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THEMATIC ARTICLE

Intersection between access difficulties and obstetric violence in abortion itineraries

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Abstract *In Brazil, several limitations are imposed upon the access of women undergoing abortion to the healthcare network, primarily caused by the influence of moral and religious values and gender iniquities. In this light, the present study aimed to analyze the experience of women who had an abortion regarding the care provided by healthcare services as part of the abortion itinerary. This is a qualitative study, carried out with 18 women in three cities – one small city, one mid-sized, and one big – in the state of Bahia. Data were produced by face-to-face or online interviews. The empirical material was analyzed using the discourse analysis technique. The results show, in the three municipalities, abortion itineraries under social and gender iniquities, with greater access difficulties for low-income women. Better financial conditions allow access to clandestine private clinics but without guaranteeing humanized care. In the three municipalities, economically disadvantaged women self-induced abortions and delayed seeking services, having faced embarrassing and prejudicial professional attitudes. The results point to the urgency of implementing public policies in which reproductive rights are as effective as human rights.*

Key words *Abortion, Itineraries, Obstetric violence, Reproductive rights*

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Introduction

Worldwide, a large proportion of pregnancies are unwanted and a significant portion of this total ends up in induced abortion[1]. In the developed world, these rates have fallen proportionally with increases in the use of contraceptive methods, unlike the developing world, which has presented high abortion rates. Moreover, since the 1990s, changes in these numbers have been relatively insignficant[1].

Access to information and a variety of effective contraceptive methods is a less costly strategy when compared to the possible consequences of an unwanted pregnancy. In situations of abortion, adequate care can ensure a better emotional, social, and clinical outcome for the woman[2].

Unsafe abortions cause 8% to 11% of all global maternal deaths and are highly prevalent in low and middle-income countries. In these places, access policies are more restrictive, and unfavorable socioeconomic factors influence who can be reached[1].

Abortion is considered a crime in Brazil, and is only legally allowed under Article 128 of the Brazilian Penal Code, in cases of risk to the mother's life, pregnancy resulting from rape, or fetal anencephaly[3]. Although Brazilian legislation allows for a safe abortion under these conditions, women continue to face difficulties in accessing services that provide a legal abortion. Among the most significant obstacles are unequal access, the lack of qualified professionals, and the stigmatization of women who choose abortion[4]. This favors the search for unsafe abortions, defined by the World Health Organization (WHO) as a means of terminating pregnancy by individuals with no basic skills or in inappropriate places to carry out the procedure[5].

The limitations on access to services imposed upon women with an abortion in progress, or shortly after an abortion, are diverse. There is a coexistence of social and religious factors and gender inequities, which influence and shape the practices of professionals and, in health services, culminate in abusive or disrespectful attitudes, based on power relations between medical professionals and users, which constitutes institutional violence.

Although the scenario of women's care has made progress in preventing obstetric violence in recent years, a quarter of all women experience some form of violence during childbirth and around half of all women who reported miscarriages also experienced it, especially in the case of induced abortion[6].

Health professionals are often not sufficiently prepared to deal with delicate issues, such as those related to abortion, sexual and domestic violence, and gender relations. The fact that abortion is associated with a criminal event makes many professionals judge women who have abortions, acting in a disrespectful and unethical manner[7].

Access to health services in cases of abortion can be considered a course of multiple paths, which take into account barriers to accessing the service, delays in receiving care, among other resistances. However, women always seem to find a way to terminate a pregnancy, be it leaving their locality to seek access, by promoting self-induction, or with the help of third parties, even using medical abortion. Their abortive itineraries are conducted with great difficulty, in decision-making as well as in accessing safe means and people with whom they can share conflicts and solutions[8].

Abortion itineraries are understood as the path of women, from the identification of menstrual delay, to the discovery of pregnancy, to the decision to abort, to the abortion itself and post-abortion care, which depends on the specific context of each woman[8]. Abortive itineraries can also be understood as an interactive set of actions and decisions that consolidate the outcome of the abortion, considering all the barriers and limitations to finding a means through which to conduct the procedure[9].

Little is known about the itineraries of women seeking abortion in Brazil, especially in the countryside of the Northeast, nor about gender, class, and generation issues related to the topic. Hence, there is a serious lack of studies in this realm. The gap in the literature in Brazil, regarding studies on abortion itineraries, especially in the Northeast region of the country, implies the novelty and originality of studies on this theme.

In this research, abortion itineraries of women from three small, medium, and large municipalities in Bahia-Brazil were studied, illustrating the intersection between access difficulties and obstetric violence in the health care of women undergoing abortion, a theme that is the core issue of this article. Thus, the present study aims to analyze the experience of women who have undergone abortion, regarding care provided by health services, as part of the abortion itinerary.

Method

This is a qualitative research study using gender as an analytical category. Gender is a construct that organizes social life in a concrete and symbolic manner, and establishes power relations, hierarchies, and inequalities based on definitions of men and women[10]. Gender relations are configured and reconfigured under social constructions, influenced by the culture traits of each society. Thus, bodies, psyche, sexuality, and human reproduction need to be understood as sociocultural constructions[11].

The empirical research was carried out in three small, medium, and large cities, located in the state of Bahia-Brazil. The choice of participants allowed for contact with different realities of women who opted for an abortion in scenarios of unplanned pregnancies.

According to the Brazilian Institute of Geography and Statistics (IBGE), the classification of municipalities follows the following parameters: small size – cities with a population of up to 100,000 inhabitants. These generally rely on local commerce and the rural economy; medium size – cities with a population between 100,000 and 500,000 inhabitants, act as regional centers, offering support to neighboring municipalities as a reference for specialized care services; large – cities with more than 500,000 inhabitants, considered large and having greater structural resources[12].

The study participants were women of reproductive age, who had already experienced induced abortion, regardless of the number of procedures, in a period less than or equal to 10 years. The following inclusion criteria were adopted: being over 18 years of age and having a place of birth and permanent residence in the chosen city. The exclusion criterion was: having reported a spontaneous abortion and/or legal abortion.

To identify potential participants, the snowball or non-probabilistic network sampling technique was used, which consists of the first informant indicating other informants to participate in the research, respecting eligibility criteria[13].

The first contact with the women occurred through the identification of potential informants, in the researcher's social spaces, which included meetings of feminist non-governmental organizations (NGOs) and conversation circles on abortion, in which some women spoke openly about their experience. From these initial informants, other women who belonged to their social network and who met the criteria for participating in the research were contacted.

Given that they belong to the same social network, social insertion converged, with a predominance of young university students in the three municipalities, who connected with at least one other young woman because abortion was part of their life story. This connection was a starting point, and ensured the continued application of the snowball technique in the process of identifying participants.

Data production was carried out from June to December 2017, through the application of the interview technique, using a semi-structured script and applied in person, through calls or audio conversations via WhatsApp and one by letter electronics. The different strategies adopted to carry out the interview met the interviewees' suggestions concerning such issues as time and fear of someone overhearing.

The identification of each woman's speech is recorded with the letter E (Interviewee) and an identifying number, which refers to the order in which the interview was carried out, followed by the letter M (Municipality) and the numbers 1 - small, 2 - mid-sized, and 3 - large, presented as follows: E1M1 to E4M1; E1M2 to E4M2; and E1M3 to E12M3.

The face-to-face or telephone interviews were recorded, with prior authorization from the participants, transcribed in full and then analyzed using the Discourse Analysis technique[14]. This technique allows for explanations to be obtained about what is written in a given text, clarifying the norms that constitute the meanings, as well as the order of needs that were answered by the text; therefore, there is not just one analysis, but rather discourse analyses[14].

Therefore, based on the Discourse Analysis[14] technique, the following steps were carried out to analyze the empirical material: reading the text in search of concrete (figures) and abstract (themes) elements, parts of the meaning construct; grouping data according to its elements, both concrete and abstract; and understanding of core themes through the creation of categories and subcategories. Finally, an analysis and discussion of the empirical categories was carried out in conjunction with the literature and the theoretical framework of gender.

The ethical aspects that govern research involving human beings were considered throughout the study. The participants received, in person or electronically, the Free and Informed Consent Form (FICF) and, likewise, returned their acknowledgment and agreement. The research project was approved by the Research

Ethics Committee of the School of Nursing at the Federal University of Bahia.

Results

This study counted on the participation of 18 women, four in a small municipality (M1), four in a mid-sized municipality (M2), and ten in a large municipality (M3). The ages of the study participants ranged from 25 to 39 years. Regarding race, in the small municipality, the majority declared themselves black, while in the mid-sized and large municipalities the majority declared themselves white. Regarding the number of pregnancies, in small and large municipalities, this factor ranged from one to four pregnancies, and in mid-sized municipalities, only one pregnancy. Educational level varied in both municipalities, with the majority in small and mid-sized cities having complete and incomplete levels of higher education, whereas in the large municipality, among the women interviewed, the majority reported an incomplete secondary and higher education. In relation to religion, there was a predominance of participants from the Catholic religion in mid-sized and large municipalities, as compared to participants without religion in the small municipality. Personal income ranged from ½ to 4 minimum wages, and family income ranged from ½ to 10 minimum wages.

The reality in the search for care by women with a history of abortion and who participated in this study is presented below, in three empirical categories, which show the intersection between access difficulties and obstetric violence as part of abortion itineraries.

Overlapping personal values with professional ethics in the care of women undergoing abortion

For some women who participated in this study, it was necessary to undergo the abortion in a hospital unit, with reports of disrespect and embarrassment attributed to the fact that they were undergoing an abortion:

After I had the abortion, I had to have three curettages [...] in relation to medical care itself, they treat us with a lot of disrespect, as if it were the worst thing in the world to cause an abortion, [...] we're embarrassed to go to the doctor and say: oh, I took medicine to lose [...] We suffer rejection from the doctors who treat us, even more so when they ask if the abortion was induced (E1M3).

I immediately went to a hospital where, until then, I was treated normally, waiting for my turn and so on, but as soon as they said it was an abortion, I was treated disrespectfully [...] It started with the delay in admitting me for the curettage, and then, after I was admitted, I still felt pain for a few hours [...] I remember it as if it were yesterday, I screamed, screamed, until a lady who worked there said: 'listen here, girl, stay quiet, otherwise they'll ignore you even more', that's when I realized that, in this case, they treat us disrespectfully (E4M3).

One of the participants, E4M2, suffered another type of institutional violence with the threat of being reported by the medical professional. In the records, this woman had already reported that she having been attacked by her partner. In her report, after being attacked, she states:

The health service I went to was the emergency room at the nightclub [...] then I went to another emergency room, all the while having to hear insults from the doctor who threatened to report me [...] They didn't know what I did, I was afraid of being arrested right there, it was a huge mess (E4M2).

In these situations, personal values incorporated from the social imaginary are institutionalized through professional action in caring for women undergoing abortion, disrespecting rights, criminalizing them, and denying professional ethics.

Mediations for access to health services under rules of clandestinity

Mediations for access to health services, under rules of clandestinity, are essential to ensure that women undergoing abortion have access to adequate and safe care, even in a context where the practice is criminalized. These mediations can involve support networks, such as reproductive rights advocacy groups, telephone advice lines, counseling services, and referrals to safe and capable clinics.

According to the research results, women who were aware, in advance, of the resistance she would face at the health services regarding abortion, turned to friends or people they knew in the health service who made themselves available to act as a bridge between the hospital and the user, as can be seen in the reports below:

My friend was the one who arranged everything, it was a public hospital in another location, another town in this case, she made it happen, made an appointment, and I went with her [...]

when we got there, they gave me the medicine and I didn't need to do any curettage or anything, it was all quite calm (E3M2).

It wasn't that easy, but I received the treatment right away [...] a friend of mine had friends at the hospital and that helped me to resolve the issue at the public hospital [...] I was treated, my cousin went with me and before I knew it, the curettage had already happened (E2M2).

I had curettage done at the health service here, I know the people there and when it started to come out, I immediately went to the hospital to get medical care (E3M1).

Next, we see that the clandestine conditions of abortion and the fear of judgments are part of a reality in which the resistance of professionals generates a sequence of referrals based on the medical condition, which was suggestive of an ongoing abortion. This constitutes an obstacle to one's rightful access to health care and culminates in a pilgrimage:

We went to a hospital, I had a private plan, and there they didn't treat me, they said that without a test to prove that I wasn't pregnant, they wouldn't treat me [...]. The next day, I went to another hospital , but [...] I needed a test to confirm that I was not pregnant, [...] they recommended another hospital, I filled out the form, I didn't say directly that I was having an abortion, [...] and then the shame, the fear of not knowing what was going to happen to me [...] I went for an imaging test [...] I came back, he looked at it and then he administered the medication and the bleeding stopped (E5M3).

Situations in which acceptance and respect for a woman's dignity are denied increase insecurity, discomfort, and fear in relation to what could happen, the risks to her own life, which constitutes obstetric violence.

Access to private clinics with no guarantee of embracement for women

Access to private clinics was made possible through favorable socioeconomic conditions, which allowed for faster abortions. In this environment, the participants were able to resolve the issue, but clandestine conditions distance relationships and harms embracement, as shown below:

It's very complicated to access the clinics, it's very confidential [...] nothing is talked about much, or even verbalized, everything is very hidden, camouflaged, you don't verbalize what you want [...] I went through a screening, where I was asked about socioeconomic issues and the certainty of carrying out the procedure [...] you don't have easy access to the doctor, only after you go through this screening [...] an ultrasound was performed to confirm your gestational age [...] you stay in the room alone, resting, taking medications, kind of like anesthetics, and you can't have anyone else present (E9M3).

It all happened very quickly, I found out on Wednesday, Friday afternoon I managed to call a clinic and made an appointment for Monday and on Tuesday I already had the procedure [...] I wanted to resolve everything very quickly [...] The doctor [...] prescribed some medicines for me and emphasized that [...] in case of emergency, I should talk to him first, he gave me his contacts and those of his employees [...] two women work with him, one of them stayed with me in the room, during and after (E10M3).

He requested an ultrasound, when he arrived at the ultrasound, the doctor said: 'can you hear the heart?', they injected me with the stuff [...] I woke up in a room and I think that on the same day, they put in a tampon and I was sent home, goodbye, and kisses [...] practical [...] I saw people [...] coming and going as if nothing had happened (E2M3).

In an environment with eminently technical relationships, where all people protect themselves from the risk of being judged by the State and society, impersonal conduct is the rule. They carry out quick and non-explicit actions, expressing their non-involvement through attitudes that guarantee confidentiality about what happens there.

Discussion

Access to hospitals to complete an abortion or to a private clinic to perform it is part of the abortion itinerary and depends on the social and economic context in which women are inserted. In this study, the strategies were different and, in the presence of better financial conditions, especially in larger municipalities, women sought out clandestine private clinics that seemed safer to perform the abortion, without guarantees, but with humanized care. On the other hand, in all three municipalities, there were economically disadvantaged women, who sought to self-induce an abortion and delayed their search for health care.

A significant portion of women who undergo abortions in Brazil require hospitalization due to an unsafe procedures[9]. This reality affects a large number of the female population, considering

that one in every five women, up to forty years of age, has already had an abortion in unsafe and illegal conditions[15].

The profile of women who present the most post-abortion complications are people in an unfavorable economic situation who seek to carry out the procedure in secrecy. This reflects a series of disadvantages in access to health care, a situation of individual and social vulnerability to unsafe abortion and health repercussions[16].

The abortive itineraries involve strategies, time spent in the commute, and the search for health care, factors that vary according to the context of each woman's life. The user must seek out a formal health service or resort to informal systems recommended by herbalists, abortion marketers, pharmacists and private clinics[17].

In this sense, the results of this study reaffirm that social disparities are an important obstacle in the search for abortion, which forces women to use quite unsafe and, at times, unhealthy methods, putting their own lives at risk. Above all, women from mid-sized and small municipalities, with greater socioeconomic limitations, were more exposed to the risks of clandestine abortions.

It is well-known that there are different types of clandestine and health service clinics; however, although the procedure is paid directly by the user, there is no guarantee that it will take place in a safe and humanized environment, and there are even reports of abuse and institutional violence[18].

As there is no State regulation to perform abortions, private clinics tend to guide their services with their own rules and without supervision. In these places, women are subordinated to professionals who are presumed to be willing to assist them and to be capable and qualified for such demands[19].

When choosing private clinics for abortion, the women participating in the study sought to ensure access to services that would guarantee confidential care in a safe and judgment-free environment. However, the conditions reported by the participants of this study expose clearly aseptic relationships that generate a feeling of isolation, discomfort, and lack of emotional support during a delicate moment in their lives.

Regarding access to abortion care, disparities are linked to several aspects: individual, institutional, and women's social and health conditions, influenced, above all, by the laws in force in each country[17]. During this search, women experience multiple types of inequalities related to the stigma of abortion, resulting in difficulties in accessing health care[20].

The stigma that comes with having an abortion makes access to health services difficult, even in places where the practice is legal. In this context, the losses are diverse: disrespect for the woman's privacy; conscientious objection without referrals; and discouragement attributed to the woman so that she does not have an abortion, leading, in some cases, to a forced search for legal representation in court cases[21].

Women who seek health services in the process of abortion usually expect certain punitive and discriminatory attitudes, which may be associated with the delay in seeking the service, including cases in which complications occur. In our study, women put off finding a resolution for as long as possible, alone, avoiding exposure to the health service, suffering, worried, in fear of death and the disclosure of their status as a woman who had had an abortion.

The institutional environment legitimizes the violation of rights when health professionals impose their own values, placing themselves above a woman's right to make decisions about her body and her life. It was from this reality that the women participating in this study sought to defend themselves, but the outcome of each abortion process required some to seek out the official health network or private clinics, inscribing in their stories the scars of the care they received.

Therefore, the care related to women's abortion care is outlined by professionals who work in these services, whose attitudes influence the context of access to health[22]. Abortion care based, on the concepts of humanization, requires an ethical practice that guides the rights of human dignity, free from discrimination or difficulty in accessing health services[23].

The qualification of care is required for comprehensiveness, one of the principles of SUS and which guides the National Policy for Comprehensive Care for Women's Health (PNAISM). Attention to women's health implies ensuring access to resolving actions, valuing the context in which women live their experiences with "embracement and sensitive attention to their demands, valuing the influence of gender relations, race/color, class, and generation in the process of women's health and illness"[24].

Among the types of violence, those characterized by actions of negligence, discrimination, verbal aggression, physical violence, and even sexual violence form the framework of institutional violence[25]. This can be considered a com-

plex phenomenon, as it involves social interrelations, propped up by parameters of awareness and subjectivity[26].

Such statements are in line with the results of this research, which confirm the distance and aridity of relationships between professionals and women undergoing abortions, as they need care, regardless of whether they are in small, mid-sized, or large municipalities. This includes non-facilitation, through indication and/or referral to reference services, in order to enable ultrasound or other medical procedures, as evidenced in the participants' speech.

Violence can be characterized as the abuse of power present in the professional/user relationship, and manifests itself through the omission of information, delay in requested answers, and failure to carry out required therapies at the given moment[27]. This list includes: negligence, discrimination, aggression, inappropriate use of technology, and the use of unnecessary interventions with a strong potential for risk to women's health[28].

Obstetric violence acquires specific contours in the different realities faced by women, which, in situations of abortion, occurs among people who have underlying physical, emotional, and psychological demands. Such violence occurs under the denial of embracement and respect for women's dignity, which are fundamental to mitigating the risks to their lives, promoting an environment of trust and guaranteeing access to adequate healthcare. In the reality studied, health care for women who have had an abortion in the public system should provide the guarantee of protection, but stigmas are imposed upon them that will accompany them throughout their lives.

Worldwide, the stigmatization of abortion interferes in health service practices, especially with regard to the incorporation of post-abortion contraception counseling. Some common examples include the United States, where these barriers still limit access to the practice of counseling; Scotland, where abortion is offered by the National Health Service, but with its demands almost always exceeded, making dialogues about contraception difficult; and Kenya, where the population has difficult access to services and methods for reproductive planning, as well as a shortage of supplies for proper sexual education, thus resulting in a limited use of contraceptive methods among women in that country[29].

Regarding access for women undergoing abortion or post-abortion to health care in SUS services in Brazil, there are advances, especially from the PNAISM. The health care is better outlined, with the publication of the Technical Standard for Humanized Abortion Care and its re-editions[30].

Thus, in the field of public policies, there are proposals for the reorganization of services within the scope of SUS and for the work of professionals in abortion situations, with guaranteed access, reception, sensitive, and resolute listening, congruent with the needs of women, which translates into comprehensive care. Such actions are reflected in the reduction of abortion complications, protection for women against physical and psychological harm, and the providing of guidance for reproductive planning.

Therefore, the way in which obstetric care is provided impacts the health and life of women experiencing an abortion and seeking health services. Furthermore, disrespectful and abusive attitudes are characterized as obstetric violence, perpetrated by power relations between professionals and users in the abortion process. In this way, practices are guided by references that overlap with the ethics necessary for health care, underestimating the defense of the lives of women who need care in the healthcare network, thereby distancing them from the care necessary to ensure protection of the women's health and life.

The experience with abortion in Brazil, due to clandestine abortions, creates fear in women of exposure, which constitutes limits for this study, also restricting the number of participants; however, the technique used to gain access to women and the freedom to choose the strategy to narrate their abortive itineraries guaranteed the success of this research. This aspect could also constitute a limitation for comparisons between access and experience in health services, by women from three municipalities of different sizes. However, the participants' experiences allowed us to observe a common context of gender and social and programmatic vulnerability.

Conclusion

The results of this study show that social and gender disparities continue to influence abortion itineraries, causing disadvantages to women from lower social classes, who are unable to access clandestine private services, considered to be of lower risk, using insecure methods. They also highlight that care for women undergoing an abortion as part of the abortion itinerary is marked by obstetric violence perpetrated by

health service professionals, by attitudes that neglect their demands and cause embarrassment. Therefore, there is a certain apprehension among women that they will be disrespected, which takes place in different ways and leads them to postpone their search for health services.

Under the gender lens, it is understood that many obstacles that still occur in the health care of women undergoing abortion are linked more commonly to moral, religious, and gender values than to legal restrictions for the procedure, considering that women arrive to health services, often at the end of the abortion.

Therefore, the research results reveal that public policies, although built on the principles of reproductive rights, have not been able to transform care for women in situations of abortion in the realities studied here. These remain under the influence of schemes of mentalities and health practices that reproduce obstetric and gender-based violence. The stigmatization of women undergoing abortion reveals one of their faces and shows similarities with the reality in other countries, as can be seen in the scientific literature.

Eradicating obstetric violence is a fundamental step towards ensuring that women have access to safe health services, adequate information on contraceptive methods and sexual education, as well as ensuring respect for women's autonomy and dignity in all circumstances. To this end, it is necessary to strengthen public policies and legal frameworks that promote these practices.

Guaranteeing access and expanding the health service network, investing in the training of health professionals, introducing telecare, providing counseling for the use of contraceptives, carrying out clinical follow-up with sensitive listening and non-judgmental dialogues, as well as creating and enforcing official guidelines for care provided to women undergoing abortion are some of the conditions to qualify care.

The critical issue is how to intervene in the healthcare network, with the aim of deconstructing discriminatory views held by health professionals about women who have abortions. They must assume ethical, embracement, and resolute attitudes, compatible with comprehensive care, in order to protect women's lives and minimize physical and emotional damage, when an unplanned pregnancy results in abortion.

This study is unique in that it was carried out in municipalities whose characteristics of access to health care change depending on their size (small, mid-sized, and large). In their services, women who underwent abortive itineraries in secrecy and under clandestine conditions, sought the protection of their lives, but this guarantee came under the burden of being subjected to a symbolic system and values that, despite public policies, contradict professional ethics and deny reproductive rights as human rights.

Collaborations

JG Fonseca: conception, data collection, analysis, discussion, writing and/or critical review of content, review and approval of the final writing. EAC Coelho: conception, data collection, analysis, discussion, writing and/or critical review of content, review and approval of the final writing. LSA Rodrigues: analysis, discussion, writing and/or critical review of content, review and approval of the final writing. JMQ Silva: analysis, discussion, writing and/or critical review of content, review and approval of the final writing. RP Evangelista: analysis, discussion, writing and/or critical review of content, review and approval of the final writing. ACCA Melo: analysis, discussion, writing and/or critical review of content, review and approval of the final writing.

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