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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

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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

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 well-being 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.