care from the users' perspective in our study in Chile. We found that participants valued the quantity and quality of information; having direct, personalized and timely communication with service staff; being treated with respect; and feeling safe, cared for and supported in their decision. All these elements are also present in patient-centered approaches to quality of care (Sudhinaraset et al, 2017; Altshuler & Whaley, 2018). We also found that women's perceptions on the quality of the care they receive are deeply contextual and tightly linked with their social, political and economic contexts, as well as with past experiences with reproductive health services.

Altshuler and Whaley (2018) applied Sudhinaraset et al. framework to assess recent publications looking into women's experiences with abortion and post-abortion care. They found that the framework encompasses key dimensions of what women having abortions value in the care they receive, and that health services worldwide generally fail to provide patient-centered abortion and post-abortion services. Coinciding with these findings, in our study in Chile, as well as in a study in Brazil, Poland and Nigeria in which I participated (Appendix IV), the results suggest that formal healthcare often falls short in some of the key aspects of patient-centeredness. We thus posit that measuring and developing improvements in quality of care necessitates a focus on users' experiences and perspectives, as well as a good understanding of the local contexts.

11. Implications and recommendations

The results of this research have several practical and conceptual implications. Our results underpinned gaps in equitable access to feminist services, as well as strategies to overcome them, which would help improving accessibility, equity and quality of care. Therefore, our results show several opportunities for improvement of the feminist initiatives that we studied. Additionally, our findings could be used to improve formal abortion services and be applied in contexts where abortion is legally available. During the COVID-19 pandemic, the latter application became a reality as a growing number of health institutions and governments started using remote support for self-administered medication abortion, building on the experience that feminist activists have developed in the last decades (Moreau, 2020; Montanari, 2021). This experience shows how the development and understanding of informal health practices can benefit formal healthcare provision.

From a conceptual perspective, the study of health care that occurs outside formal facilities enables the understanding of health issues in a more integral way, as it centers neglected healthcare needs and social responses to solve them. From the lenses of medical practice, the study of informal healthcare has the potential to reveal the variety of possibilities that exist to cover a health need, and boost creative solutions for difficult problems. Along with harm reduction models and other activist driven practices, feminist support for self-managed abortion is an example of this. However, more research on understudied informal healthcare practices is needed. In the region, other examples of informal health practices that need to be better understood and have this potential are informal care for mental health issues, hormone therapy and gender affirming procedures among transgender communities, and --way better studied-- indigenous approaches to health. In our particular case of study, applying the social inequalities perspective to analyze the outcomes of other models of self-managed abortion support, such as hotlines and accompaniment groups, is also a pending task.

The development of more appropriate methodological tools is also needed to continue understanding and analyzing informal and movement-driven healthcare practices. Traditionally, health sciences research has been conducted in controlled environments where the variables of study can be closely monitored at all times. However, approaching informal health care requires the development and testing of new ways of measuring the variables of interest, and to rely on the situated knowledge of those who participate in these health practices to find the best ways to do it. For example, if we are to investigate informal health practices with the lenses of social inequalities of health, we will need to develop indicators of social class that take into account how economic informality and healthcare informality interact and compound. Traditional approaches to social class and labor markets are insufficient to under-

stand the makings of social inequalities in health in contexts such as Latin American and the Caribbean.

Further research is needed to have a full picture of inequalities in abortion access in legally restrictive settings. Taking from our conceptual framework, more research is needed to understand the relation between macroeconomic policies, the labor market and social protection policies on one hand, and inequalities in abortion access on the other. With Latin America currently facing several migrations crises simultaneusly, more attention should also be put on the linkages between migration status and abortion. The relation between types of health systems, their funding and their impact over inequalities in abortion is also understudied in the region. So are the connections between gender based violence and abortion.

As previous research has shown, health inequalities are driven by the particular ways in which structural and intermediate determinants combine in a specific context (Coast et al., 2018). Thus, conducting comparative research in contexts where social determinants of health interact among them in different ways, which results in different social and economic structures, can contribute to deepen the understanding of how social inequalities in health operate, and show new paths to tackle them. For example, researchers analyzing the linkages between socioeconomic status and abortion incidence have found different patterns in diverse contexts (Diniz et al., 2017; Huneeus et al., 2020). Studies focusing on the comparison of the drivers of inequalities in abortion incidence would allow for better explanations on why this happens, and also help tackling the inequalities in abortion need, one of the drivers of abortion incidence, that are also linked to inequality in contraception use and access, labor markets, socioeconomic position, power to negotiate the terms of sexual and emotional relationships, etc.

In terms of policies, our studies suggest that complete decriminalization of abortion is needed to enable a key aspect of reproductive justice for women and gender nonconforming people. However, legal reforms take time and are driven by the slow process of changing people's perceptions on women and power relationships within a society (Blofield et. al., 2017). While this slow process develops, more effort could be put in implementing policies that aim to facilitate access at least in the cases in which abortion is already decriminalized and in supporting life-saving feminist initiatives such as the ones that we studied. In the longer term, law reforms should work to actually safe lives, protect people's health and improve access. To do so healthcare professionals need to be informed and trained on how to treat such cases, and policies and regulations should have the aim to facilitate access and dismantle barriers.

Regarding abortion care provision, we believe that including a social justice perspective in medical training, so that health professionals understand the relationship between the social context and inequalities, the health of their patients and their attitudes towards some specific health conditions, would improve quality of care, not only for abortion but for other socially controversial issues.

12. Strengths and limitations

In the studies conducted for this thesis we approached feminist abortion support applying a variety of concepts, theories and methods. This multidisciplinary and mixed methods approach allowed us to describe a specific healthcare practice with the detail that is appropriate to translate the study findings into improvements in care practices in a wide variety of contexts.

Our conceptual and methodological choices also enabled us to place feminist theory and activism in the central position it deserves in the

study of self-managed abortion. Self-managed abortion support is a practice that arose from restrictive environments and that was grounded in the ideology and action repertories of a social movement whose struggles have translated into countless victories for Latin American and Caribbean women and gender nonconforming people. Feminist activism in the region has been credited with the liberalization of legal regulations and social beliefs pertaining marriage and sex; with the opportunities and the legal ability of women to own land and resources; with the realization of social movements' demands such as water and sanitation, health and education, among others. More over, the Latin American and Caribbean feminist movement can be credited the realization of social revolutions and outbreaks and with the radical change in the distribution of power between men and women that materialized in the last few decades (Venticinque, 2015).

However, feminist activism is only rarely credited for its contributions to the advancement of health sciences and practices. By studying feminist abortion support from a public health lenses, we believe we have contributed to the visibilization and recognition of yet another movement achievement: the evolution of a game-changing medical technology, such as medication abortion, and the development of models of care with the potential to distribute the benefits of healthcare advancement to more women and gender nonconforming people around the world.

Another strength of this set of studies is that, by framing them in the broad geopolitical context of Latin America and the Caribbean, we were able to analyze our findings in relation to the history and socioeconomic conditions that the countries of the region have in common. Carrying out our study in various countries of the region and, above all, analyzing our data from a regional perspective, allowed us to shed light on an innovative practice which has strong roots in the Global South.

However, as in any research project, we weren't able to accomplish everything we set out to do, and our study has some limitations. First, we were unable to compare the different outcomes and user's experiences in diverse feminist models of care. We recognize that feminist abortion support initiatives in Latin America and the Caribbean are diverse, and we know that activists from these organizations have developed models of care that are different among them, because they are context specific and grounded on specific political projects. We also understand that it is possible that the differences in the models of care are associated with different outcomes, user's experiences, and strategies to tackle social inequalities and quality of care. However, when we approached feminist initiatives at the beginning of this project, we realized that many of them were lacking the data collection systems that would allow for rigorous research and for the generalization of our conclusions. This lack of appropriate data collection systems is linked to issues of confidentiality and security, as well as to the limited resources that these organizations have.

Another limitation is that our quantitative studies are not representative of the population of people having abortions in the region, and that the data we analyzed may have a selection bias. People requesting support from feminist initiatives in the region are likely to have more resources than their peers who do not contact feminists when seeking for an abortion, as shown in our analysis of Brazilian requesters. Nonetheless, we believe that our limited data is valuable in a region where analyzing abortion information is always limited by clandestinity, stigma and the risk of criminalization.

Finally, our conceptual frameworks where developed along with the studies of the thesis and are, in a big part, the result of our own study findings and our reflections while conducting the research. While developing an evidence-based conceptual framework has

some merit on its own, not having a previously set conceptual framework also limited the kind of data we collected and were able to analyze.

CHAPTER 4

CONCLUSIONS

• Women and gender nonconforming people with diverse socioeconomic positions and demographic characteristics request feminist abortion support. Feminist initiatives provide a life-saving service that is neglected by states and formal healthcare institutions in the region.

• Access and utilization of feminist e-health services providing support for self-managed abortion in the region are determined by social and economic factors, which results in inequalities marked by age, social class, territory and race.

• Socioeconomic characteristics at the state level explain service utilization independently of individual factors.

• From a clinical perspective, the outcomes of medication abortion provided through feminist e-health initiatives are similar to those of the same type of abortion provided in formal health facilities.

• Outcomes of the medication abortion provided by e-health services such as post-abortion complications and treatment, also vary by users' socioeconomic characteristics.

• Feminist abortion support initiatives have developed strategies to achieve good quality abortion care that are mostly in line with common definitions of quality of care used across health issues and for formal health systems.

• By developing models of care for legally restricted settings and applying feminist ethics into health care practice, activists

contribute to a redefinition of quality of abortion care. They underscore autonomy in reproductive and health care choices, a horizontal perspective for interpersonal relations in healthcare, the potential of new communication and medical technologies to improve efficiency, accessibility and equity and a broader perspective on safety that accounts for legal and social circumstances.

• Women's trajectories, experiences and assessments of quality of abortion care are determined by the intersection of structural, intermediate and individual factors. Support, accompaniment and information are key to improving pregnant people's experiences and enabling their decisions, particularly in legally restrictive settings.

• Abortion-related stigma and fear of criminalization are central to women's experiences of self-managed abortion in legally restrictive settings. The centrality of stigma and fear of criminalization persist even for women who accessed feminist abortion care that they considered of good quality.

• Legal and social change around abortion is needed in the region to enable the realization of the right to access safe, equitable, high-quality abortion care. While feminist abortion support can facilitate abortion access and show a path to improve quality of care, the full realization of the right to choose when to terminate a pregnancy and how to do it will only be enabled by abortion decriminalization, destigmatization and a profound change in the social beliefs about the role of women and gender nonconforming people in Latin American and Caribbean societies.

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APPENDIX

This section includes four published articles that I coauthored while I was doing my PhD. While these articles are not strictly part of my thesis, the research process of these articles contributed with new insights on my study subject and some of its findings are discussed in the thesis.

The articles included in this section are the following:

Appendix I: Larrea S, Assis MP, Ochoa Mendoza C. "Hospitals have some procedures that seem dehumanising to me" Experiences of abortion-related obstetric violence. Agenda. 2021:1-15

Appendix II: Assis MP, Larrea S. Why self-managed abortion is so much more than a provisional solution for times of pandemic. Sex Reprod Heal Matters. 2020;28(1):1-3

Appendix III: Wollum A, Larrea S, Gerdts C, Jelinska K. Requests for medication abortion support in Brazil during and after the Zika epidemic. Glob Public Health. 2021;16(3):366-377

Appendix IV: Baum SE, Ramirez AM, Larrea S, et al. "It's not a seven-headed beast": abortion experience among women that received support from helplines for medication abortion in restrictive settings. Health Care Women Int. 2020;0(0):1-19

Appendix I. Larrea S, Assis MP, Ochoa Mendoza C. "Hospitals have some procedures that seem dehumanising to me" Experiences of abortion-related obstetric violence. *Agenda*. 2021:1-15.

Agenda
Empowering women for gender equity

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"Hospitals have some procedures that seem dehumanising to me": Experiences of abortion-related obstetric violence in Brazil, Chile and Ecuador

Sara Larrea, Mariana Prandini Assis & Camila Ochoa Mendoza

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article

"Hospitals have some procedures that seem dehumanising to me": Experiences of abortion-related obstetric violence in Brazil, Chile and Ecuador

Sara Larrea , Mariana Prandini Assis and Camila Ochoa Mendoza

abstract

Abortion-related obstetric violence is an under-documented global phenomenon that seems more frequent in settings that legally restrict abortion. Seeking to document and critically assess this phenomenon, we analyse testimonies of obstetric violence shared by abortion seekers in Latin America. Data were collected through the communication channels of Women Help Women (WHW), a feminist non-profit organisation that supports self-managed abortion where access is restricted. We conducted in-depth review of 20 cases of women from Brazil, Chile and Ecuador who reported being subjected to several forms of obstetric violence while seeking abortion and post-abortion care in formal health facilities. This obstetric violence included denial of care and failure to meet standards of care, criminalisation, gaslighting, physical violence, and discrimination. We show how abortion-related obstetric violence is used as a means to punish and control feminised subjects that contradict social and legal mandates regarding abortion and gender. We also highlight the role of modern legal and medical systems in reproducing oppressive structures that deny people proper care.

keywords

abortion, obstetric violence, reproductive health, reproductive justice, testimonies

Introduction

Obstetric violence is a feminist epistemic construct that names a multifaceted and diffuse phenomenon happening during the reproductive lives of people who get pregnant[1] (Sesia 2020), particularly in pregnancy and childbirth, in the formal health system (Sadler et al. 2016). At the centre of this construct are the needs and experiences of women of African descent, racialised, indigenous and poor women who, in capitalist societies structured through interlocking systems of oppression – race, social class and gender (Hill Collins 2000) – make up the largest population subjected to obstetric violence (Jardim & Modena 2018; Calvo Aguilar, Torres Falcón & Valdez Santiago 2020). By placing under the same umbrella several forms of mistreatment, such as physical, verbal and sexual abuse, experiences of discrimination and neglect, and denials of privacy, confidentiality, and high-quality care (Khosla et al. 2016), obstetric violence operates a radical shift in the framing of these events. Rather than individual rights violations, they are understood as manifestations of the same structural

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pp. 1–15

problem that health systems often tolerate, reproduce and, not least, promote.

Brazil was the stage for a landmark conference in the historical chain of events that led to the recognition of obstetric violence as a specific form of harm based on gender, social and racial inequalities. The First International Conference for the Humanisation of Birth, held in Brazil in 2000, provided the space where a group of participants – activists, researchers and healthcare providers – from 12 countries founded the RELACAHUPAN - *Red Latinoamericana y del Caribe para la Humanización del Parto y el Nacimiento* (Latin American and Caribbean Network for the Humanisation of Childbirth) (Sadler et al. 2016; Quattrocchi 2019).

Obstetric violence quickly moved from the realm of civil society to national and global institutions, laws and policies. Over the past two decades, obstetric violence has been defined and addressed in new legal frameworks adopted by several countries across Latin America. Venezuela was a pioneer, in 2007 passing a law on women's right to a life free of violence that contains the most often cited definition of obstetric violence.[2] Other countries quickly followed suit. The concept has been similarly embraced by international human rights and public health institutions, such as the Inter-American Court of Human Rights (2016), the World Health Organization (2015), and the United Nations (2019).

Along with the ongoing process of legal and policy recognition, obstetric violence has also become an issue largely investigated in the fields of public health and social sciences since the mid-2000s. Researchers using obstetric violence as an analytical framework highlight its intersectional and structural dimensions, often defining it as a form of structural violence and highlighting how axes of oppression other than gender (i.e. social class, race, ethnicity, nationality and age) operate in its (re)production. For example, Castro and Savage (2019) studied obstetric violence in the Dominican Republic as a form of reproductive governance, and analysed the linkages between obstetric violence, social class, racism, and coloniality, to explain the common normalisation of this kind of violence among people who suffer it. In their view, normalisation is an adaptive strategy that enables people to cope with mistreatment by entering "the self-control mode they have been subjected to by the moral regime for the poor" (p. 132).

Figure 1. Artist Yaneris González Gómez worked together with the authors on this project.

Briceño et al. (2018) studied experiences of childbirth in Colombia and argued that obstetric violence is rooted in the imbalanced power dynamics between patients and healthcare staff in the context of formal health systems that deepen inequalities based on patients' purchasing power. Similarly, in a systematic review, Bohren et al. (2015) found strong evidence of expressions of obstetric violence linked to discrimination based on race and ethnicity, age, socioeconomic status, and medical conditions, therefore confirming its intersectional nature.

However, absent from most activist initiatives, legal and policy frameworks, as well as academic literature, is the recognition that obstetric violence also takes place – and at an alarming rate – in the provision of abortion and post-abortion care. With this study, we aimed to contribute to filling this gap by documenting expressions of abortion-related obstetric violence experienced by cis women and analysing its relationship with medical and legal systems. We collected and examined communications exchanged between Women Help Women (WHW), a feminist non-profit organisation, and cis women from Brazil, Chile and Ecuador seeking abortion support. Through an online service (womenhelp.org), WHW staff answer over 120 000 emails each year, providing accompaniment, information and access to people in need of abortion. As such, WHW supports people in self-managing their abortions and navigating formal health systems where abortion is restricted by law, regulations, and other social barriers.

Self-managed abortion is today a common practice worldwide, recognised in the field of public health (WHO 2012) and spread across the world through activist support and access initiatives (Drovetta 2015; Walsh 2020; Zurbriggen, Keefe-Oates & Gerdts 2018) such as that of WHW. Self-managed abortion is usually defined as the use of medication, misoprostol alone or in combination with mifepristone, to end a pregnancy outside of the formal health system, and has its roots in informal experimentation by women in Latin America and the Caribbean (Barbosa & Arilha 1993), a region with some of the most restrictive abortion laws in the world (Guttmacher Institute 2018).

In many of the communications exchanged between WHW and the people it supports, users have described various types of abortion-related obstetric violence, either during an attempt to access abortion services through formal healthcare or after having self-managed an abortion and seeking post-abortion healthcare. While medication abortion is highly safe and effective, some people may experience complications, or an incomplete abortion, and may require medical attention. Other people may approach the formal health system because they want to confirm that the abortion was successful and complete. However, in approaching formal health systems, in addition to the power structures, hierarchical values and corporate discipline of biomedicine (Sadler et al. 2016), people seeking care also often encounter the strong and internalised stigma surrounding abortion. Abortion stigma not only acts as a barrier to access abortion and post-abortion care in a variety of legal contexts (Horgan 2019; DePiñeres et al. 2017; Casas & Vivaldi 2014), but also influences abortion experiences and limits the availability of healthcare professionals willing to provide abortion-related care (Norris et al. 2011).

We analysed those communications using a framework that sheds light on the theoretical and empirical connections between the concept of obstetric violence and abortion and post-abortion care in Latin America and the Caribbean (Assis & Larrea 2022). This analytical framework provided us with the five most common expressions of abortion-related obstetric violence, namely denial of care and failure to meet standards of care; criminalisation; gaslighting; physical violence; and discrimination. These categories are not meant to be exhaustive nor are they mutually exclusive. On the contrary, we recognise that obstetric violence is a complex form of harm where several of these expressions are bound together. However, we believe that disentangling them serves an important analytical purpose of excavating these specific operations and making them visible and palpable. Therefore, following in the steps of activists who three decades earlier named obstetric violence, our primary goal with this work was to call attention to the specific forms of obstetric violence experienced in abortion and post-abortion care,

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while also identifying some of its root causes.

Grounded on feminist epistemology, we acknowledge that the position of a researcher in society is relevant to knowledge production (Vivaldi 2020). We are feminist activists from countries where abortion is criminalised, who have invested several years of our lives in the struggle for reproductive justice. Our work for expanding abortion care despite restrictive laws has facilitated our access to information about practices that are clandestine and highly stigmatised. In addition, through our work providing information and legal advice, we have witnessed experiences of abortion-related obstetric violence in formal health-care facilities that have led us to question the commonly held view that a medicalised and institutionalised abortion service guarantees people's dignity, rights and autonomy. Yet, as activist-researchers either located in or affiliated with organisations in the global North, we enjoy privileges that have protected us from living the events that we narrate here. As such, our research does not intend to speak for the women whose experiences we portray, but rather to make this article a vehicle for their voices.

We believe that acknowledging and combatting abortion-related obstetric violence is a requirement of reproductive justice. Addressing obstetric violence in abortion and post-abortion care allows us to understand how two powerful systems of knowledge and control, that is modern medicine and law, operate to further entrench patriarchal values, exercising control over pregnant people who challenge prevailing social norms on reproduction. Our ultimate goal with this article is to contribute to dismantling the legitimacy of these systems so that people can enjoy their reproductive lives with autonomy, dignity and free from discrimination and violence.

Methods

In this case series study we analysed testimonials of people who have experienced abortion-related obstetric violence, using a revised version of a set of categories developed in a previous study (Assis & Larrea 2022). This framework incorporates and expands the different expressions of obstetric violence described in existing literature about mistreatment, abuse and disrespect in childbirth and abortion-related care, to analyse obstetric violence testimonies found in WHW communication threads.

Sampling strategy

Testimonies of obstetric violence were collected through the WHW communication channel, by searching through all communication with Spanish and Portuguese speakers between September 2016 and November 2019, as well as the internal notes written by the WHW staff responsible for each case. During this period, WHW received 88 164 cases of people seeking abortion support in these languages. In order to flag cases of obstetric violence, we identified a list of keywords based on information from previous research as well as personal experiences working with abortion seekers who had suffered obstetric violence. After several tests and revisions for the sensitivity of different words in both languages, we found that many keywords (such as 'hospital', and 'pain') were not specific enough, and presented cases that were relevant to broader abortion experiences and not specific to obstetric violence. Other keywords, such as 'intimidation' and 'interrogation', were too specific or technical and did not present any cases. Additionally, to increase the sensitivity of our final list we also used incomplete and misspelt words. The final keywords used for data collection were: 'threat', 'curettage', 'rape', 'denunciation', 'investigation', 'violence' and '(il)legal', in their Spanish and Portuguese versions.

We identified all communication that contained our keywords. For most of the keywords we reviewed each case, reading through the communication thread to familiarise ourselves with its content and to discard cases that were not relevant. However, some keyword searches resulted in a high number of cases – such as 'rape', which presented >600 cases, and 'curettage', which presented >300 cases; in these cases we reviewed a sample until we reached data saturation. Out of over 900 cases of obstetric violence, we selected 20 cases to analyse in-depth. We manually extracted information on location, age,

Table 1: WHW user's location, age, pregnancy length, education level and race	
Characteristics	Number
Country	
Brazil	13
Chile	5
Ecuador	1
Missing	1
Age	
<26	9
26-30	1
31-35	1
>35	5
Missing	4
Pregnancy length	
<12 weeks	15
13-24 weeks	3
Missing	2
Education level	
Primary/elementary completed	3
Secondary / high school completed	7
University studies (complete and incomplete)	1
Master/postgraduate studies	1
Missing	8
*Race**	
White	4
Black	4
Brown	2
Missing	10

*Race is filled out in the consultation form only in requests from Brazil.

gestational age, educational level, and race from consultation requests and internal communication (see Table 1) as well as relevant quotes to exemplify the case.

Data analysis

We conducted the analysis using the data entered in the table that summarised study cases. We examined and distinguished the cases using the following categories: (i) denial of care and failure to meet standards of care; (ii) criminalisation; (iii) gaslighting; (iv) physical violence; and (v) discrimination. Several cases were labelled with more than one category. Once we decided which cases were going to be used to present our study results, we translated the selected quotes into English. We also analysed the relationships between categories through an iterative discussion process.

It is important to highlight that we understand obstetric violence as an intersectional phenomenon that is constructed by race, class, gender, sexuality, ethnicity, nation, ability, and age, not in a mutually exclusive manner but rather reciprocally (Hill Collins 2015). As such, obstetric violence is not a mono-categorial phenomenon explained solely by one of those axes of power, but occurs at the intersection of multiple forms of inequality and oppression. However, for analytical and heuristic purposes we find it useful to disentangle various categories of obstetric violence in order to expose their inner operations and thus enable responses that might best tackle them.

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Ethical issues

Upon acceptance of the service terms and conditions, WHW users agree to having their anonymised data made available for research. Only the researchers had access to the database of study cases and no personal or identifiable information was included in the summary of cases analysed for this study. To ensure anonymity and protection of participants' privacy, we assigned pseudonyms to each of the cases and only kept the information about their countries of origin and year of communication. Because we conducted a secondary analysis of anonymised data, this study did not require ethical committee approval.

Strengths and limitations

Our approach allowed us to fulfil the aim of making visible abortion-related obstetric violence experiences that are often hidden because of stigma and threat of criminalisation, without compromising the safety of WHW users. However, this study has some limitations. By choosing to use the least invasive method available to us, we relied solely on pre-existing information and did not question anyone for follow-up information. This may have prevented us from gaining a comprehensive understanding of the individual cases of obstetric violence and from identifying cases that happened after the communication with WHW ended. By using keyword searches as the method to gather data, it is possible that we also missed other cases of obstetric violence.

Results and discussion

Obstetric violence in abortion and post-abortion care is manifested in different ways, both through explicit threats and denial of services as well as through implicit practices that produce physical and psychological harm. Through our analysis of WHW communication with abortion seekers, we found testimonies that illustrate the ways that people, especially those assumed to have induced their abortion, are exposed to violent practices at the hands of healthcare professionals. At the root of all these manifestations of obstetric violence is the pervasive stigma that surrounds abortion. Abortion stigma refers to the negative attributes that are ascribed to people who have abortions, and that marks them as inferior to ideals of womanhood (Kumar, Hessini & Mitchell 2009). Abortion stigma is prevalent in healthcare institutions in the ways that healthcare professionals impose their personal moral stance on individuals seeking care, and allow it to interfere with the quality of healthcare. Furthermore, abortion stigma contributes to the normalisation of the violent and harmful practices that abortion seekers are exposed to, as such practices are viewed as acceptable or even justified.

The results of this study reflect findings of previous research. In particular, we show that abortion-related obstetric violence is a pervasive practice that functions as a means of discipline, punishment and control of those who challenge social and legal norms regulating abortion and mandatory motherhood (Castro & Savage 2019; Cevallos Castells 2011). In addition, our cases illustrate how obstetric violence works to re-establish medical authority over the abortion process in a context where self-managed abortion has become a common practice.

Denial of care and failure to meet standards of care

In our review, denial of care and failure to meet standards of care was the most common form of obstetric violence. We define this category as the refusal of provision of legal abortion services as well as the institutional and individual practices that violate existing healthcare protocols and evidence-based recommendations. Of our sample, 15 cases fit this category, including cases of denial of legal abortion services and unnecessary medical interventions. These practices are similar to those illustrated in previous studies in the region, showing that in spite of legal exceptions to abortion bans, access to abortion is limited and is connected to the lack of policy implementation aimed at facilitating access (DePiñeres et al. 2017; Larrea 2015; Espinoza Escárate 2019).

The most common example of obstetric violence was the denial of legal abortion services, specifically in cases of pregnancy resulting from rape. We identified over 600 cases of women in Brazil who sought help through WHW in such circumstances, most

often after having attempted to access abortion services through formal healthcare but being denied care. Even though Brazilian law authorises abortion in cases of rape, and does not require a police report to access abortion services, our results show that healthcare facilities often refused to provide care for people who lacked an official report.

This is illustrated through the story of Lidia, who resorted to WHW after being mistreated and denied services when trying to access legal abortion for a pregnancy that was the result of rape:

> I went to the hospital […] and they told me I had to press charges [against the aggressor]. […] I can't press charges, he [the aggressor] not only threatens, if he wanted he could have already killed me, he had a gun, I don't know what else to do, I am literally alone, and I can't tell anyone, I can't do anything, I tried to ask for help and it was worse […] I felt they were judging me because I wanted to have an abortion. […] I prefer to take [the pills] at home and manage the risk than asking for help and being neglected, it is horrible. (Lidia, 2019, Brazil)

Andrea (2019, Brazil), who was also pregnant as a result of rape, explained that she was denied legal abortion services because she could not remember the date of her last menstrual period, which exemplifies how medical staff create arbitrary requirements in order to refuse care. Cases such as those of Lidia and Andrea show how denial of legal abortion care seems to be grounded on the lack of will to provide abortion services, even when legally mandated. Individual and social stigma, as well as lack of access to information about the law or to financial resources needed to demand their rights after being denied services, often force victims of rape to take the pregnancy to term.

Another common example of failure to meet standards of care is the enforcement of unnecessary medical procedures. We identified over 300 cases of women who received a curettage after having attempted to self-manage an abortion at home, even though many of them did not have any symptoms indicating a need for surgical evacuation of the uterus. Curettage is an antiquated and invasive surgical procedure consisting of scraping the lining of the uterus with a sharp tool. Although in colloquial language the word curettage is often used to refer to a vacuum aspiration, they are different medical procedures. While vacuum aspiration is a safe procedure when done by trained providers, several international health institutions, including the World Health Organization, make recommendations against the use of curettage for abortions before 14 weeks and for post-abortion care, due to it being riskier and more painful than other methods. Yet it continues to be practised in Latin America and the Caribbean at alarming rates, as well as around the world (World Health Organization 2012).

Out of the over 300 cases, we included nine in our sample of women who were told they required a curettage at a formal health facility, and contacted WHW to ask for a second opinion. In these cases, the suggestion of unneeded and outdated medical treatment was linked to other forms of obstetric violence, including failure to provide quality post-abortion care, provision of false information and expressions of stigma, as Lucia's email illustrates:

> I went to the doctor, they did an ultrasound and verified the miscarriage. […] The physician on call was very rude when he heard about the bleeding, he inserted his finger [in my vagina] and said I would need to be hospitalised, be put in an eight-hour fast and under general anaesthesia, and undergo a surgery of endo-curettage. […] I talked again to the first doctor, and she said that [curettage] wasn't necessary. She recommended to me in secret to come back another time to be seen by a different doctor. But I caught the doctor [who wanted to do the curettage] leaving instructions to the physician who would be next on duty. This one ended up also being rude and recommended my hospitalisation. Apparently, they think the miscarriage was induced and are being very rude. I am afraid of general anaesthesia, so I am going back home to think better […] I came back home and now the bleeding has stopped and I am feeling much

better. However, I still have the doubt if a curettage is really necessary. (Lucia, 2017, Brazil)

Like Lucia, many abortion seekers were doubtful about the need for a surgical intervention, and suspected that there were ulterior motives for performing the surgery. For example, Maria's testimony explains how, in her view, the doctor wanted to perform a curettage for financial reasons:

> On Saturday I will complete 21 days since the procedure! I feel great! No pain, no fever, no complications or discharge … but my doctor wants to do a curettage!! They do not do it under my health insurance, and I have to say I became suspicious if there was a real necessity, if my health was really in danger, or if it was actually related to the financial, that is to say, that she wanted to make some money out of my situation!! (Maria, 2019, Brazil)

However, in most of the cases that we found in WHW communications, abortion seekers did not question the necessity of a curettage, nor see it as an expression of violence. This may be explained by the commonly held assumption in the region that an abortion can be initiated by taking abortion pills but must be completed at a hospital with a surgical evacuation. Moreover, the rate of surgical interventions after medication abortion provided via online consultation by Women on Web in Latin America is triple the rate of other regions. This higher rate seems to be related to medical practice rather than to symptoms indicating the need for surgical intervention (Gomperts et al. 2012).

In this study we also identified other practices that demonstrate failure to meet standards of care. For example, Carla (2016, location unknown) contacted WHW because a healthcare provider delayed her care by insisting that since she was 50 years old, she would probably have a spontaneous miscarriage and would not need an abortion. Carla explained her fear of being given wrong information. As explained in her communication, Carla was aware of her healthcare provider's anti-abortion stance, and suspected that by delaying care, the provider was trying to force her to continue with the pregnancy.

In these cases, healthcare professionals exercised their authoritative position to inflict violence on the abortion seeker. This is a clear example of reproductive governance, where powerful social actors deploy diverse methods "to produce, monitor and control reproductive behaviours" (Morgan & Roberts 2012, cited in Castro & Savage, 2019 p. 124). By imposing arbitrary barriers, enforcing unnecessary medical interventions, and delaying care, healthcare professionals exercise control and implicitly punish the pregnant person for having induced an abortion. Cevallos Castells (2011) analysed health professionals' violent practices around abortion as bio-power mechanisms, showing how in many instances these practices are wilfully used as a mean of punishing abortion seekers and putting them "in their place" as feminised subjects. In these situations, the medical professional acts as the hand of the police state, disciplining the body for defying the sociopolitical norms around motherhood and reproduction (Cevallos Castells 2011).

Criminalisation

Criminalisation is another manifestation of obstetric violence, which takes place when healthcare professionals act as law enforcement, by attempting to extract confessions, collecting evidence of the alleged crime of abortion, threatening to report people to law enforcement for inducing their abortion, or actually reporting them. Criminalisation was present in three of the cases we reviewed, which included threats of criminalisation as well as actual criminal prosecution.

This form of obstetric violence occurred in the case of Constanza, who contacted WHW while still in the hospital, reporting that health personnel were conducting an investigation to determine whether or not she had used abortion pills. In a follow-up message, she recounted being threatened with the imprisonment of her partner. Out of fear and pressure from the continuous threats, she confessed to having self-induced the abortion. Later she contacted WHW, disclosing that she faced prosecution

for the crime of abortion due to the confession obtained by healthcare providers:

> [...] They are investigating me for the pills, both in me and in the baby to see if there are traces [...] The problem is that they made me declare. At the beginning everything was fine, but since I was confined they told me that they were going to my house and they were going to turn everything, that my partner was going to go to jail and they were going to tell everyone, but if I confessed by myself nothing would happen. So they pressured me until I confessed; just yesterday I could see my partner and he told me that none of that happened, that they were only intimidating me, so now for my confession I am under investigation. (Constanza, 2018, Chile)

Amanda, who contacted WHW after being denied care at a health facility without explanation, also detailed threats of being reported to the police by her doctor:

> Dears, I indeed have the embryo retained in my womb. I went to the doctor, but he threatened me by saying he would report me to the authorities. Well, I don't know what to do any more and I need to expel the embryo from me, it is lifeless (Amanda, 2017, Chile)

The cases of Constanza and Amanda highlight the ways in which healthcare professionals exploit their authority, and take advantage of the vulnerability and fear of patients to collect evidence for prosecution. Aware of this power dynamic, many abortion seekers fear criminalisation even if there is no explicit threat. An email from Beatriz illustrates this fear:

> I had blood tests done. I believe that they did not detect anything in that step because otherwise they would have denounced me [...], but I am worried that the remains of the curettage will be analysed by the pathologist and that there they can confirm something since the person who saw me in the clinic had suspicions that I may have induced the process (Beatriz, 2019, Ecuador)

Previous studies have shown that the formal health system can be a dangerous place for abortion seekers. Although regulations protecting patients' right to privacy and to post-abortion care are in place in many countries in the region, most cases of abortion criminalisation begin with health professionals reporting a patient to the police and then providing evidence and testimonies that lead to conviction (Zaragocin et al. 2018; García, Lozano & Arias 2019; Casas & Vivaldi 2014; Steele & Chiarotti 2004). In addition to the pervasive fear of getting support from health professionals when seeking an abortion, this criminalising context may deter people from pursuing healthcare even in cases of severe need, thus increasing the risk of health consequences, as shown in other contexts (Horgan 2019).

Gaslighting

We define gaslighting as a specific form of manipulation and epistemic injustice in which a person is made to doubt their own experience and interpretation of events, through expressions of neglect, dismissal of their perceptions and other forms of epistemic abuse, even when this outcome is not intentional (Cohen Shabot 2019). Many of the expressions of obstetric violence described thus far include women being disbelieved, distrusted and questioned by health professionals. However, we also identified six cases where there was explicit neglect and dismissal of women's experiences and perceptions about their self-managed abortion and health in general.

These manifestations of obstetric violence were often intertwined with discrimination and failure to meet standards of care. This is shown in the case of Carolina, who sought medical care because of severe pain and suspicion of an infection after a self-managed abortion. She wrote to WHW explaining that she had been admitted to one hospital, and after an ultrasound that ruled out the infection, she was referred to a larger facility for a curettage. In this second hospital, health professionals told her that no procedure was needed, sending her back to the first clinic. Although she had contact with several health professionals in different institutions, no one gave her an explanation about her clinical condition or the treatment or protocols

applicable. When describing her experience, she wrote:

> The truth is that I don't feel that they did anything to help me in the hospital, I didn't feel they were taking my situation seriously or facing the gravity of what could happen. I feel very strong contractions and I want to know what is your opinion to know what I should do. (Carolina, 2019, Chile)

In another case, Gabriela explained that she felt judged and neglected while asking for medical help:

> [...] I told them that I had cramps from hell and that I was bleeding abnormally, they kept not even looking at my face, they only injected physiological saline solution in my vein, and that was all. (Gabriela, 2019, Brazil)

The experience of Alcira, who sought legal abortion service, is another example of how medical power subjugates women and makes them doubt their own authority and knowledge over the process. In Alcira's case, even the usefulness of her knowledge as a lawyer about her rights was put into question, as she states: "this day, nothing I had learned in law school about the law helped me". Alcira felt that hospital procedures are "dehumanising" and justified herself for being "apprehensive" (Alcira, 2019, Brazil).

Another common expression of gaslighting is the use of ultrasound images to dissuade people from interrupting a pregnancy. Forcing someone to look at ultrasound images also works as a mechanism to make abortion seekers doubt their own ability to decide about their bodies and lives, as Lidia described:

> ... [the nurse] told me to do the ultrasound to confirm, I did not want to see the ultrasound to not feel worse, but she kept calling me to see it as if to convince me not to have the abortion, it was a horrible experience. (Lidia, 2019, Brazil)

Gaslighting has appeared in public discussions about rape and sexual abuse, where social and legal institutions seem determined to make survivors distrust their memory and perceptions of their own experiences. The same logic, applied by medical authorities, is also apparent in the testimonies about delay and denial of legal abortion in cases of rape. In many of the cases we reviewed, women were manipulated by healthcare professionals to doubt their own perceptions around their rape experience. Zaira explained that she was denied a legal abortion because health professionals could not find evidence of rape, although she had a police report. Because hospital staff did not believe her, Zaira's access to abortion was delayed by five weeks:

> I went to a hospital with the police report, they did an ultrasound and found there was indeed a foetus. But they claimed there was no evidence of rape. They gave me the morning-after pill and post-exposure prophylaxis, and sent me home. My struggle is not of today, I went there again and almost begged to have the abortion. They told me to go to the Public Defender's Office, and today I am waiting for a judicial order. However, at the time of the events, I was only 5 weeks pregnant, the days have passed and today I am 10 weeks. (Zaira, 2017, Brazil)

Similarly, Andrea explained how medical professionals did not believe she had been raped, thereby denying an ultrasound or any kind of care:

> For them, sex had been consensual and they did not want to do an ultrasonography or any other tests [...] I tried [to access legal abortion] but I am traumatised with all that happened, I am becoming crazy, taking teas, one girl suggested that I could insert a catheter myself, but I saw a picture [of how to do it] and got too scared! I am going to the hospital, but the best I can get is a vaginal finger inspection. And a request for the ultrasound test. (Andrea, 2019, Brazil)

In a subsequent email, Andrea wrote:

> I am in line here at the public health system. No one gives me attention or priority, and they treat me strangely because I have not done the prenatal care. The

doctor who examined me said that, from the size of the uterus, it is 8 weeks. In a private clinic it [the ultrasound test] is [the equivalent to US $25.00], but if I use the money for this I won't be able to pay my phone bill or transportation … that is why I am here at the line waiting … Here … it is horrible, the treatment women receive amounts to being inhumane. I am afraid to try needles [to induce an abortion] and hurt myself. (Andrea, 2019, Brazil)

As these cases show, gaslighting manifests itself in the ways that healthcare professionals dismiss and neglect the experiences of people seeking abortion and post-abortion care. In doing so, healthcare professionals make people having abortions distrust their own experiences, emotions, and healthcare needs. Gaslighting often exists in combination with other forms of obstetric violence, as the dismissal of people's healthcare needs goes hand-in-hand with failure to meet standards of care and even physical violence.

Physical violence

We define physical violence as any act that is inflicted over a pregnant person with the intention to cause harm through physical means. In this study, we identified cases of physical violence where women were denied or delayed access to pain management and other necessary treatments.

The case of Alcira shows the ways that healthcare professionals deny necessary pain management to incite suffering in the pregnant person: "in the day of pain, they told me I would have to feel it, they couldn't give me any painkiller because this was the hospital's procedure" (Alcira, 2019, Brazil). Similarly, Martha (2019, Brazil) experienced a haemorrhage, for which treatment was delayed. In Carolina's case, mentioned earlier as an example of gaslighting, healthcare professionals kept her waiting and denied her quick treatment in spite of her pain and fear of complications. In both of these cases healthcare professionals neglected their patients to make them suffer as punishment for inducing an abortion.

Physical violence also intersects with failure to meet standards of care, although it is differentiated by the explicit intent to inflict pain on the person experiencing abortion. By denying timely and adequate treatment and pain management to a patient in severe pain, healthcare professionals exploit their own gatekeeping position to ensure the continuation of suffering.

Discrimination

We define discrimination[3] as unequal treatment based on race, ethnicity, gender, sexual orientation, age, religion, (dis)ability, citizenship, or socioeconomic status. In WHW communications we found seven testimonies that included distinctive expressions of discrimination enacted by healthcare professionals. Specifically, women experienced discrimination based on their gender, facing obstetric violence for defying gendered expectations around motherhood, as well as from women who experienced differential treatment based on their race.

There were cases of women discriminated against because they had been perceived as transgressing their gender roles, particularly as expectant mothers. In these cases, discriminatory treatment enacted by health professionals is linked to the suspicion that the person wants an abortion, as happened to Andrea (2019, Brazil), who believed she had been mistreated and gaslighted because the staff knew she had not done prenatal care. The suspicion of the abortion being self-induced – which is another transgression of gender roles – can also result in discrimination, as Lucia highlighted: "Apparently, they think the abortion was induced and are being very rude" (Lucia, 2017, Brazil).

In turn, Alcira's narration exemplifies the connection between racial discrimination and physical violence. Health professionals denied Alcira pain management and told her she had to feel the pain. In her view, racism and suspicion were the reasons behind this violent treatment:

> I kept imagining if I were a white woman, I wouldn't have waited that long (I could be wrong, but I think they were investigating the cause of the abortion), hospitals have some procedures that seem dehumanising to me, and we become apprehensive, right? (Alcira, 2019, Brazil)

There is strong evidence that perceived discrimination has negative effects on a wide array of health-related outcomes and experiences (Williams & Mohammed 2009; Borrell et al. 2010). The compounding effect of discrimination, stigma and other expressions of abortion-related obstetric violence disproportionately affects marginalised populations, and further entrenches structural violences through medical and legal systems (Goes et al. 2020; Nandagiri, Coast & Strong 2020).

Conclusion

Through the review of communication threads from an organisation providing self-managed abortion support, we found numerous testimonies of people in Latin America being denied legal abortion services and experiencing different forms of obstetric violence while attempting to access care. This includes self-managed abortions happening outside the law as well as in the few cases permitted by law.

The results of this study show that people seeking abortion care in countries where abortion is legally restricted and highly stigmatised are exposed to obstetric violence in formal healthcare institutions. In addition, they are also evidence of the ways in which systems of oppression such as heteropatriarchy, racism and classism interact in the production of harmful encounters between people seeking care and health professionals.

The recent history of naming and recognising obstetric violence in childbirth has been a necessary step towards a new framing in which a variety of social actors, from activists to scholars, and national and international health and human rights institutions, are committed to envisioning models of care centred around pregnant people's needs and experiences. The lack of attention to how similar forms of violence also happen in the context of abortion care underscores the importance of making abortion-related obstetric violence experiences visible.

Through the analysis of 20 cases of women seeking abortions in Ecuador, Chile, and Brazil, we found that obstetric violence occurred in the form of denial of care and failure to meet standards of care, criminalisation, gaslighting, physical violence and discrimination. Many of the expressions of obstetric violence are fuelled by the imbalanced power relations in the doctor/patient dyad and the prevailing stigma around abortion. In this context, obstetric violence is often used as a means to enforce authority and punish abortion seekers in both implicit and explicit ways. In addition, obstetric violence is also rooted in heteropatriarchal, classist and racist beliefs and practices that are often (re)produced in facility-based healthcare.

Although we found that abortion-related obstetric violence is a common occurrence, we also found that these experiences are often normalised by people who suffer them. While normalisation can be attributed to social environments where structural violence is common, in the case of abortion it is clear that stigma and restrictive laws also play an important role. The use of violent practices to informally punish people who defy laws and morals, or intend to do so, becomes socially accepted whenever authorised by social norms, laws and regulations.

While our set of categories allowed us to identify frequent expressions of abortion-related obstetric violence, we found that these are usually intertwined and compounded, meaning that people will experience more than one at the same time. For example, several testimonies included experiences of gaslighting, and failure to meet standards of care and discrimination, while others included physical violence and threat of criminalisation and/or discrimination. Therefore, we are convinced that obstetric violence is an intersectional phenomenon, but further research is needed to properly identify the linkages among the diverse expressions and the paths to dismantle them. More studies are also necessary to understand the experiences of those more vulnerable to abortion-related obstetric violence, who are also a population less likely to access internet-based services such as WHW.

Research of this kind would also help to understand the connection between structural violences such as racism and classism and their role in violent abortion care. The case of abortion-related obstetric violence illustrates the strong interconnection between stigma, criminalisation,

medicalisation, and quality of care provided at formal health facilities. By shedding light on the injustices occurring in these spaces, we hope to bring attention to the importance of shifting power to centre people's autonomy and dignity in healthcare.

Indeed, we see a strong need to address obstetric violence both in medical practice and in legal frameworks in Latin America. One such urgent reform is the decriminalisation of abortion throughout the region, as restrictive laws expose abortion seekers to various forms of harm, and place those already in a marginalised position at higher risk. In addition to reducing risk and harm, abortion decriminalisation would allow for abortion to be framed as what it is – a common healthcare practice that should be enjoyed with the highest standards of quality and according to people's needs and choices. Initiatives to socially decriminalise abortion, reduce abortion stigma, include a social justice perspective in health professionals' training and increase abortion access, including outside formal health systems, are also important steps towards ending abortion-related obstetric violence.

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Notes

1. We recognise that people with diverse gender identities (cis women, trans and non-binary people) have abortions and are exposed to obstetric violence and we strive to use neutral language that acknowledges this diversity. However, in this text we mainly refer to cis women's experiences regarding abortion-related obstetric violence, thus using the term 'women' to refer to them. We believe that abortion-related obstetric violence affects trans and non-binary people in specific ways, which might be even more brutal because of their generally more marginalised identities and material conditions in a heteropatriarchal society. Nonetheless, we do not have enough data to describe obstetric violence experienced by people other than cis women.
2. The Venezuelan law defines obstetric violence as "... the appropriation of women's bodies and reproductive processes by health personnel, which is expressed by a dehumanising treatment, an abuse of medicalisation and a pathologisation of natural processes, resulting in a loss of autonomy and ability to decide freely about their bodies and sexuality, negatively impacting their quality of life" (República Bolivariana de Venezuela 2007).
3. While we recognise the value of the concept of obstetric racism to highlight the centrality of racism in the production of violence and mistreatment experienced by Black women in pregnancy and childbirth (Davis 2018), in this article we opted for the broader category of discrimination because not all of our research participants identify as Black, and nor are the forms of mistreatment they suffered clearly connected with racism.

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article

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Appendix II: Assis MP, Larrea S. Why self-managed abortion is so much more than a provisional solution for times of pandemic. Sex Reprod Heal Matters. 2020;28(1):1-3.

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Why self-managed abortion is so much more than a provisional solution for times of pandemic

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COMMENTARY

SRHM SEXUAL AND REPRODUCTIVE HEALTH MATTERS
MORE THAN A JOURNAL

Why self-managed abortion is so much more than a provisional solution for times of pandemic

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Keywords: abortion access, COVID-19, self-managed abortion

The COVID-19 pandemic is striking health care systems around the world through an unprecedented increase in demand. In responding to this crisis, governments and health care providers face the challenging question of how to continue providing essential health services, while taming the new disease. In these times, access to abortion is more contested than ever.

Conservative governments have seized upon the pandemic as an opportunity to declare abortion an elective procedure and shut down services. In the USA, where abortion rights have again become a heated topic, several states have imposed restrictions on access that amount to effectively banning abortion care.[1] In Latin America and the Caribbean, a region with the most restrictive abortion laws in the world, activists have exposed added difficulties faced by those who qualify for abortion on the few grounds where it is legal.[2] In Poland, a country with some of the strictest abortion laws in Europe, a controversial tightening legislative proposal has been pushed through during the lockdown.[3]

In an alternative approach, a few countries have acknowledged that abortion is an essential health service and shifted to telemedicine to secure access during the crisis. After much discussion and public confusion over prematurely leaked regulations, the United Kingdom adopted guidelines that allow women and pregnant people to manage their own abortions. According to the new regulation,[1] the person in need of abortion care can have a telemedicine consultation with a registered medical practitioner, receive the pills (mifepristone and misoprostol) by mail, and use them at home.

While advocates in the field of reproductive health and rights have celebrated the UK's decision and are encouraging governments across the world to follow suit, the new regulation is temporary. Adopted in light of the mandatory lockdown, access to abortion through telemedicine will last for two years or until the end of the pandemic, whichever is earlier.[4] The assumption underlying the regulation and, indeed, the field of public health in general, is that once the coronavirus crisis is over, people should go back to having abortions "as usual", i.e. in formal health facilities. Even in these extraordinary times, medical control of abortion remains the prevailing principle.

The history of abortion medicalisation is a relatively recent one. For centuries, abortion was routinely used to regulate fertility, along with "calendar-based" contraception and other methods then available. Even after the ban of abortion, the practice remained common within women's circles, and midwives were a central figure in family planning services. Only in the nineteenth century was law invoked to regulate abortion provision. Physicians were among the loudest voices calling for such regulation, which eventually extended medical jurisdiction to a life event that, for centuries, had been under people's control and happened within their intimate circles of care.[5]

The relaxation of abortion regulation that is only a temporary response to a health crisis ignores this past history. It also assumes that the more recent experiences of self-managed abortion – that is, the use of abortion pills outside formal health facilities without medical supervision[6] – is abnormal and less desirable. Such an approach overlooks much of

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what we already know about the relationship between self-management, increase in abortion access, and safety and quality of methods.

Extensive research today shows that self-administration of pills for early abortion with limited involvement of health professionals is effective and has similar outcomes to medical abortion administered by professionals in health facilities.[7] Moreover, the use of abortion pills outside of formal systems is credited with the decrease of abortion complications and maternal mortality worldwide, but particularly in low- and middle-income countries.[8] For a vast number of women and pregnant people across the world, self-managed abortion is not a provisional solution; it is indeed the best option.

For decades now, feminist organisations around the world have supported pregnant people in self-managing their abortions, especially in places where abortion is restricted by laws and regulations, stigma, or lack of resources. Building on the knowledge first developed and disseminated by Brazilian women in the 1980s, feminist initiatives for self-managed abortion have created diverse frameworks of knowledge and resources that operate both locally and within a transnational network. People access abortion pills online or in local pharmacies and activists provide them with evidence-based information on how to effectively and safely use the pills, as well as assistance throughout the process.

The ways that activists provide support vary, but they all share an underlying commitment to feminist ethics. *Socorristas en Red* is a nation-wide Argentinian network that provides access and information through telephone and in-person accompaniment and group meetings.[9] In Africa, *MAMA*, a network of grassroots activists and feminist groups, works towards expanding knowledge and eliminating stigma around self-managed abortion at the community level. *Samsara*, in Indonesia,[10] similarly to activists in many countries in Latin America and the Caribbean,[11] operates a safe abortion hotline that offers information about self-managed abortion with pills in countries where abortion is criminalised. *Women Help Women* and *Women on Web* both run telehealth services that deliver access to pills, as well as information and accompaniment over email to people all over the world.[12] By doing this essential work, feminist activists fulfil a need that is often neglected or denied by many states in "normal" times, and even more so in times of a pandemic.

Feminist activists have demonstrated that self-managed abortion support initiatives are indeed so much more than a provisional solution. People report preferring self-managed abortion because it fosters privacy, autonomy, and confidentiality.[6] The method also allows pregnant people to be at home or in any space of their choice, surrounded by those whom they trust. And above all, self-managed abortion puts control over the process back into the hands of pregnant people.

Women and gender non-conforming people have long struggled for the demedicalisation of their bodies and health. Yet, public health approaches usually do not consider autonomy and control over medical processes as indicators of quality of care. The advent of abortion pills opened up the possibility of realising the political demand for autonomy, at least in abortion care. Seizing this opportunity, feminist initiatives on self-managed abortion show us what demedicalised, respectful, and dignified care that enables people's power looks like.

Indeed, the stories behind the feminist initiatives on self-managed abortion speak of solidarity and non-judgmental support,[5,6] experiences that pregnant people, particularly those from marginalised communities, do not always encounter in formal health systems. Every person, regardless of their context, deserves good quality abortion care when choosing to terminate a pregnancy, and access to emergency medical attention if needed. They should be able to decide also how they want to have their abortion, without fear of prosecution or moral judgement: in a formal health facility, overseen by a health professional, or at a place of their choice, with accessible information and care from whomever they cherish. It is now up to national governments and formal health systems to take the opportunities brought by COVID-19 and make permanent improvements that are long overdue in abortion provision.

Abortion care needs to be contextualised in relation to local sociopolitical circumstances and tailored to personal needs and preferences. This means that there is no universal formula for improvement. However, some simple measures could have vast impact on abortion access and quality of care. For example, decreasing barriers to access abortion pills, such as regulations that restrict distribution and use to authorised health facilities or that require prescription for purchase in pharmacies, could improve accessibility and safety. Eradicating censorship of online abortion

information would improve people's ability to make safe choices regardless of their context. Local production of abortion medicines and measures to set affordable prices could decrease global inequalities in access as well as reduce the unjust burden of post-abortion morbidity and mortality that impoverished and marginalised people suffer. Interventions to decrease abortion-related stigma and to develop skills for respectful care within the health professions could make hospitals a safer space for women and pregnant people as well as increase access and quality of abortion and post-abortion care. Finally, self-managed abortion could be offered as one of many options, along with surgical interventions and medical abortion administered in health facilities, depending on people's preference and needs.

The Covid-19 emergency has led some formal health systems to acknowledge and learn from activist strategies, as the example of the UK shows. Perhaps it will also drive society and governments alike to understand that while medical professionals are irreplaceable in some areas of care, their control over every health process under all circumstances is neither necessary nor desirable. Indeed, the case of abortion shows that medicalisation functions as a barrier for an essential healthcare service, both in "normal" and exceptional times. The current moment is ripe for trusting people in their choices and openly embracing the power of self-management.

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Requests for medication abortion support in Brazil during and after the Zika epidemic

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ABSTRACT
Brazil declared a public health emergency during the Zika virus epidemic, recommending avoiding pregnancy. This study analyses requests received by Women Help Women for information about and support for self-managed medication abortion (MA) in Brazil during and after the Zika epidemic to understand how Zika may have impacted requests to the service. This analysis considered 20,609 requests for MA support received between January 2016 and June 2017. Reasons for seeking an abortion were analysed alongside geographic trends in the percent and rate of requests citing Zika as a reason for seeking abortion. The average number of daily requests for MA support increased from 31 in January 2016 to 48 in June 2017. The average percent of daily requests citing Zika as a reason for seeking an abortion decreased from 15% in March 2016 to 1.5% by June 2017. The most common reason for abortion seeking during and after the Zika epidemic was not being prepared for a child or not wanting any or additional children (between 52%–59% of requests). As the Zika epidemic slowed, MA requests citing Zika as a reason decreased, while requests increased overall. Few people cited Zika alone as a reason for abortion seeking, necessitating a broad contextualisation of abortion access in people's daily lived experiences and realities.

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1. Introduction

In November of 2015, Brazil declared a national public health emergency because of the sharp increase in microcephaly cases linked to the Zika virus (Governo do Brasil, 2015; Marinho et al., 2016) and the World Health Organization (WHO) declared a Public Health Emergency of International Concern (PHEIC) in February of 2016 (World Health Organization, 2016). During the Zika epidemic, some countries encouraged women to avoid pregnancy indefinitely given the link between the virus and microcephaly and other brain malformations. The Brazilian government stressed the importance of counselling and access to family planning (Ministério da Saúde, 2015).

It is estimated that, under normal circumstances, more than 50% of births in Brazil are unintended, resulting, in part, from unequal access to contraceptive services (Ministério da Saúde, 2009; Theme-Filha et al., 2016). In addition, abortion is severely restricted in Brazilian law, allowing for abortion only when a woman's life is endangered, in cases of rape, or if a fetus is ancephalic – leaving few legal options for pregnancy termination. Despite these legal restrictions, it is estimated that approximately 500,000 abortions take place each year in Brazil (Diniz et al., 2017).

Zika emerged in the context of widespread economic and social inequity in Brazil, factors that also influence access to reproductive health services (Castro et al., 2018; Marteleto et al., 2017). In Brazil,

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those who are socioeconomically disadvantaged are more likely to live in areas with poor access to sanitation and in houses without screens, air conditioning, or insect repellent – increasing the likelihood of contact with mosquitoes ('70,3% dos domicílios', 2013; Paradella, 2018). In 2016, municipalities with the lowest socioeconomic levels were concentrated in the Northeast of Brazil (Albuquerque et al., 2017). Literature suggests that the North and Northeast regions of Brazil, where Zika incidence was highest, have the highest unmet need for family planning and the lowest levels of contraceptive use (Farias et al., 2016; Tavares et al., 2007). Research has shown that lack of information about free public services may limit access to contraceptive services among those for whom cost is a barrier to access (Center for Reproductive Rights, 2018). In Brazil, previous research has also shown that access to safe abortion services varies by socioeconomic status and people who cannot pay for the high cost of an illegal abortion at a private clinic turn to other methods (Diniz & Medeiros, 2010; Fusco, 2013; Fusco et al., 2016; Kane et al., 2013; Marteleto et al., 2017). In the wake of the Zika epidemic, there has been an increased awareness of many of these dynamics and efforts have been made to better monitor the demand and quality of services for contraceptive and abortion services in Zika-affected areas; however, these efforts focus almost exclusively on how Zika alone impacts the demand for services (Ali et al., 2017). Given the broader social and economic constraints faced by those at higher risk for Zika, it is important to contextualise the need for abortion services more broadly, among other reasons that people may have to seek an abortion.

Self-managed abortion using misoprostol is thought to be common in Brazil and self-managed medication abortion is increasingly recognised as a safe and acceptable option to terminate a pregnancy (Aiken et al., 2017; Diniz & Medeiros, 2010; Foster et al., 2017; Gerdts et al., 2018; Gomperts et al., 2008; Gomperts et al., 2014; Grossman et al., 2018; Moseson et al., 2020; World Health Organization, 2007). Previous research has suggested that requests for self-managed medication abortion support increased significantly after national public health advisories were implemented in countries with autonomous transmission of the Zika virus, including Brazil (Aiken et al., 2016). This evidence comes from requests made to one specific website, Women on Web, which provides information and access to abortion medications through an international telemedicine service. Aiken et al. (2016), however, used only information on the total number of requests and did not parse apart the reasons for abortion-seeking, limiting the conclusions that can be drawn with these data. The current study aims to describe the requests received for medication abortion support by a different organisation with a similar service: Women Help Women. Women Help Women is an international organisation that provides access to abortion medication as well as email support during the self-managed abortion process to people in countries where abortion access is restricted. We use data collected by Women Help Women to describe trends in medication abortion during and after the Zika epidemic in Brazil. Our analysis has two aims (1) to characterise requests for medication abortion support related to Zika and (2) to understand how important concern about Zika was in the context of other reasons for seeking an abortion.

2. Materials and methods

2.1. Data and measures

In the process of requesting Women Help Women's service, people fill in an online form. The form collects data to determine the requester's eligibility for medication abortion (days since the last menstrual period, possible contraindications for the use of Mifepristone and Misoprostol, method of pregnancy confirmation), as well as some demographic information needed for the service logistics (birth date, address, and other personal data). In mid-February 2016, after the declaration of the public health emergency in Brazil, questions about the reasons for seeking an abortion were included in the online form.

For this study, we analysed online requests from Brazil received by Women Help Women between January 1, 2016 and June 30, 2017, capturing the time period after the start of the Zika epidemic through

the end of the public health emergencies. We categorised the time period covered into four phases to characterise the Zika epidemic. These stages were informed by the declarations of public health emergencies by the Brazilian government and the WHO and included: (1) January 1, 2016 (after the start of the Brazilian declaration of a public health emergency) through the day before the declaration of the WHO PHEIC (January 31, 2016), (2) Declaration of the WHO PHEIC (February 1, 2016) to the end of the WHO PHEIC (November 18, 2016), (3) November 19, 2016 through the end of the Brazilian public health emergency (May 12, 2017), and (4) May 13, 2017–June 30, 2017.

Reasons for seeking an abortion were collected through a close-ended question. Requesters were asked to select all relevant reasons for their specific case. Possible responses were (1) not being prepared to have another child at that time, (2) considering their family complete, (3) not wanting children, (4) having financial problems, (5) facing housing issues, (6) having health problems, (7) feeling too young or too old to have children, (8) facing problems in their couple, (9) being single, (10) being unemployed, (11) having concerns about a child interfering with a job or career, (12) having concerns about a child interfering with education plans, (13) having concerns that the partner would not accept the pregnancy, (14) having concerns about family not accepting the pregnancy, (15) having a pregnancy that was a result of rape, (16) being afraid of Zika, (17) having a reason other than those listed, and (18) preferring not to share. If the requester indicated that they had another reason for seeking an abortion, they had the opportunity to enter text to describe the reason. We reviewed the reasons specified in the 'Other reason' field for any mention of Zika (n =4), however all requesters that mentioned Zika in the open responses had already selected Zika in the close ended options. If a requester selected that they were concerned about Zika, they were prompted to answer three follow-up questions probing for more information about whether they had been formally diagnosed with Zika, whether they thought they might have had Zika but were not diagnosed, and whether they were concerned that they were at risk of Zika during the pregnancy. These options were not mutually exclusive. To analyse the reasons for seeking abortion, we combined reasons about future plans (reasons 11 and 12), reasons related to concerns from partners and family members (13 and 14), financial reasons (reasons 4, 5, and 10), and reasons related to not wanting children at this time or any time (reasons 1, 2, and 3). Reasons 6–9 and 15–18 were analysed individually.

We categorised states into five regions defined by the Instituto Brasileiro de Geografia e Estatistica of Brazil: North, Northeast, Central-West, Southeast and South (Instituto Brasileiro de Geografia e Estatística, 2018). Where the state could not be ascertained from the information included in the state field, we considered the state and region of residence to be unknown. We calculated the number of weeks since last menstrual period at the time of the request based on the number of days since the last menstrual period and grouped responses into the following categories: ≤4 weeks, >4 weeks-≤6 weeks, >6-weeks-≤8 weeks, >8-≤12 weeks, and >12 weeks. We calculated age based on birth date provided and analysed it in five groups (<18, 18–24, 25–29, 30–34, 35+). When the age of the person requesting medication support was 56 or older, or less than 9, we considered age to be missing. Options for pregnancy confirmation methods were ultrasound, blood pregnancy test, urine pregnancy test, and no confirmation. Requests that listed more than one method were assigned to the most invasive test following the order of the methods listed above (from most to least invasive).

The dataset also included information on whether the person requesting support followed up with Women Help Women after the initial consultation and reported accessing medication. Follow up data was not analysed for this study and researchers did not have access to any personal identifiable information of the requesters.

2.2. Analysis

2.2.1. Overall requests to Women Help Women during the study period

We present the overall number of daily requests for medication abortion support over the study period. Requests were stratified by the region of Brazil in which the person resided, weeks since the last menstrual period at the time of contact, age, and method by which the current pregnancy was confirmed.

2.2.2. Characterising requests that listed Zika as a reason for seeking abortion

We analysed the total number of requests and the percent of requests listing Zika as a reason for seeking abortion services. We examined total requests by day and as daily averages by month. To standardise the measure of the number of requests across geographies, we present the number of requests per 100,000 women between the ages of 15–49, representing an average rate per person day for a given month.[1] With this measure we do not aim to represent the total abortion rate in a given geography, but to standardise the number of requests in relation to the size of the population for comparison purposes. The number of requests per 100,000 women reflects how the total number of requests, as well as the number of requests citing Zika as a reason, changed over time. We used population estimates from the 2010 census (Instituto Brasileiro de Geografia e Estatística, 2014).

We constructed mixed-effects logistic models to analyse whether the proportion of requests listing Zika as a reason for seeking an abortion varied by age, method of pregnancy confirmation, and weeks since last menstrual period. We included these variables because those at later gestational ages and those who had ultrasounds may have received additional information about the possibility of malformations related to Zika. Methods of pregnancy confirmation may also be indicative of socioeconomic status, as urine pregnancy tests may be cheaper and more accessible than a blood pregnancy test or an ultrasound (de Almeida Gomes et al., 2019). We included age to understand whether concern about Zika was more prevalent among certain age groups (Chiavegatto Filho & Kawachi, 2015). We ran separate mixed-effects logistic models for each characteristic to evaluate whether there was an association between each characteristic and the probability that a request listed Zika as a reason for abortion seeking. In these models we include a random effect on each month-year. We consider a p value of less than or equal to 0.05 as significant, however, we emphasise that these models are meant only to be associative and not causal.

2.2.3. Contextualising Zika concern amongst other reasons for seeking abortion

We calculated the monthly unweighted average of the daily percent of requests made for each of the possible reasons for seeking an abortion to understand how the prevalence of citing Zika as a reason for seeking abortion changed in relationship to all requests received by Women Help Women. We also compared the total requests by reason as a rate at the national level to understand how the overall frequency of reasons changed over the time period, comparing Zika to all other reasons listed.

We calculated the average number of reasons that each user provided for seeking an abortion and examined the mean number of reasons stratified by whether the user listed Zika as a reason for seeking an abortion. We calculated the percent of requests that listed Zika as the sole reason for seeking abortion services, considering all requests and those that chose Zika as a reason for seeking abortion in turn.

Women Help Women users consented for their anonymized data to be analysed for research purposes. Our study does not qualify as human subject research under Title 45 Part 46 of the United States Code of Federal Regulations and therefore approval from an ethical review board was not required.

3. Results

3.1. Overall requests to Women Help Women during the study period

20,609 requests from people reporting they lived in Brazil were received by Women Help Women from January 1, 2016 to June 30, 2017. Throughout the study period, the number of daily requests ranged from 13 to 70 (Figure 1). The daily number of requests appeared to be increasing over time, despite cyclical variation. From January 1, 2016 to the start of the WHO PHEIC, the service received

951 requests for medication abortion support, or an average of 30.7 a day (Table 1). During period spanning the WHO PHEIC, Women Help Women received almost 10,500 requests for medication abortion, translating to an average of 35.9 requests per day. After the end of the WHO PHEIC, the daily average continued to increase, from 39.3 between the end of the WHO PHEIC and the end of the Brazil public health emergency to 46.6 requests per day in the time after Brazil ended its public health emergency. The percent of days with over 30 requests increased from 56.7% in June of 2016 to 96.7% in June of 2017.

Requests from the Southeast region of Brazil were the most frequent in each time period, followed by the South and Northeast regions. The proportion of total requests from these regions remained relatively constant throughout the periods defined by the Zika epidemic (Table 1). Throughout all time periods, approximately half of the requests came from those between the ages of 18 and 24. In the period between January 1, 2016 and the start of the WHO PHEIC, 42% of requesters reported that they did not remember when their last menstrual period started, 32% of requests were submitted by those whose last menstrual period started 6 weeks ago or less, 18% reported their last menstrual period started between six and eight weeks ago, and 8% reported their last menstrual period started more than 8 weeks before the time of the request. The distribution of time since last menstrual period across requests remained stable throughout the study period. Between 44% and 46% of pregnancies were confirmed with a urine pregnancy test while 11% to 13% were confirmed with an ultrasound with little change documented over the time periods included in this study.

3.2. Characterising requests that listed Zika as a reason for seeking abortion

During March of 2016, the first month with complete data on reasons for seeking medication abortion support, an average of 15.0% of requests listed concern about Zika as a reason for seeking an

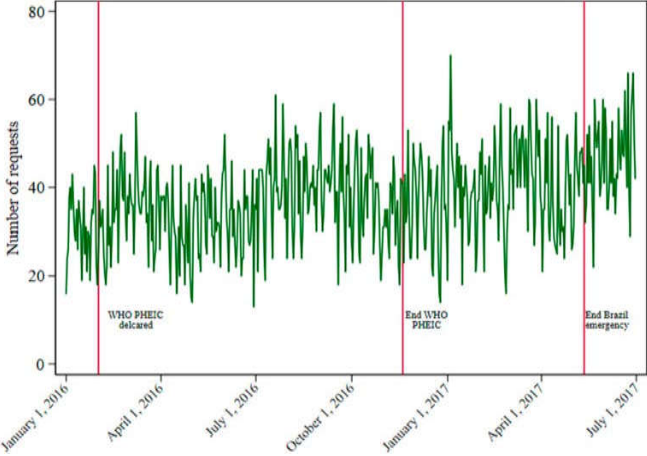

Figure 1. Requests for medication abortion support by day in Brazil: January 1, 2016- June 30, 2017. Caption: Graph represents the daily number of requests for medication abortion support received by Women Help Women over the course of the study period (January 1, 2016 to June 30, 2017). Important dates in the Zika virus epidemic are noted. Acronyms: Public Health Emergency of International Concern (PHEIC).

Table 1. Characteristics of requests from Brazil for medication abortion support to Women Help Women.

N (%)	January 1, 2016 – Start of WHO PHEIC declaration		Start of WHO PHEIC – end of WHO PHEIC		End of WHO PHEIC –end of Brazil public health emergency		After Brazil public health emergency		Full time period	
	All requests ($n = 951$)	Zika related (n = NA)*	All-requests (n = 10,494)	Zika related* ($n = 793$)	All requests (n = 6,881)	Zika related ($n = 250$)	All requests (n = 2,283)	Zika related ($n = 40$)	All requests (n = 20,609)	Zika related (n = 1,083)
Request per day Mean (range)	30.7 (16–45)	–	35.9 (13–61)	3.3 (1–15)	39.3 (14–70)	1.9 (1–6)	46.6 (22–66)	1.5 (1–4)	37.7 (13–70)	2.7 (1–15)
Region										
North	37 (3.9%)	–	395 (3.8%)	24 (3.0%)	285 (4.1%)	18 (7.2%)	74 (3.2%)	3 (7.5%)	791 (3.8%)	45 (4.2%)
Northeast	122 (12.8%)	–	1236 (11.8%)	167 (21.1%)	857 (12.5%)	55 (22.0%)	276 (12.1%)	11 (27.5%)	2491 (12.1%)	233 (21.5%)
Central-West	64 (6.7%)	–	971 (9.3%)	85 (10.7%)	583 (8.5%)	16 (6.4%)	201 (8.8%)	2 (5.0%)	1819 (8.8%)	103 (9.5%)
Southeast	576 (60.6%)	–	5710 (54.4%)	408 (51.5%)	3942 (57.3%)	132 (52.8%)	1347 (59.0%)	16 (40.0%)	11575 (56.2%)	556 (51.3%)
South	150 (15.8%)	–	1750 (16.7%)	82 (10.3%)	1148 (16.7%)	29 (11.6%)	356 (15.6%)	7 (17.5%)	3404 (16.5%)	118 (10.9%)
Unknown	2 (0.2%)	–	432 (4.1%)	27 (3.4%)	66 (1.0%)	0 (0.0%)	29 (1.3%)	1 (2.5%)	529 (2.6%)	28 (2.6%)
Weeks since last menstrual period										
≤4 weeks	78 (8.2%)	–	1173 (11.2%)	100 (12.6%)	668 (9.7%)	22 (8.8%)	226 (9.9%)	3 (7.5%)	2145 (10.4%)	125 (11.5%)
>4 weeks-6 weeks	228 (24.0%)	–	2898 (27.6%)	248 (31.3%)	1901 (27.6%)	83 (33.2%)	635 (27.8%)	17 (42.5%)	5662 (27.5%)	348 (32.1%)
>6-weeks-8 weeks	173 (18.2%)	–	1905 (18.2%)	152 (19.2%)	1425 (20.7%)	58 (23.3%)	472 (20.7%)	7 (17.5%)	3975 (19.3%)	217 (20.0%)
>8–12 weeks	62 (6.5%)	–	867 (8.3%)	61 (7.7%)	628 (9.1%)	20 (8.0%)	193 (8.5%)	3 (7.5%)	1750 (8.5%)	84 (7.8%)
>12 weeks	13 (1.4%)	–	137 (1.3%)	5 (0.6%)	96 (1.4%)	2 (0.8%)	33 (1.4%)	0 (0.0%)	279 (1.4%)	7 (0.6%)
Unknown	397 (41.7%)	–	3514 (33.5%)	227 (28.6%)	2163 (31.4%)	65 (26.0%)	724 (31.7%)	10 (25.0%)	6798 (33.0%)	302 (27.9%)
*Age***										
<18	105 (11.1%)	–	1279 (12.2%)	59 (7.5%)	777 (11.3%)	18 (7.2%)	207 (9.1%)	7 (17.5%)	2368 (11.5%)	84 (7.8%)
18–24	470 (49.5%)	–	5443 (51.9%)	412 (52.1%)	3445 (50.2%)	120 (48.2%)	1158 (50.9%)	19 (47.5%)	10516 (51.1%)	551 (51.0%)
25–29	172 (18.1%)	–	1873 (17.9%)	151 (19.1%)	1309 (19.1%)	62 (24.9%)	450 (19.8%)	8 (20.0%)	3804 (18.5%)	221 (20.5%)
30–34	127 (13.4%)	–	1150 (11.0%)	108 (13.7%)	795 (11.6%)	21 (8.4%)	283 (12.4%)	5 (12.5%)	2355 (11.4%)	134 (12.4%)
35+	75 (7.9%)	–	736 (7.0%)	61 (7.7%)	534 (7.8%)	28 (11.2%)	179 (7.9%)	1 (2.5%)	1525 (7.4%)	90 (8.3%)
Method of confirming pregnancy†										
Not listed	52 (5.5%)	–	682 (6.5%)	48 (6.1%)	397 (5.8%)	12 (4.8%)	123 (5.4%)	6 (15.0%)	1254 (6.1%)	66 (6.1%)
Urine pregnancy test	425 (44.7%)	–	4854 (46.3%)	329 (41.5%)	3187 (46.3%)	98 (39.2%)	1014 (44.4%)	15 (37.5%)	9480 (46.0%)	442 (40.8%)
Blood pregnancy test	348 (36.6%)	–	3830 (36.5%)	324 (40.9%)	2460 (35.8%)	94 (37.6%)	849 (37.2%)	13 (32.5%)	7487 (36.3%)	431 (39.8%)
Ultrasound	126 (13.2%)	–	1128 (10.7%)	92 (11.6%)	837 (12.2%)	46 (18.4%)	297 (13.0%)	6 (15.0%)	2388 (11.6%)	144 (13.3%)

*Reasons for seeking abortion were introduced to the online form February 19, 2016.

**Age is missing for 41 requests.

†Requests that listed more than one method to confirm their pregnancy were assigned to the most invasive test in this order (least to most invasive): none, urine pregnancy test, blood pregnancy test, and ultrasound.

Acronyms: Public Health Emergency of International Concern (PHEIC).

abortion. At the national level, the percent of requests that named Zika as a reason for seeking an abortion decreased over the time period; from an average of 7.9% of daily requests in June of 2016 to an average of 4.0% in December of 2016 and 1.5% in June of 2017 (Figure 2a). Between the start of the WHO PHEIC to the end of the WHO PHEIC, Women Help Women received approximately 3.3 requests per day citing Zika as a reason for abortion seeking compared to 1.5 requests per day in the time period after the Brazil emergency ended (Table 1). The average daily rate of requests that listed concern about Zika as a reason for seeking an abortion also declined at the national level, decreasing from 0.01 average daily requests per 100,000 women aged 15–49 in March of 2016 to 0.0026 in December of 2016 and 0.0014 in June of 2017 (Figure 2b).

Among regions, the Northeast and Central-West regions had the highest percentage of requests that cited concern about Zika as a reason for seeking an abortion (Figure 3a). In March of 2016, the average daily percent of requests that listed Zika as a reason in these regions was 21.8% and 20.5% respectively. Fifteen percent of requests from the Southeast region cited concern about Zika as a reason in March of 2016. In these three regions there was a marked decline in the average percent of daily requests that listed Zika as a reason for seeking an abortion, mirroring the trend at the national level. The North region and the South region, with a lower proportion of Zika-related requests, had less marked declines in the percent of requests that listed Zika as a reason over the time period. By June of 2017, the average daily percent of requests that listed Zika as a reason for seeking an abortion was less than 5% in all regions. We observed sharp declines in the daily average rate of requests per 100,000 women aged 15–49 that listed concern about Zika as a reason for seeking an abortion in the Central-West and Southeast regions (Figure 3b). There appeared to be smaller declines in the Northeast and South regions, while the rates in the North region showed less of a trend.

Among those citing concern about Zika as a reason for seeking an abortion ($n = 1083$), most worried they were at risk of Zika during their pregnancy (80.5%), while fewer reported having been diagnosed with Zika (12.7%) or worrying that they had Zika but were not diagnosed (20.8%). There was evidence from our mixed-effects logistic models that requesters under the age of 18 had lower odds of citing Zika as a reason for abortion seeking in comparison to all other age groups. Those who estimated more than 12 weeks from their last menstrual cycle were also less likely to report Zika as a concern compared to those who estimated it had been four weeks or less since the start of their last menstrual cycle at the time of request. Those who used an ultrasound or a blood pregnancy test to confirm their pregnancy were more likely to report Zika as a reason for abortion seeking

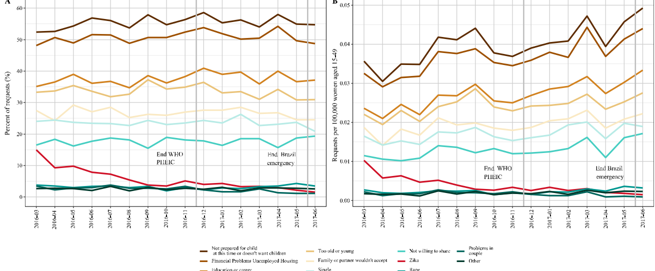

Figure 2 . (A) Average percent of daily requests by reason(s) listed for seeking abortion, by month (B) Average daily rate of requests by reason(s) listed for seeking abortion per 100,000 women aged 15–49, by month. Caption: Figure represents the average percent of daily requests and average daily rate of requests that list each pictured reason as a reason for seeking an abortion. These data are shown by month over the study period. Acronyms: Public Health Emergency of International Concern (PHEIC).

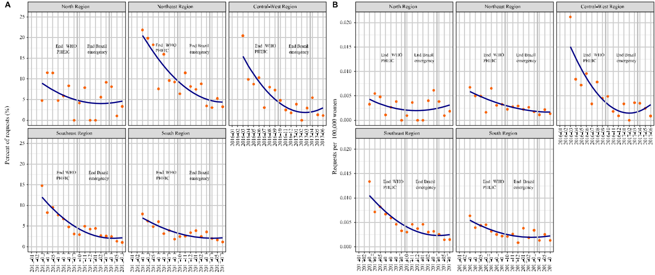

Figure 3. (A) Average percent of daily requests citing Zika as a reason for seeking an abortion as percent of total requests over time, by region (B) Requests citing Zika as a reason for seeking an abortion as average number of daily requests per 100,000 women aged 15–49 over time, by region. Caption: Points represent the average daily percent of requests citing concern about Zika as a reason for seeking an abortion and the average daily rate of requests citing concern about Zika as a reason for seeking an abortion per100,000 women aged 15–49 in each month. Blue lines represent a loess curve for the average daily percent of requests citing concern about Zika as a reason for seeking an abortion and the average daily rate of requests citing concern about Zika as a reason for seeking an abortion per100,000 women aged 15–49. Acronyms: Public Health Emergency of International Concern (PHEIC).

compared to those who used a urine pregnancy test to confirm their pregnancy. Descriptive statistics supporting these findings are shown in Table 1.

3.3. Contextualising Zika concern amongst other reasons for seeking abortion

Throughout the study period, the most common reason cited for seeking an abortion was not being prepared for a child at the time of the pregnancy or not wanting any or additional children (Figure 2a). Between 52% and 59% of requesters cited these reasons. This was followed by financial reasons (financial problems, being unemployed, and housing). The average percent of daily requests listing each of the reasons not related to Zika stayed relatively constant during the study period, in contrast with the percent of requests listing Zika. Between 15% and 20% of requesters did not share a reason for requesting medication abortion support.

Examining the rate of requests, the most frequent reasons given for abortion seeking (not wanting children at this time or any time and financial reasons) increased over the time period (Figure 2b). The rate of requests noting Zika as a reason ranked eighth in overall frequency in March of 2016 during the height of the epidemic and declined to the second least frequent reason named in June of 2017.

Overall, 5.7% of requests included Zika as a reason for seeking an abortion. Zika was listed as the only reason for seeking abortion services in 0.2% of cases overall and in less than 1% in every region. Those who named Zika as a reason for seeking an abortion named on average 4.5 additional reasons they were seeking an abortion in their request (a total of 5.5 reasons) compared to three reasons among those who did not name Zika. In 3.3% of the requests including Zika as a reason for abortion seeking, Zika was the only reason listed. This percentage ranged from 0.0% in the South region to 6.7% in the North region.

4. Discussion

This study shows that the number of requests for medication abortion support received by Women Help Women increased over the study period, even after the Zika epidemic ended in Brazil. The distribution of requests by age, method of pregnancy diagnosis, region, and gestational age changed

little over this period. Our results show that concern about Zika as a reason for seeking an abortion was highest during the peak of the Zika epidemic and declined as the epidemic slowed. This decline was reflected both in terms of the percentage of requesters that mentioned Zika as a reason for the abortion and in absolute numbers. Citing Zika as a reason for the abortion was more common in regions where incidence of Zika was highest. However, Zika was rarely the sole reason mentioned at any point during the study period and in any region. On the contrary, reasons related with personal decisions about parenting and financial situations were most commonly mentioned and this remained stable through different periods. These results suggest that alongside an unmet need for contraceptive services (Farias et al., 2016; Tavares et al., 2007), there is a large unmet need for abortion services in Brazil and that the decision to have an abortion in this context is linked to a wide range of reasons.

In our study, citing Zika as a reason for the abortion was more prevalent among those older than age 18 and among those who confirmed their pregnancy with a blood pregnancy test or ultrasound. We also found that mentioning Zika as a reason was less common among those who requested support at higher gestational ages. These results, though not causal, speak to the potential that there was differential concern about Zika among different groups of pregnant people in Brazil. It is possible that a lower prevalence of concern about Zika as a reason for the abortion among those under the age of 18 reflects the broader structures and constraints young people face when they get pregnant. This would make concern about Zika secondary to broader considerations such as educational factors, financial concerns, or readiness to have a child (Heilborn & Cabral, 2011). The ways pregnancy diagnosis method and gestational age interact with Zika concern to influence decisions about seeking abortion deserve further exploration. Blood pregnancy tests and ultrasounds may be more common among people of higher socioeconomic status or with better access to health services. Additionally, an ultrasound may provide more information about the development of the fetus that would lead to a decision to seek abortion services. Blood pregnancy tests and ultrasounds may be more likely to take place at a health facility and lead to conversations with a provider about potential risks of Zika during pregnancy.

Although these results are descriptive, they point to a more nuanced picture than prior results have suggested about drivers of abortion in Brazil during and after the Zika epidemic (Aiken et al., 2016). Our results do suggest that Zika was part of the general consciousness of those requesting abortion, especially in areas where incidence of Zika was higher. Concern about Zika may have influenced abortion seeking overall; however, in large part, our study documents that need for abortion during and after the Zika epidemic was driven by factors outside of the concern caused by Zika. Even during the peak of the Zika epidemic when Zika factored more prominently into decisions to seek abortion services, concern about Zika often intersected with other reasons for seeking abortion. These results add to the mixed findings from prior research on changes in pregnancy intention, contraceptive purchasing, and contraceptive use in the context of Zika in Brazil (Bahamondes et al., 2017; Borges et al., 2018). Taken together, these results likely reflect the ongoing complexity of reproductive decision making even in the midst of a public health crisis (Center for Reproductive Rights, 2018).

Our results, although representing only a small percentage of the approximately 500,000 abortions that take place in Brazil annually, point to a large unmet need for abortion services that is being covered in part by online services like Women Help Women. These findings support the need for a broad conversation about access to comprehensive sexual and reproductive health services including abortion. Such conversations should acknowledge the need for abortion in relation to crises such as Zika, but also should recognise the need for abortion services in the broader context of people's lives. The August 2018 Supreme Court hearing on decriminalising abortion in Brazil was a step in this direction, emphasising the right to abortion services for all people regardless of socioeconomic position or reason for abortion seeking (Andreoni & Londoño, 2018; Correa, 2018).

This study has several limitations. First, we utilised data collected from online consultations regardless of the outcome of the request. It is possible that these data include duplicate entries

and potential errors in data entry into the online form. However, analysing a large dataset from people in need of abortion in a legally restricted context provides an invaluable opportunity for exploring the complexities of an understudied clandestine phenomenon. Second, given the fact that this is an online based service, requesters may be more likely to have access to internet and IT literacy than the general Brazilian population. Lower income and marginalised communities in Brazil were more likely to be affected by Zika (Castro et al., 2018; de Oliveira et al., 2017; de Souza et al., 2018), and may have had a harder time enacting changes in reproductive behaviour to respond to risks of Zika (Marteleto et al., 2017). This suggests that our sample may not include the population hardest hit by the Zika epidemic. These data are also not representative of abortion seeking across Brazil. Thus, the geographic pattern of our data cannot be generalised to be representative of abortion seeking in each region. It is likely that the number of requests in each region is more related to outreach strategies from the organisation than the need for abortion in each region. The time period included in this study began during the Zika epidemic. As such, we do not observe the rate of requests prior to the start of the epidemic. Finally, although we tried to control for the seasonal pattern of abortion in our analyses of differences in requests citing Zika as a concern by individual characteristics, these results should not be interpreted causally as additional temporal trends may still exist in our data and we have not controlled for potential confounders.

5. Conclusion

This study highlights that although concern about Zika was highest during the peak of the Zika epidemic, Zika was rarely the main reason for seeking an abortion at any point during the study period and often interacted with other reasons for seeking an abortion. These results show that the complexity of the abortion decision making process persists in the face of public health emergencies, drawing attention to the need for safe, accessible, quality abortion services. While the Zika epidemic increased visibility of lack of access to abortion services in Brazil, access to abortion must be understood in the broader context of people's lives and their reproductive choices.

Note

1. We acknowledge that not all people who are in need of abortion care and who submitted requests for medication abortion support identify as 'women'. However, the best approximation for the population who are able to become pregnant and may be in need of abortion care is women of reproductive age. Throughout this manuscript we use the gender-inclusive term 'people' where possible, and use the more specific 'women' when referring to the standardized rates we have created using the population of women 15–49.

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Disclosure statement

No potential conflict of interest was reported by the author(s).

Data Availability Statement

Due to our commitment to protect the confidentiality and anonymity of those requesting support from Women Help Women, we cannot make the data used for this study available for download. We are happy to answer any inquiries related to the data used for the manuscript and provide additional information, where possible.

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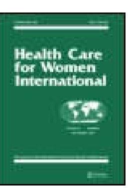
Appendix IV: Baum SE, Ramirez AM, Larrea S, et al. “It’s not a seven-headed beast”: abortion experience among women that received support from helplines for medication abortion in restrictive settings. Health Care Women Int. 2020;0(0):1-19



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“It's not a seven-headed beast”: abortion experience among women that received support from helplines for medication abortion in restrictive settings

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"It's not a seven-headed beast": abortion experience among women that received support from helplines for medication abortion in restrictive settings

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ABSTRACT

There are a growing number of abortion helplines where counselors provide person-centered medication abortion services in legally restrictive settings. Few researchers have explored the perceptions and experiences of the people who obtain support from these helplines. Between April and August 2017, we conducted 30 interviews with women who had a medication abortion with support from helpline counselors in Poland, Brazil, or Nigeria. Before seeking care with the helpline, women often heard negative stories about abortion and faced enacted stigma from the formal healthcare sector, or chose not to seek services from their doctors due to fear of stigmatizing treatment. Conversely, during their care with the helpline counselors, women received clear information in a timely manner, and were treated with kindness, compassion, respect, and without judgment. Many women gained knowledge and understanding of medication abortion, and some gained a sense of community among those who experienced abortion. Helpline models can provide high-quality, person-centered abortion care to people seeking abortions in legally restrictive contexts. Evidence from these service-delivery models could help improve service within the formal healthcare systems and expand access to high-quality, safe abortion by redefining what it means to provide care.

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People around the globe deserve access to high-quality abortion care (Jelinska & Yanow, 2018). However, pervasive legal restrictions limit access to safe abortion and restrict reproductive rights. It is widely accepted that restrictive abortion laws do not limit the number of people who seek and obtain abortions (Sedgh et al., 2016). Yet, those who want to end their pregnancy in these settings often face difficulty accessing reliable

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information and experience a limited availability of quality, affordable providers, among other barriers (Footman et al., 2018; Gerdts et al., 2015; Lavelanet et al., 2019; Zamberlin et al., 2012).

Social stigma can exacerbate these legal, financial, logistical, and informational barriers. Abortion stigma is the shared understanding that abortion is morally wrong or socially unacceptable (Cockrill et al., 2013). While stigma can exist in any context, it is likely more pervasive in legally restrictive settings. It can manifest as fears about judgment from family or community members, experiences of exclusion or discrimination, and negative attitudes about oneself (Cockrill & Nack, 2013; Shellenberg et al., 2011). In addition to impacting the type of information that people access, stigma can lead to delays in care seeking, fears of interacting with formal healthcare systems, low expectations of abortion care, use of unsafe methods in order to keep the abortion a secret, or delay of treatment for complications—if they occur—due to concerns about discrimination or even criminalization (Araújo et al., 2018; Coleman-Minahan et al., 2019; Constant et al., 2019).

In restrictive legal contexts, people who need abortions are increasingly relying on the use of safe, effective, World Health Organization (WHO)-recommended medications for abortion (mifepristone and misoprostol, or misoprostol alone) (Jelinska & Yanow, 2018). In many countries, however, people seeking medication abortion outside of the formal healthcare system access pills from a pharmacy or other drug seller, often without a prescription. While local access to medications through these vendors is critically important, it can leave people without accurate information about how to take the medications, what to expect, and where to seek help if they need it (Footman et al., 2018; Hendrickson et al., 2016; Weaver et al., 2020). In order to leverage the availability of medication abortion and counteract these challenges, advocates and clinicians in restrictive settings around the world have established programs and services to deliver medical and emotional support and information to people who are managing an abortion with medications. A growing number of abortion hotline counselors or online telehealth counselors (together we will call these helplines) provide these services in restrictive and low-resource settings. These groups are most often grassroots organizations made up of non-clinician volunteers or community members who are trained in evidence-based protocols and person-centered models of support, accompanying people through each step of managing their abortion (Erdman et al., 2018). The helpline counselors aim to provide accurate information on medication regimens, dosage, what to expect, warning signs, and where to obtain trusted care if adverse events occur. Recent studies assessing these models of care in Argentina, Indonesia, Ireland, Peru, and along the Thai-Burma border contribute to a

growing body of evidence that the use of medication abortion outside the formal healthcare system is safe and effective when people have access to accurate information and support systems (Aiken et al., 2017; Foster et al., 2017; Gerdts & Hudaya, 2016; Grossman et al., 2018; Zurbriggen et al., 2018). Helpline support for medication abortion in restrictive settings has the potential to increase use of safe methods, which would decrease morbidities from unsafe methods and therefore reduce burdens on healthcare services that treat these complications (Grimes et al., 2006; Vlassoff et al., 2009). Few researchers have explored the perceptions and experiences of people who obtain support from helpline counselors, particularly regarding how they assess the quality of their care.

The WHO defines quality of care as the provision of services that are safe, timely, efficient, effective, equitable, and patient-centered (*Quality of care: a process for making strategic choices in health systems*, 2006). While person-centered abortion care is a relatively new area of study, there are reproductive health frameworks that provide a foundation in understanding the domains. In a framework of person-centered maternity care published by Sudhinaraset *et al.*, the authors identify key aspects of care, such as trust, support, autonomy, dignity and respect (Sudhinaraset et al., 2017). Altshuler and Whaley used this framework to assess findings from studies published in 2017–2018 addressing client experience in abortion care. The authors conclude that many service providers around the globe lack person-centered care (Altshuler & Whaley, 2018). It is important to identify how these concepts contribute to a definition of high-quality abortion care and which aspects are most prioritized by people who access services. Quality—and especially interpersonal aspects of quality—apply not only to provision of care in clinic settings, but also to provision of medication abortion in care models like helplines and pharmacies.

In this qualitative study, we partnered with staff and counselors at three helplines in Poland, Brazil, and Nigeria that provide their services to women living in legally restrictive settings, in order to gain a deeper understanding from women who sought support for medication abortion. We explored women's expectations and experiences with the service they received, the role of stigma and their perceptions of quality care, and how their knowledge and attitudes toward medication abortion shifted in the process.

Methods

Between April and August 2017, we conducted 30 interviews with women who had a medication abortion with support from a participating helpline in Poland, Brazil, or Nigeria. Women had to be 18 years or older and speak

English, Polish, or Portuguese to participate in the study. We identified one or two interviewers at each site; each interviewer participated in a training on qualitative research methods, including use of the interview guide and probing, as well as ethical principles. Each interviewer was affiliated with the helpline where they conducted interviews but did not act as the main counselor for any of the participants that they interviewed.

We developed an interview guide in partnership with study staff from all three helplines. The topics included perception of abortion and knowledge of medication abortion prior to contacting the helpline, experience seeking general medical care in their community, abortion attempts prior to contacting the helpline, acceptability of the helpline service, perception of quality of care, and shifts in their beliefs on abortion following their experience.

In Nigeria, we partnered with the Ms. Rosy hotline, which is part of Generation Initiative for Women and Youth Network (GIWYN), a nonprofit organization that advocates for women's human rights. Ms. Rosy hotline is a toll-free line providing information about reproductive health, including evidence-based protocols about the use of mifepristone and misoprostol, or misoprostol alone, for abortion. The helpline is run by trained community health workers and counselors. In Poland, we partnered with Kobiety w Sieci, a nonprofit organization that operates a telephone hotline as well as a moderated internet forum for people seeking information about safe abortion methods, including safe self-managed medication abortion and emotional support throughout the process. The hotline and the online forum are run by a group of trained lay health workers. In Brazil, we interviewed women who were supported by Women Help Women's (WHW) online service. WHW is an international feminist nonprofit organization that provides access to and information about medication abortion through a telehealth service and engages in global advocacy for self-managed abortion. A team of expert counselors answers questions and accompanies women through email before, during, and after the procedure in six languages.

At each helpline, women were recruited by study staff throughtelephone or email. Women who were eligible and interested provided contact information, were given an identification number, and scheduled a telephone interview at a convenient time. The interviewer completed an informed consent immediately prior to the interview; all interviews in Nigeria were conducted in English, in Poland were conducted in Polish, and in Brazil were conducted in Portuguese. Interviews were audio recorded and lasted between 20 and 60 minutes. Participants received the local equivalent of approximately 12 Euros (approximately 40 BRL, 50 PLN, 3860 NGN at the time of data collection) in exchange for their participation. This study was approved by Allendale Investigational Review Board (Old Lyme, CT, USA).

We transcribed interviews in the language in which they were conducted and then translated the interviews to English, if applicable. The research team developed an initial codebook and two researchers applied the codes independently to two transcripts. After the team met to discuss discrepancies and gaps, we collapsed and clarified code definitions and again two researchers applied the new codebook to two additional transcripts. The research team came to consensus on inconsistencies, revised the codes, and then applied the final list of codes to all transcripts with two researchers each coding half of the dataset. We conducted a content analysis of emerging patterns and themes among the entire sample, as well as differences based on country of recruitment. We present findings with illustrative quotes, which are identified by country and age of the participant.

Results

Participant characteristics

The mean age among the 30 participants was 31 years with a range from 18 to 44 years. The majority of participants were married ($n = 13$), were paid for work at the time of the interview ($n = 17$), and had one or more children ($n = 16$). Participants were early in pregnancy with the majority under twelve weeks' gestation ($n = 26$), two were over 12 weeks' gestation, and two are missing gestational age (Table 1).

Table 1. Participant characteristics.

	Total ($n = 30$)	Brazil ($n = 10$)	Nigeria ($n = 10$)	Poland ($n = 10$)
Age (years)				
Mean	30.9	31.9	31.4	29.3
18-25	9	3	2	4
26-35	10	2	4	4
36+	9	5	3	1
Missing	2	0	1	1
Relationship status				
Single	8	3	3	2
Married	13	2	6	5
Partnered	9	5	1	3
Paid for work	17	6	7	5
Student	4	2	2	0
Number of children				
0	13	5	4	4
1-2	11	4	1	6
3+	5	0	5	0
Missing	1	1	0	0
Gestational age (weeks)				
≤7	17	6	7	4
8-12	9	4	1	4
13+	2	0	1	1
Missing	2	0	1	1

Obtaining information about medication abortion

Prior to seeking abortion care, some women knew that abortion pills existed, but most had very little or no knowledge about medication abortion safety or how to obtain pills. Some participants had heard about surgical procedures, but found out about medication abortion directly from the helpline counselor or by searching online after they were pregnant. For example, this Polish woman explained,

> I did not know anything at all. When I was thinking about getting an abortion, I was thinking about curettage, about surgical abortion. I didn't have any idea about a pill. Only when I searched the internet I started to read and I learned that there is such an option. (*Poland, 25 years old)*

Women obtained information about the method and where to access pills from various sources, including: internet searches, family and friends, or acquaintances who worked in the medical field. One participant from Brazil said:

> I needed [an abortion], then I went and researched it, how I could get it and … there I found out that there are a lot of people who sell it through the Internet, a lot of people that even promise to deliver it directly to you, right? Through a 'motoboy', or asking for a deposit and shipping it … a lot, a lot of people. I found a lot of people who deliver the pills. (*Brazil, 40 years old*)

A woman in Nigeria described strategies for what to say when purchasing the pills, which she learned at a seminar hosted by a non-governmental organization near her home.

> They said that it's a miracle drug, without you going to the clinic, you can terminate a pregnancy by yourself. Do you get me? Though it may be that you want to buy it for grand mum who needs it for further cure because I learned it could also be used for some other things, cures like arthritis or something. (*Nigeria, 42 years old*)

Perceptions of safety and effectiveness

The participants were asked to consider what fears or expectations they had of medication abortion and a number of women mentioned having safety concerns once they learned about the method. In some cases, these fears included infertility and death; consequences that were often derived from misinformation or hearsay reiterated by friends, or an overwhelming negative narrative surrounding abortion in their community. A Brazilian participant reported "I had heard that people who took it had a very hard time and that … you could hemorrhage and even die" (*Brazil, 39 years old*). A woman in Poland echoed the same and cited the role of stigma:

> I heard it is very dangerous. Ends with bleeding, sometimes death. Later, often you cannot get pregnant. This is a very invasive undertaking. These are the common

> opinions that were often heard in the media during the black protest[1]. This is a taboo topic so no one talks about it. The woman is condemned. Usually, in the context of abortion, it is extremely negative. (*Poland, 28 years old*)

Yet not all stories shared by others were negative. A Nigerian woman heard from a friend that medication abortion would be a "stress free" and reliable experience:

> I heard it from [a friend] and they were of the view that the pills make it kind of stress free. It was a stress-free method of removing an unwanted fetus. (*Nigeria, 22 years old*)

There were others who specifically noted concerns about the quality of medications they might get online or from drug sellers. For example, a 25-year-old Polish woman was afraid to order medications from an "unknown source," but said that confirmation from other women who had experience with the drug would help her feel more confident.

In some cases, participants discussed concerns about other methods for abortion including surgical procedures or herbs. In these cases, concerns about safety included fear of potential legal consequences. Two Brazilian women were worried about this and the financial burden if they went to an unknown provider. One had heard of a clandestine provider who encountered legal trouble in the past, leaving her uneasy to seek services from him for fear of police involvement. The other woman had a general distrust of seeking an abortion from a provider in a clinic.

> Oh, the clinic is extremely expensive and you're never going to be sure that [the] doctor is really one, right? That he really is prepared and everything … the clinic would only really be the last resort. (*Brazil, 24 years old*)

Regardless of the methods that women heard about, many described feeling uncertain about the safety and effectiveness of the methods and those providing them.

Seeking or avoiding care in formal healthcare systems

Among our sample, ten women inquired or sought abortion services from a formal sector provider at some point during their pregnancy, while others considered it but decided against it. A few women in each country described inquiring about or seeking care at their primary provider or a public facility and facing rejection, judgment, or denial of services. Sometimes these reactions were from trusted clinicians who they had known for years leading up to the encounter. Unsupportive providers in Brazil responded with words such as "Please do not talk to me about it because I am against it. I'm completely against it!" (*Brazil, 40 years old*) or "Don't even think about abortion!" (*Brazil, 22 years old*). Similarly, a Polish

woman said that when she brought up the subject, the provider became defensive. “She told me that it was forbidden, illegal. I have no right to demand such things from her. I cannot give her exact words.” (*Poland, 27 years old*).

In other cases, women did receive pregnancy-related services and were stigmatized or humiliated by the provider. For example, this woman described how she was spoken to at her ultrasound.

> ‘Your mates are coming here to do scanning to keep children and you are coming here to do scanning for abortion.’ Though I was insulted, [it] is my right to keep it if I want to keep it. I felt bad for what she said. (*Nigeria, 35 years old*)

A few women encountered understanding and supportive medical providers, but among participants in our study, even supportive medical providers only offered referrals, not abortion services. In Brazil, one participant’s doctor told her about Women Help Women and provided her with a referral for an ultrasound (*Brazil, 35 years old*). A Polish woman said that as soon as she confirmed the pregnancy, she received supportive, trustworthy advice as well as aftercare. Interestingly, she reported that her provider explained the reason for not providing a prescription for the pills was because of her own fears.

> I asked [my doctor] if she would help me get rid of it. She said that she cannot give a prescription because she is afraid, but she had heard about Women Help Women and Women on Web and I could order a kit on such sites. She said that it is safe and that she is available by phone if something happens, and that’s how it was. (*Poland, 25 years old*)

Many women chose not to talk to their formal sector providers about their abortion at all due to fear of rejection, judgment, or that they would “see you as a killer” (*Nigeria, 35 years old*). One woman explained how she assessed the risk of communicating with a doctor.

> I was afraid that the doctor would quarrel that this cannot be done. I felt restricted. I did not want to talk to anyone from outside about it. I figured that I’m not sure whether this doctor will help me, and maybe would raise a stink so I let go of this idea. (*Poland, 24 years old*)

Another woman in Brazil chose not to speak to any medical providers because she had heard they might try and dissuade her from getting the procedure by inciting fear that the medications could kill her or cause her to lose her uterus. These concerns emerged most often in the interviews with women in Brazil who spoke about concerns of judgment, bad treatment, or the possibility of being criminalized or legally prosecuted.

Women in all three countries spoke about trying other abortion methods before accessing care with the helpline. Some described attempting to

terminate with tea, herbs, or drinking copious amounts of alcohol. A woman in Brazil explained,

> I took some teas of… there are several teas that they say, that makes the period faster. I started taking it before when my period did not come and I did not know about the pregnancy, and then I continued taking it. (*Brazil, 24 years old*).

In Nigeria, a woman talked about taking traditional medicine and "strong alcohol," which ultimately caused vomiting for several days but did not cause an abortion. Other women described the process of attempting to obtain abortion pills from pharmacies or drug sellers or other methods, but ultimately did not use them. Participants described various reasons as to why they did not self-manage on their own: ultimately deciding that "such experiments on my body did not seem right to me," that the hotline would be safer than "going to the quacks," or even that they were concerned they might pay informal sellers for pills who would take their money but not deliver.

Finding and receiving support from the helplines

Most women in Brazil and Poland found out about the helplines from searching online using terms such as "pharmacological abortion" (*Poland, 33 years old)* and "how to do an abortion" (*Brazil*, *22 years old*) and clicking on websites or news articles. A number of women, particularly in Nigeria, learned about the helpline prior to becoming pregnant from information or materials that were disseminated. One woman received the phone number from a friend, who said that "I could call the helpline when I have any issue concerning my body," while another had obtained a flyer:

> Yes, [the flyer] was very handy because I was not even very sure of where I kept it. I didn't think about it after I collected it [that] day they gave it me, but I remembered it when I was kind of at the cross road, thinking of how to go about it, where to go, I stumbled on that flyer, and then felt I can call this and see if they can be of any assistance to me. (*Nigeria, 33 years old*)

Women determined that the helpline and their staff were trustworthy primarily by hearing or reading about other women's experiences. For example, a participant in Brazil contacted another woman *via* WhatsApp and "asked if it was safe, if she had gotten help, and she said yes, she had settled it and thought she considered it safe" (*Brazil, 44 years old*). Another woman in Poland initially did not trust that she would get the pills from the helpline, but felt more confident after reading on the forum about the experiences of other women who had used the services.

Although the helpline models in each country are slightly different, and the counselors use or combine different media for communication, all participants reported feeling well informed about the abortion

process. Universally, women felt they received clear information in a timely manner — either *via* email, on the online platform, or over the phone. Women described the information they received as “clear,” “detailed,” “above and beyond” what they expected, “all the information I needed to make my decisions,” and “invaluable” to their abortion experience overall. One Brazilian woman spoke about the ongoing communication she received from the helpline counselor that made her feel confident.

> They sent several emails asking how the abortion was, if I had had pain, how I was feeling … they were very attentive, they sent me a lot of emails and I always replied. It was very good, they are very competent. I wasn’t afraid that anything might go wrong precisely because they were always following up. (*Brazil, 22 years old*)

Generally women felt that counselors were “very available” to answer any of their questions when they needed them. In one case, a Brazilian woman said that she had to wait longer than she would have liked for an email response. However, she said that overall she received the information she needed on time. These experiences were in stark contrast to general healthcare experiences with medical providers in the formal sector; particularly in Brazil and Poland, where many women felt that they had not previously received all the details of their care or complete answers to their questions. A few Polish women spoke harshly about their formal system medical providers being uninterested and unwilling to explain their services or take the time to talk to them.

In addition to detailed information and timely responses to their questions, women also reported being treated with kindness, compassion, respect, and without judgment. Some women in all three countries said they felt personally connected to their counselors, like speaking to an older sister, or a friend. A few mentioned that counselors created a sense of closeness by using endearing terms like “dear” to refer to women who called in; one participant in Brazil noted that she had not anticipated feeling her counselor’s concern over email communication. A Polish woman was surprised that she could receive “so much understanding and support and willingness to help” from someone she did not know (*Poland, 27 years old*). She said the level of this care was something that even family members are not always able to provide.

Women spoke in diverse ways about the benefits of the virtual platforms through which they received care. Several women reported that telephone or online communication with counselors increased their sense of confidentiality and made it easier to communicate freely about a taboo topic, as exemplified by this woman in Poland.

> It’s easier, it’s not face to face. And with doctors you can’t always tell them. You want to say something, but can’t think of the right words. Whether on the forums or

> on the phone, it is easier to express your thoughts, your feelings, or your doubts. (*Poland, 25 years old*)

When speaking about the online forum in Poland, participants described a sense of community and connection and the comfort that came from knowing they were not alone or unique in their circumstance. For one woman, "reading stories of people that went through it and experienced this before calmed me down a lot. I had faith that it can happen and I can get out of this unwanted pregnancy" (*Poland, unknown age*). Similar to how Polish women described their relationships with their counselors, they also described support, friendship, and confidence among other women on the forum. One participant explained that the forum provided her more support than the formal healthcare system, and though her interaction with the helpline was all digital, she still felt "held by the hand and stroked in the head" (*Poland, 33 years old*). Some women frequented the forum after their abortion, and one woman appreciated that she could start providing support to newer members.

Changes in knowledge and attitude after abortion

In each interview, women were asked whether they believed that their knowledge, beliefs, or attitudes toward abortion had shifted after their experience. Many women spoke about how their knowledge and understanding of medication abortion changed. They learned for the first time about mifepristone and misoprostol, the regimens, and options for abortion in the second trimester. This woman in Brazil highlighted:

> That it is the safest procedure, in fact it is the WHO protocol. That. Ah yes! And that the combination of these two drugs makes the procedure 99% effective. Until then I only knew of the … of … misoprostol. I was not aware of mifepristone. (*Brazil, 44 years old*)

Some women described how this new information helped to dispel myths or shift their understanding of the safety risks of medication abortion. A woman in Poland stated:

> I had heard a lot around that the medicines are awful for your organism, that they cause harm, while actually, as it turned out, they provoke no harm; they help. There was a big change in regards to my concerns before taking the medicines, they are not that bad, and they actually help. (*Poland, 24 years old*)

In addition to safety and effectiveness, some women highlighted why they preferred medication abortion, such as this woman in Nigeria who explained her surprise that she could have an abortion at home.

> I never knew one could stay in the comfort of your house. I think I really never knew about all that before, all my mind was that abortion must be done in the

hospital or you start to use all those local concoctions that you don't even know what the future holds. (*Nigeria, 29 years old*)

A few participants considered how their knowledge might be useful in the future for themselves or their loved ones.

Interestingly, women who reported changes in their knowledge often spoke about feeling surprised by the option to use medication abortion safely and recognizing shifts in their expectations of abortion as a traumatic or difficult process. "It's a simple procedure, it's not a seven-headed beast; it's possible for anyone who wants to do it."(*Brazil, 39 years old*). A woman in Poland echoed:

> It was quite easy to solve this problem. I would never have expected that the solution is at our fingertips. And it can be so simple. It seemed to me that it would require me a lot of gymnastics, including traveling to another country, to get a huge sum of money that I did not have at that moment. And it turned out to be a lot simpler than I thought. (*Poland, 27 years old*)

Women described a range of attitudes toward abortion prior to their recent pregnancy, although most reported support for abortion access. One woman in Nigeria did have a change in her beliefs and no longer considered abortion a sin as she had before. Others felt that their experience had made their convictions stronger. A few women reflected on abortion as a right for all women. For example, this woman in Brazil explained,

> Learning that it is a human right made me feel really empowered in my decision. It relieved my feelings of guilt… and it took away the air of shadiness and criminality that it can invoke. (*Brazil, 39 years old*).

Another woman in Nigeria spoke about how her views on bodily autonomy and women's empowerment shifted after her interaction with the helpline counselors. She feels more strongly about shifting social norms in her community.

> I actually learned that every woman have her right, her body right. Whether you want, you want the child to live or not, it all depends on the woman and no other person has the right to decide for her….people actually think that women they are, are second class people. From this interaction with [the helpline], I've been able to believe and have that it's time for women to wake up and start believing in themselves. (*Nigeria, 22 years old*)

A woman in Poland agreed that men should not be the ones to decide about abortion access. She expressed frustration at the required secrecy around abortion in the restrictive setting.

> What annoys me is that we are doing it in hiding that we have to get these [pills] 'illegally.' I started to look at what is going on here in Poland, these old men decide what I can do and what I can't do. I'm even more convinced that if someone needs help, then they should be made aware and informed that something like this exists. (*Poland, 42 years old*)

Women, particularly in Poland, who obtained support through an online forum, described shifts in their understanding that there were "other women like me" and that abortion was more common than they realized. For example, multiple women shared this participant's experience when she described, "[my feelings about abortion] have not changed. Same feelings and thoughts as I had before, I have now. I realized there are a lot of people, women, who think like me." (*Poland, 35 years old*)

Discussion

Through this study, we gain insight into the experiences of women who obtain support from medication abortion helplines in restrictive legal settings. Women across the three country contexts — Nigeria, Brazil, and Poland — spoke about their experiences with person-centered, quality care provided by the helplines. Participants described compassionate, kind counselors who took the time to explain the abortion process and answer their questions. They reported establishing meaningful connections with helpline staff, and among participants in Poland, also connecting with a network of other people seeking abortion through the online forum. These interpersonal aspects of care can be defined as dignity, trust, support, and effective communication, which align with existing frameworks and measurements in other fields of reproductive health, like the Person-Centered Care Framework for Reproductive Health Equity (Sudhinaraset et al., 2017) and the Interpersonal Quality in Family Planning scale developed for family planning and adopted for abortion provision in clinics (Dehlendorf et al., 2018; Donnelly et al., 2019). While frameworks and measurement of person-centered quality of care are still lacking for abortion provision (Darney et al., 2018; Dennis et al., 2017), and most especially for out-of-clinic provision such as the helplines models, findings from this study demonstrate that helplines not only fulfill current conceptualization of person-centered quality of care, but they also provide new components of care, like community building.

The experiences described by women who received support from helpline staff were in sharp contrast to the poor-quality treatment they described in the formal healthcare system, either with their current pregnancy or prior interactions. In some cases, participants described ways in which hospital or clinic providers perpetuated abortion stigma, for example, trying to convince women to keep a pregnancy, or refusing to provide information, resources, or referrals. In other cases, women explained that they intentionally avoided seeking care within formal health systems due to fears of judgment or concerns about denial of services—a finding that highlights high levels of perceived stigma, and is consistent with a recent systematic review

that found that one of the main reasons women chose informal sector abortion providers was fear of unwilling or stigmatizing providers (Chemlal & Russo, 2019). The articles included in the systematic review describe contexts where abortion was legal; yet it is reasonable to assume that the levels of stigma increase and unwillingness of providers is more prevalent in legally-restrictive settings, such as those in the present study. The inability of formal sector service providers to meet the needs of people who seek abortion in this study demonstrates a failure of public health systems to guarantee reproductive rights for all people. Public health experts often focus on improvements to the formal healthcare system to increase access to abortion services, however we posit that staff at grassroots organizations rooted in feminist principles, such as the helplines, are providing critical, and sometimes lifesaving, services that formal healthcare systems in restrictive legal environments have not. Further, the findings suggest the staff at the helplines in Nigeria, Brazil, and Poland are providing compassionate, comprehensive, and high quality person-centered abortion care.

Our analysis of the interviews also adds to the growing body of literature documenting the manifestations of stigma in people's experiences with abortion care-seeking. Participants in the study often learned about abortion through stories, myths, or rumors from others in their social networks. In all three countries, women described an overwhelmingly negative narrative around abortion within their communities, which could be a reflection of prevalent poor-quality care, unsafe abortion, and/or the silencing of positive abortion narratives. As a result, women tended to approach abortion with fears about their own safety and future fertility, misinformation about the availability and dangers of medication abortion, and low expectations of how they would be treated. This misinformation about safety and low expectations of quality of care are consistent with other studies in both legally restrictive and nonrestrictive contexts where there is silence around people's abortion experiences and women are exposed to negative narratives and descriptions of abortion through their social networks, providers, and communities at large (Coast et al., 2018; DePineres et al., 2017; Hajri et al., 2015; Hossain et al., 2016; Marlow et al., 2014; Puri et al., 2015). Yet, while negative social norms and stigma around abortion can be perpetuated in people's social networks, trusted community members can also help people connect with others who have experienced abortion, which may reduce isolation and even provide a sense of agency (Jelinska & Yanow, 2018). Researchers and organizations that implement interventions to combat abortion stigma through the use of social networks have thus far focused on abortion providers and people with abortion histories (Belfrage et al., 2019; Debbink et al., 2016; Littman et al., 2009). However, we suggest that social support networks have value for those both seeking and experiencing

abortions. Further research to document models of care that provide social support networks, such as the qualitative study by Zurbriggen *et al.*, with a helpline in Argentina (Zurbriggen et al., 2018) is needed.

The experiences of the helpline callers in this study challenge common presumptions about the formal health system being the desired, paradigmatic locus of all abortion care. It has profound implications for advocacy and policy making around abortion access, and medication abortion in particular. While advocates across the globe must continue to demand quality and affordable abortion care as part of the formal healthcare system's sexual and reproductive services, we know that these systems are falling short based on reports of stigma, poor quality of care, and discrimination (DePineres et al., 2017; Hajri et al., 2015; Harries et al., 2015; Hossain et al., 2016; Puri et al., 2015).It is these experiences, and the advent of abortion pills, that led to community organizing to support people needing abortion though helplines. The professionals working in alternative, demedicalized, safe models of care provide services which, despite being acceptable to their users, are still underused globally or even contested. Helpline staff in restrictive settings, often in sharp contrast to the formal systems of care, provide person-centered and reliable care, based on the evidence and in accordance to the newest WHO protocols (Medical Management of Abortion, 2018). They can be seen as harm-reduction interventions, strongly grounded in human rights standards and feminist ethos (Erdman et al., 2018). Relevant research questions should identify how to integrate lessons learned and best practices from these novel approaches to revitalize and improve formal healthcare systems.

The main limitation to this study is that the sample was self-selected, and it is possible that people with negative experiences and perceptions chose not to participate in this study. Although interviewers were trained and were not the main service providers to anyone they interviewed, it is still possible that participants may have felt the need to withhold some of the negative feedback from their experiences. However, the main strength of our study is that it begins to fill a gap in the scientific literature about what we understand about people's experiences accessing safe abortion care outside of formal healthcare systems with helplines in restrictive contexts. Helpline counselors are offering high-quality abortion care. Even in restrictive settings, their goals are not just to fill service-delivery gaps left by the formal system, but to provide holistic person-centered care. This model prioritizes not only safety, in terms of effectiveness, but safety understood also as person-centered interpersonal measures such as support, kindness, solidarity, autonomy, criminalization prevention, and empowerment. More evidence on the quality of services and models of care from helplines is needed, as lessons from these service-delivery models could

help improve service within the formal healthcare systems and expand access to good quality, safe abortion by redefining what it means to provide care.

Note

1. The Black Protest was a series of mass street demonstrations in Poland in 2016, to oppose proposal for further legislative restrictions of abortion. https://en.wikipedia.org/wiki/Abortion_in_Poland#Black_Protest

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