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In-person later abortion accompaniment: a feminist collective-facilitated self-care practice in Latin America

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Abstract: *In Argentina, Chile and Ecuador, abortion at later durations of pregnancy is legally restricted. Feminist collectives in these contexts support people through self-managed medical abortion outside the healthcare system. The model of in-person abortion accompaniment represents an opportunity to examine a self-care practice that challenges and reimagines abortion provision. We formed a collaborative partnership built on a commitment to shared power and decision-making between researchers and partners. We conducted 28 key informant interviews with accompaniers in Argentina, Chile and Ecuador in 2019 about their model of in-person abortion accompaniment at later durations of pregnancy. We iteratively coded transcripts using a thematic analysis approach. Accompaniers premised their work in a feminist activist framework that understands accompaniment as addressing inequalities and expanding rights, especially for the historically marginalised. Through a detailed description of the process of in-person accompaniment, we show that the model, including the logistical considerations and security mechanisms put in place to ensure favourable abortion outcomes, emphasises peer-to-peer provision of supportive physical and emotional care of the accompanied person. In this way, it represents supported self-care through which individuals are centred as the protagonists of their own abortion, while being accompanied by feminist peers. This model of supported self-care challenges the idea that "self-care" necessarily means "solo care", or care that happens alone. The model's focus on peer-to-peer transfer of knowledge, providing emotional support, and centring the accompanied person not only expands access to abortion, but represents person-centred practices that could be scaled and replicated across contexts.* DOI: 10.1080/26410397.2021.2009103

Keywords: accompaniment, self-managed abortion, later abortion, medical abortion, Latin America, person-centred care, self-care

Introduction

In much of Latin America, access to legal abortion is highly restricted.[1] Even where legal abortion is allowed under limited circumstances, such as in Argentina, Chile and Ecuador, additional barriers – including fear of discrimination, fear of criminalisation or lack of health systems infrastructure – prevent people from accessing legal abortions.[2] Yet, the legality of abortion does not determine the demand for abortion services. In the absence of legal, clinically available abortion care, people continue to have abortions, through both safe and unsafe methods.[3,4] In this paper, we examine a novel self-care practice by which people can safely end their own pregnancies:

This article has been corrected with minor changes. These changes do not impact the academic content of the article.

in-person abortion accompaniment for self-managed medical abortions at later durations of pregnancy. This self-care practice relies on self-administration of medical technologies available outside the healthcare system – specifically, the abortifacient pills mifepristone and misoprostol – used with support from a feminist, in-person accompaniment model that centres the experience of the person having an abortion.

Self-care has long been an integral part of sexual and reproductive health (SRH),[5] including management of abortion. The World Health Organization (WHO) defines self-care as "the ability of individuals, families and communities to promote health, prevent disease, maintain health, and to cope with illness and disability with or without the support of a healthcare provider."[6] Self-care interventions encourage the individual to have an active role in maintaining their own health, and typically serve to complement the formal healthcare system, rather than replace it.[7,8] Self-care practices are increasingly important as a way to expand the reach of healthcare systems, but also as a means to reimagine how health care is delivered with a focus on shifting power to people themselves as both self-carers and caregivers.[6] This paradigm shift is particularly important in abortion care, as a way to minimise the harm to abortion-seekers from embedded sexism and patriarchy that is present in the formal healthcare system and, often, the law.

In recent decades, medical abortion without clinical supervision has emerged as an important self-care practice for people to access safe abortion and exercise their reproductive autonomy.[7] A self-managed medical abortion involves taking misoprostol, alone or in combination with mifepristone, to end a pregnancy without clinical supervision.[9] Self-managed medical abortions are common across legal contexts, and a robust body of evidence has demonstrated that self-managed medical abortions are safe and effective self-care interventions when the person has access to accurate information on how to take the pills.[10] Medical abortion, both with and without clinical supervision, is highly effective in the first trimester of pregnancy.[11,12] Additionally, the World Health Organization (WHO)'s "Medical Management of Abortion" guidelines provide guidance of use of these medications at later durations of pregnancy, beyond 12 weeks, and with no upper limit.[11] Furthermore, research suggests that people can safely and effectively self-manage medical abortions beyond 12 weeks gestation.[13–15]

Self-managed medical abortion does not always mean unsupported abortion. One way that people safely and effectively self-manage medical abortions is with the support of accompaniment groups. Abortion accompaniment is a feminist collective-supported model of self-managed abortion care whereby a collective of trained volunteers provide WHO-endorsed, pregnancy duration-specific information to people desiring an abortion on how to use pills to safely terminate a pregnancy, and, for earlier abortions, provide support throughout the process through phone calls and secure text messaging applications. At later durations of pregnancy (17+ weeks), this accompaniment support is sometimes provided in person. This model of self-managed abortion has emerged primarily in geographies where abortion is illegal or difficult to access through the healthcare system and local activists have responded to legal restriction by developing alternative means to meet people's health care need.[12]

The model of in-person abortion accompaniment thus represents an opportunity to examine a self-care practice that challenges and reimagines abortion provision. Moreover, it represents a self-care practice that not only takes place outside the healthcare system but also operates in settings that are highly legally restrictive. Drawing on key informant interviews with accompaniers from three collectives in the legally restrictive settings of Argentina, Chile and Ecuador, we examine the model of in-person abortion accompaniment from the perspective of accompaniers to analyse their understanding of their role in this practice, their theory of change, and how accompaniment operates in practice. Specifically, our research question was: how do accompaniers understand their role in the self-care practice of in-person accompanied self-managed abortion, and how is self-care woven into each step of the accompaniment process?

Studying this in-person model of abortion accompaniment can illuminate how self-care practices in SRH are informed and implemented as feminist practice, and in response to, but not defined by, legal restrictions. This feminist model illustrates that self-care need not mean solo care. In-person abortion accompaniment offers an example of how self-care and feminist care intersect to promote SRH and rights for all, particularly historically marginalised populations.

Methods

Partnership and study design

Data collection for this study was a collaborative effort between researchers at Ibis Reproductive Health, a non-profit research organisation focused on reproductive health, and activists affiliated with feminist collectives in Argentina, Chile and Ecuador, to conduct semi-structured in-depth interviews with key informants who were abortion accompaniers. This collaboration was intentionally structured as a partnership committed to building shared power and decision-making between researchers and activist partners. This partnership built on previous collaborations, including a prior study on second trimester accompaniment in Argentina.[13] Additionally, the three collectives have longstanding relationships of collaboration as a part of regional and global networks of accompaniment groups. After recognising that all of these collectives were providing a similar type of in-person accompaniment for later duration of pregnancy, members of the collectives approached Ibis with the idea of conducting a multi-country study about abortion accompaniment. Over the course of several months of virtual and in-person study team meetings among researchers from Ibis and members of each of the accompaniment groups, we developed research goals for the collaboration.

In a collaborative process, researchers from Ibis and members of the three collectives mutually determined and agreed upon roles and responsibilities, timelines, communication plans and budgets for the study. Much of these agreements were documented in a formal partnership document each partner organisation signed with Ibis. Among the agreements was the understanding that Ibis would lead the development of the study design, instrument design and research protocol as well as the analysis process, while partner organisations were responsible for conducting recruitment and, for two organisations, conducting data collection and managing transcription. Additionally, two to three individuals from each of the accompaniment groups provided feedback to the Ibis researchers at every step of the process. Collectively, both the Ibis researchers and the accompaniment group representatives constituted the research team.

Study settings

At the time of data collection, abortion in all three countries was only allowed in a handful of instances: in Argentina, if the life or health of the pregnant person is at risk, or the pregnancy was a result of rape[16]; in Chile, if the life of the pregnant person is at risk, if the fetus will not survive the pregnancy, and in the case of rape (up to 12 weeks gestation, or 14 weeks gestation if the pregnant person is under 14 years old)[17]; and in Ecuador, if the life of the pregnant person is at risk or when the pregnancy is a result of a rape of a mentally disabled person.[18] (As of January 2021, abortion has been legalised up to 14 weeks gestation in Argentina.[19]) In all three countries, abortion accompaniment collectives arose as a way of facilitating access to safe abortion for all.

Since 2010, *Collectiva Feminista La Revuelta*, the collective in Argentina, has operated as an abortion accompaniment network which provides services and information to support access to safe medical abortions for people desiring an abortion. *Con Amigas y en la Casa*, the collective in Chile, was formed in 2016 as a network of people trained to provide abortion accompaniment. Since 2015, *Las Comadres*, the collective in Ecuador, has run a hotline through which people desiring an abortion can receive information on safe abortion options as well as supportive emotional care throughout their self-managed abortions. The collective in Argentina began accompanying abortions in person, generally beyond 17 weeks gestation, in 2016, followed by Chile in 2017 and Ecuador in 2018. The groups in Chile and Ecuador began providing in-person accompaniment in consultation with the Argentine group, adapting their model of care.

Participant recruitment

We recruited accompaniers as key informants for in-depth interviews. Given the depth of knowledge and the range of expertise across accompaniers, we anticipated that we would need a sample size of up to 10 accompaniers per group. To be eligible, potential participants had to be at least 18 years of age, have participated in at least two in-person accompaniments, and have volunteered as an accompanier with one of the three accompaniment groups within the prior three years. (Some participants began accompanying abortions prior to formally joining their collective or to the collective's formation.) In Argentina and Chile, participants were purposively recruited based on the number of in-person accompaniments they had provided, in order to understand perspectives

from both highly experienced and newer accompaniers, recognising that newer accompaniers might notice aspects of the process that highly experienced accompaniers take for granted. In Ecuador, the accompaniment group included only eight accompaniers that met the sample selection criteria at the time of the study, so we invited all accompaniers to participate. Potential participants were invited by a member of the research team to complete an in-depth interview about the ways in which they provide in-person accompaniment and their experience as accompaniers.

Data collection

The research team collectively developed a semi-structured interview guide that was used across study settings. Relevant to this analysis, interview questions elicited information on each key informant's experience providing accompaniment for in-person self-managed medical abortions at 17 weeks gestation or later, a step-by-step description of the in-person accompaniment process, and reflections on the accompaniment model in general.

Interviews were conducted in Spanish by four members of the research team, all of whom were fluent in Spanish: two (MT and EWS) were members of the accompaniment groups, whose relationships with participants varied from personal to professional, and two (including the first author) were researchers at Ibis who did not have any prior relationship with interviewees, with the exception of three interviewees (one from each country) who also served as members of the research team. Although it is not conventional for an interviewer and interviewee to have a pre-existing personal relationship, the research team judged it both appropriate and important given the sensitive nature of the subject, the necessity of trust between interviewer and interviewee and the difficulty outsiders could have establishing trust, and the access these specific interviewers had to potential participants. Participants were assured that their participation was voluntary and would not affect their ability to continue serving as volunteers with the collectives. Prior to conducting interviews, all interviewers participated in a training on the ethical conduct of research, with a focus on qualitative interviewing.

Interviews were conducted in-person or over the phone between February and April 2019 at a time and location convenient to the interviewee. Before beginning the interview, the interviewer reviewed the informed consent materials and the interviewee gave verbal consent to participate and have their voice recorded. The interviews were audio-recorded on an encrypted device and were transcribed verbatim. The interviews lasted between 60 and 90 minutes and participants were offered remuneration of approximately $US 20 for their time and transportation. One of the groups, including interviewees from that group, collectively decided not to disburse the remuneration individually and instead use it to support the group's accompaniment work.

Analysis

Three researchers from Ibis, all fluent in Spanish, including two authors (CB & HM), analysed the interview data using thematic analysis, creating an initial codebook using *a priori* identified codes based on themes from the interview guide. We applied the initial codebook to one interview in each of the three study locations using MAXQDA software. The researchers then met to discuss discrepancies in coding and modified or redefined code descriptions. The same three researchers then applied this revised codebook to all the transcripts, meeting regularly to discuss challenges with coding and to develop new codes based on emergent themes in the data. All coding was done in Spanish.

After all the transcripts had been coded, the three coders discussed prominent themes that emerged from the data, based on their initial impressions. The research team then developed a matrix to outline the similarities of the models of care across the three countries and returned to the coded interviews to populate the matrix. This allowed the research team to create a rough outline of the model across the accompaniment groups. Finally, we presented our preliminary analysis back to all members of the research team, which included some of the interviewees, as a validation check. Two authors (KK & JMP) joined the research team at this point, consulting on additional coding and the framing and preparation of this manuscript. The accompaniment group collaborators also provided feedback on the results section of this manuscript as another validation check, and several serve as co-authors (EWS, BG, MT, RZ, CC, MM, VD).

The Allendale Investigational Review Board, based in the United States, served as the central

institutional review board (IRB) of record for this multi-country study, and reviewed and approved the study protocol (Approval Number: IBIS-SECT09021018). Local ethical review was not sought for this study due to safety and security concerns expressed by the partner organisations. However, we followed local guidelines and regulatory procedures for research with human subjects in Argentina, Chile and Ecuador. All participant names are pseudonyms. Quotes have been translated into English. Original quotes in Spanish are available in Appendix A.

Results

Sample description

We conducted interviews with 28 key informants: 10 participants from Argentina, 10 from Chile and 8 from Ecuador. Participants ranged in age from 20 to 54 years, with a median age of 31 years. Accompaniers identified not as volunteers, but explicitly as activists in their accompaniment work. In addition to their activism as abortion accompaniers, which is unpaid, most had full-time paid employment. A few participants had formal clinical training: one was a physician, three were psychologists, and one person had recently begun a nursing programme. Participants had been accompanying in-person abortions (above 17 weeks gestation) from 1 to 8 years prior to the interview. Additionally, participants had from 1 to 18 years' experience providing accompaniment by phone and/or text (not in person) for abortions.

Accompaniers defined their work using a feminist rights-based framework, constructing accompaniment as both activism and a practice for safe abortion in legally restricted settings. One accompanier, for example, described the experience of accompanying as "*having become part of feminism, getting to know popular feminism*" (Paula, Argentina). Accompaniment, for Paula, was rooted in an understanding of the vulnerable, particularly those at risk of dying of an unsafe abortion,

"… of being able to sit down and discuss with fellow women from the neighbourhoods, where the most vulnerabilities exist, and who are the first to run the risk of dying as a result of a clandestine abortion or of being forced into obligated motherhood, where the churches have destroyed any chance of freedom and autonomy for women." (Paula, Argentina)

In the face of entrenched patriarchy and often insurmountable legal restrictions on abortion, accompaniers understood accompaniment itself as a tactic of resistance:

"I always think that accompaniment is one of the strategies we have in our fight for our rights, let's say. So, for me, it is like the safest way, the most cared for way and the best possible way to improve access to that right, is through accompaniment." (Juliana, Argentina)

As these excerpts highlight, accompaniers saw their work as part of a broad philosophical commitment to a feminist philosophy of addressing inequalities and expanding rights, with a special focus on the most vulnerable. In brief terms, accompaniers described their role as ensuring that the accompanied person is the protagonist of their own abortion story, in control of decisions about their body and empowered to act on those decisions. Below, we describe the process of in-person accompaniment step-by-step and then discuss the central role that emotional support plays in this model.

Screening for in-person accompaniment

The three collectives hosted either a local hotline or information services via email for people seeking information about abortion. When a person desiring an abortion called or emailed, they were asked to provide the duration of their pregnancy based on either clinical confirmation or the date of their last menstrual period. If the person calling provided information to suggest that they were beyond 17 weeks gestation (or in rare cases with earlier gestations, such as for an adolescent), the hotline operator began the process of scheduling them for an immediate accompaniment. Given the collectives' constrained financial and human resources, most individuals who are beyond 17 weeks' gestation are supported virtually. However, some accompaniments take place in person. The collectives prioritised providing in-person accompaniment for vulnerable individuals, such as victims of domestic violence, adolescents, or those who lacked the financial resources or social support to manage their abortions on their own.

As a first step, their contact information was noted and given to an in-person accompanier who would call them back to set up a face-to-face meeting. The pregnant person was also asked to get an ultrasound printout in advance

of this in-person meeting, both to confirm the duration of pregnancy and as a way to get information about the pregnancy such as the position of the fetus and placenta. An accompanier explained why it is important to have an ultrasound: "*they have to have an ultrasound to know the location of the placenta and to know there is no risk of having a placenta previa which may cause bleeding during the expulsion because that is really dangerous*" (Vanessa, Ecuador).

The accompaniers used the initial face-to-face meeting as an opportunity to explain the logistics of how the person will be able to end their pregnancy outside the healthcare system and despite legal restrictions (outlined in Figure 1). They frame this information, however, with emphasis on the legitimacy of the person's emotions and the importance of their autonomy in decision-making. One accompanier in Chile explained:

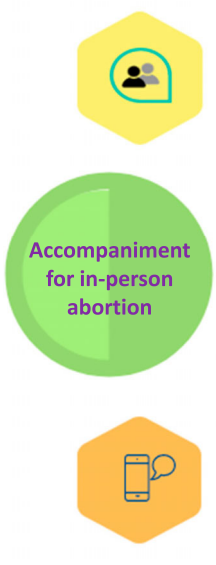
"I try to inform women a lot about what is going to happen … I like to talk to them a lot about the emotional aspect, that if she is sure about the process then it will be much easier for her. We support the woman's decision no matter what she chooses, but we only take part in it if she decides to abort." (Johana, Chile)

In this way, accompaniers prepared people not just with information about the medication regimen, the pharmokinetics of how the medications work, and the physical symptoms that they might experience during this abortion outside the healthcare system and, pointedly, outside the law, but also by framing the abortion as rooted in the accompanied person's reproductive autonomy, with explicit recognition of the importance of their emotional experience. At the meeting, they set a date for when the medication regimen will commence.

Medication regimen for accompanied abortions beyond 17 weeks gestation

The medication regimen recommended by the accompaniers varied based on the duration of pregnancy. For individuals with pregnancies 17 weeks and above, accompaniers reported a collective consensus that using two mifepristone helped reduce the time it takes to complete the abortion; thus, for those with pregnancies 17 weeks and beyond, accompaniers suggested that people take one mifepristone orally, 200 mg, wait for 24 hours, take a second mifepristone orally, 200 mg, wait another 24 hours, and then begin

Figure 1. Visual model of the in-person accompaniment process



Prior to an in-person accompaniment

- The person seeking an abortion calls or emails the hotline and is put in contact with an in-person accompanier who asks them to get an ultrasound
- The accompaniers & the person aborting have an in-person meeting to orient them to the entire process
- A date is chosen & the person takes the mifepristone based on the scheduled date

Logistics leading up to an in-person accompaniment

- The person & accompaniers find a secure place for the in-person accompaniment
- Accompaniers prepare a kit which includes everything needed to take care of the person physically & emotionally

Day of an in-person accompaniment

- They all settle into the space, review the necessary information, & the person takes preventative pain/nausea medications
- The person begins the misoprostol regimen
- Accompaniers are vigilant for pain & symptoms to control for possible complications
- Emotional well-being is carefully monitored & supported
- Safety plans are arranged throughout process

Hours, days and weeks post-abortion

- Accompaniers provide comfort & support in the hours after the expulsion
- Accompaniers call to check on the person in the days, & weeks, after the abortion to monitor for possible complications & provide support

the misoprostol regimen. While accompaniers are not present at the time that the mifepristone is taken, they provide virtual support, including sending reminder messages to ensure the medication is taken at the correct time.

The accompaniment collectives reported consensus on starting with a dose of 400mcg of misoprostol sublingually, waiting 30 minutes for the pills to dissolve and then swallowing the remaining pills/residue. Three hours later, a second dose of 400mcg of misoprostol is taken sublingually. They suggested that this dose be repeated every three hours until expulsion is complete. The accompaniment groups recommended not exceeding a total of six 400mcg doses and if someone had not completed their abortion by that point, they either attempted the procedure again at a later date or they sought support from a healthcare provider. The accompaniers often used their own judgment and experience as a guide to slightly adjust dosage and timing as needed rather than strictly adhering to a protocol.

Preparation for the in-person accompaniment

For each accompaniment, the accompaniers had to identify a secure location for it to take place, taking into consideration various criteria including location, availability, the layout of the house/apartment and amenities. To further ensure the medical safety of the person aborting, accompaniers in some settings also considered the proximity to a health facility and pre-arranged transportation to get to the health facility in case of an adverse event. Their goal in selecting a location, however, was not strictly about security or proximity to a health facility; they explicitly sought a space that would facilitate a specific kind of care experience. For instance, one accompanier in Argentina emphasised that the space was not simply functional but, in contrast to clinical settings, it also needed to facilitate an ambience of harmony and comfort, *"that there is an atmosphere of harmony, if there is music that it be quiet music, that the lights can be dimmed, to respect the moments of silence and the moments of rest for that person"* (Paula, Argentina). Accompaniers looked for physical spaces that allowed the accompanied person to find moments of peace and comfort during their abortion. This meant that spaces were identified based on characteristics that accompaniers felt would help the person feel calm and safe and could provide them with privacy should they need it.

In-person accompaniments last an average of between 12 and 15 hours (and, in some cases, much longer). As such, accompaniers stressed that it was critical to have at least two accompaniers present at all times. In some cases, replacement accompaniers were scheduled to arrive to relieve the accompaniers who were there at the start of the day. The accompanier who had the initial face-to-face meeting with the accompanied person was generally present at the start of the day to create consistency and to facilitate the introduction to other accompaniers.

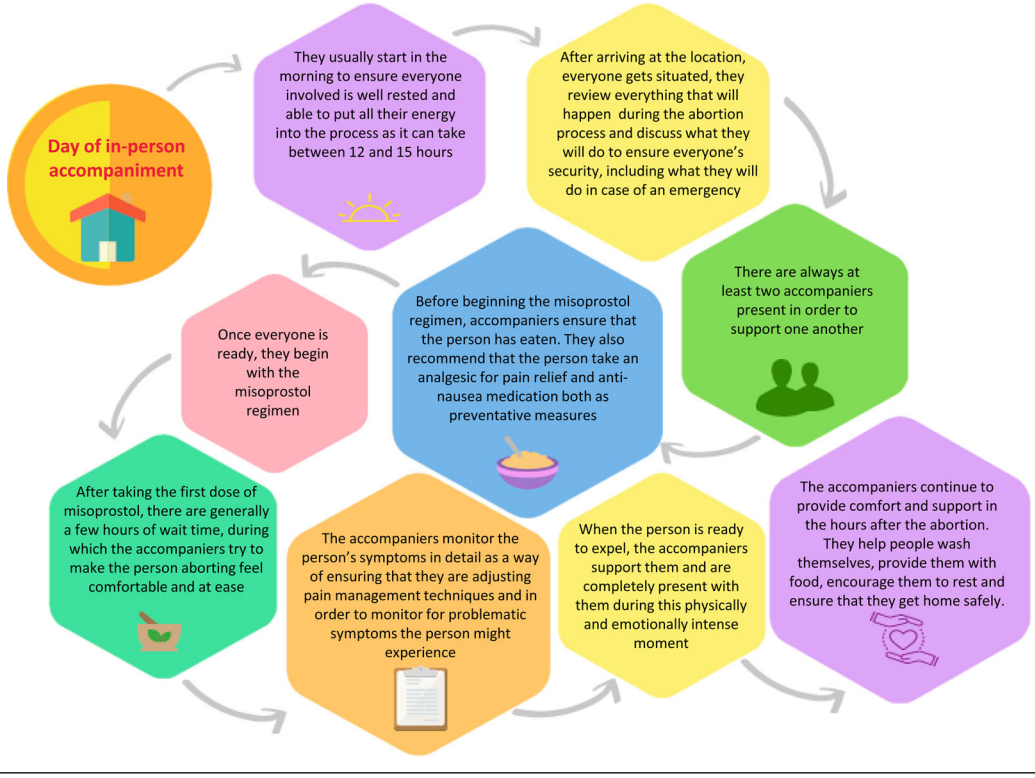
Accompaniers prepared an "abortion kit" that typically included options for pain management, for entertainment, and for sustenance during and after the process. Some of the items included in the kit were: hot water bottles, herbal teas, massage oils, pain medication, books, board games, cellphone chargers, towels, sheets, shampoo and conditioner, soap, and cleaning supplies. The kit also generally included items for the accompaniers to use to monitor progress towards a complete abortion and conduct safety checks, such as a thermometer and their collective's accompaniment logbook where accompaniers take notes on the dosage timing and physical symptoms. These kits were thus structured to include both the medical equipment and tools needed to support the abortion process as well as items intended to facilitate the accompanied person's ability to create their desired abortion experience.

Day of in-person accompaniment

Arriving at the site

The in-person accompaniments (outlined in Figure 2) usually began in the morning to ensure that both the accompanied person and the accompaniers were well rested and able to put all of their energy into the process, *"we have to begin in the morning because the woman has to have rested … to ensure that she has slept many hours and so have we"* (Claudia, Argentina). This was both practical and consistent with the philosophy of enabling the accompanied person to bring their most prepared self to the experience. Upon arriving at the location, both the accompaniers and the accompanied person got situated in the space and reviewed everything that would happen during the abortion process

Figure 2. Day of in-person accompaniment



again. Accompaniers aimed, in these introductory conversations, to help people feel prepared both for the process and in case of a medical emergency. This was not a "clinical" conversation and was not rushed, allowing time to build rapport and trust. As one accompanier described it, *"we have breakfast, if they have not had it yet, we have it all together, that way we talk a little, we see how they are feeling, we talk a bit about them and then we start with the dose"* (Johana, Chile). At the beginning of the process, accompaniers also typically recommend that the person take an analgesic for pain relief and anti-nausea medication, both as preventive measures.

Passing time, monitoring symptoms and managing pain

After taking the first dose of misoprostol, there were generally a few hours of wait time. Accompaniers took advantage of this time to further build a personal connection with the accompanied person and empower them as the protagonists of their own abortions by sharing personal stories and experiences of other people's abortions:

"we try to empathize with them, to tell them the truth, to talk to them about us as women, to tell them what has happened to us, what has happened to other women, to tell them, to remind them that women have given birth and have aborted at home throughout the entire history of humanity." (Valentina, Chile)

An important aspect of this time is that accompaniers follow the lead of the person aborting and allow them to dictate what they want to do. Accompaniers catered to their needs and desires, as one accompanier described, *"We see if she feels like chatting, if she just feels like being listened to, if she feels like watching TV or feels like doing nothing, or reading or just going to into a room with her cell phone"* (Andrea, Argentina). Although accompaniers were acutely cognisant of their responsibilities for supporting and monitoring

the safety of the physical abortion process, they centred the accompanied person and allowed them to lead all other aspects of the abortion.

Accompaniers reported that generally people started to feel symptoms after the first or second dose of misoprostol, including chills, abdominal cramping, lower back pain, dizziness, nausea, vomiting, fever and diarrhoea. As such, accompaniers came prepared with a myriad of techniques to help manage pain and symptoms. Accompaniers considered pain management to be one of the most important aspects of accompaniment. As they explained it, they are at once a guide through various pain management techniques – anticipating changes in pain levels and closely observing changes in the individual's needs – and striving to create an environment in which the accompanied person feels empowered and connected to their bodies so that they are able to successfully expel the products of conception. As one accompanier explained, managing pain was not just about physical discomfort but also about managing anxiety and creating confidence that they would complete the abortion.

"During all that process in which there is always, generally always, great discomfort, there is always a lot of pain […] So we usually prepare hot water bottles, give them back massages […] calmly and with a very soft voice so that she feels supported, but at the same time, trying not to make her anxious, 'you will get through this'. Like that, mainly to create a relaxed and warm atmosphere for the women, and if there is a moment of tension, she knows we will get through it and she can just relax and focus on herself again." (Mónica, Argentina)

In addition to pharmaceuticals such as Metoclopramide, an anti-nausea medication, and anti-inflammatory and analgesic medications such as ibuprofen, they also relied on non-pharmaceutical techniques. As one explained, "*a massage to the lower back, and also like at the beginning of the coccyx with Rue oil [used to sooth pain and ease muscle aches], for instance, oils like that … that can warm up the body, but I think the technique we have used the most is, like, foot massages*" (Paola, Ecuador). Accompaniers described systems for documenting pain, including regular scoring of 1–10 on a pain scale. During this period, they adjusted their strategies in an effort to manage the person's pain, not preferentially differentiating among techniques:

"When they are already feeling a lot of pain we start trying some techniques, if the hot water bottle no longer works, we begin to do exercises, to give low back massages, face massages, so as to relax them if they are really nervous. We do like a breathing therapy so that she can begin to connect with her body." (Johana, Chile)

As Johana describes, accompaniers encouraged the accompanied person to familiarise themselves with what was going on in their bodies, to be able to feel and verbalise the various symptoms they were having such that accompaniers could adjust pain management techniques to better meet their needs. As this description indicates, accompaniers constructed their role as one of active support, providing the language and tools to the accompanied person and taking direction from them.

Although accompaniers did not privilege medicalised approaches to pain management, they were clear that some situations required clinical care. On occasion, a medical emergency could emerge and accompaniers had to be prepared. All groups had emergency protocols in place and had outlined criteria for taking the person to a nearby health facility, including dramatic drop in blood pressure, excessive bleeding before the fetal and placental tissues are passed, or delayed passage of the placenta (up to 60 minutes).

The expulsion

The abortion neared completion when the person expelled the fetal and placental tissues. Accompaniers helped prepare people emotionally prior to and during the moment that they expelled the products of conception. Accompaniers explained that the overall rapport-building and close connection established through the accompaniment process prepared them to presage this key moment of care and be there to support it. One accompanier described how experience taught them to identify this moment,

"*You start to learn how much longer it will take for the expulsion to happen. I think you can see it in their faces, you can see it in their bodies, in the symptoms, they describe the pain they are feeling and you start noticing that the pain is increasing, or not, leading up to expulsion too."* (Juliana, Argentina)

Accompaniers described the moment of expulsion as the most intense moment of the process

for them. At the same time, they felt that it was an empowering moment for the accompanied person during which they connect with their body and understand their own strength. One accompanier describes,

"The moment of expulsion is when everything is much stronger. Most women we have accompanied, feel a pain that is so strong that it is like, 'no more, please'. There are some awful cries of pain, but the key is that during all the moments of preparation, prophylactic and pain management the women get to understand their body and get to know it." (Amelia, Ecuador)

During this moment, all of the focus is on supporting the person aborting. One accompanier describes how in this moment, it feels that they are in a world apart,

"I say that there seems to be a world of its own in the bathroom. Nothing around us matters any more … it's like at that moment the woman and the accompanier, who is holding her hand, telling her that everything will be okay, or rubbing her back, it's like, I mean. It's that, it's like they are the only two people in the world without anyone else around." (Verónica, Argentina)

As Verónica describes, the accompanied person is not alone even in this challenging and vulnerable moment: their accompanier is there with them continuing to support, encourage and centre them as protagonist of their own abortion. The tenderness and empathy with which the accompanier describes this moment presents a stark contrast to the type of emotionally detached professionalism commonly found in the healthcare system.

Hours, days and months post-abortion

After expelling the products of conception, accompaniers described that a relief and gratitude washed over people: *"I see that women are relieved because this whole painful process is over, they realised that nothing bad happened, all their fears are relieved*" (Vanessa, Ecuador). She continued, noting that people typically recognised the key role that accompaniers played in enabling them to complete their abortion, *"At that moment when everything turned out fine, many of them hug us and, above all, they thank us. That part is extremely gratifying"* (Vanessa, Ecuador). Another accompanier described a similar overwhelming feeling of gratitude and relief after the abortion is complete, *"There is a lot of gratitude from the women, at the moment when everything is over, it is like all of our faces change, we breathe a different air, we open the windows, we eat something, and at that moment also, is like a huge return on all those previous hours"* (Juliana, Argentina). In these accounts, it is clear not only that self-managed abortion is self-care because individuals are exercising their right to reproductive autonomy outside the healthcare system, but also that accompaniers are integral to the success of this kind of self-care practice. They enable a safe abortion that is emotionally supported, preventing self-care from meaning solo care.

In the hours after the products of conception are expelled, accompaniers continued to provide comfort and support, taking direction from the accompanied person. The accompaniers helped people wash, provided them with food, encouraged them to rest and ensured that they got home safely, not considering the accompaniment complete simply because the abortion was complete. The overall abortion experience, in other words, was not understood as strictly a biological experience. One accompanier explained:

"If the girls want to take a shower they can take a shower, there is always food ready for when they feel like eating. We always recommend that they lay down for at least an hour before going home, if they are wanting to go home right away. And when they feel ready to get up, to walk, to put on their clothes and go back home, we also accompany them until they leave, to the bus stop, to take the minibus, if there is any need for us to accompany them." (Ailén, Chile)

During the hours and days after the abortion, accompaniers continued to monitor for warning signs for possible adverse events, *"we try to collect information about their health, for instance, symptoms that they might be having, so that we avoid infections or we can detect haemorrhages"* (Antonela, Chile). In most cases, no adverse events occurred and accompaniers felt that it was not necessary for people to seek follow-up care within the healthcare system. However, in the event that the accompanied person expressed that they wanted to visit a health facility to confirm completion, sometimes accompaniers escorted them and supported them during their interactions with providers, some of whom might be hostile to abortion. In the rare case that they identified adverse events, accompaniers either provided

people with support in locating a friendly health provider or informed them of their rights as patients so that they would feel more comfortable when they visited a hospital or health facility.

Accompaniers always called the person within 24–48 hours after the abortion to check on them. People expressed a range of interest in ongoing communication with their accompaniers: *"There are some women who finish the process and they want to close the door and they never want talk about it again. And there are others who after a month, two months, they keep calling us"* (Valentina, Chile). As Valentina mentioned, while some individuals would rather not remain in contact with their accompaniers, it was also common that people continued reaching out to their accompaniers long after their abortions. Another accompanier described this, *"sometimes a great relationship is formed, so they keep writing to you, they send you Christmas or New Year's greetings"* (Marta, Ecuador). While sending holiday greeting texts can be a common cultural practice in Latin America, it also indicates ongoing positive feelings towards the accompanier. As with the in-person part of the process, accompaniers deferred to the person's preferences around communication, neither ending nor engaging in contact without a cue from them.

Eventually, the communication between the person and their accompaniers might subside but accompaniers felt that the bond they had created often persisted. One accompanier described that the bond that was created between accompanier and accompanied felt unique to them. They describe the mutual vulnerability of sharing such an intimate moment, reflecting the feminist philosophy of the accompaniment model which acknowledges that the accompanied person and the accompanier are equals,

"[…] there is something a bit ephemeral and intimate that is created there … it is just that, there is no other definition. It's not a trust, a friendship, it's knowing that the accompaniers are there and that the woman can give herself over, but at the same time the accompaniers give themselves over to her too, there is like a moment of vulnerability for both of them there. Because she is very vulnerable, offering you everything because she does not know what else to do, and at the same time you are also vulnerable, like 'well, I can only hold you, like, in the way I listen to you and look at you and hold your hand, there is nothing else I can do'." (Andrea, Argentina)

As Andrea highlights, the accompanier offers everything to the accompanied person and, at the same time, acknowledges that they are in service to someone else's self-care practice and, as such, face inherent limitations to what they can do. This quote also describes a somewhat common sentiment amongst accompaniers: that the people needing in-person accompaniment often reach out to them in a state of desperation as a result of the legal restrictions that exist around abortion, and particularly later abortion, in these three legal contexts. In this moment of vulnerability, accompaniers offer support and the means to end the pregnancy, but acknowledge – and, indeed, insist – that the power to complete the abortion lies only with the person aborting. Far from an effort to disavow the accompanied person's role in the abortion, accompaniers draw on this understanding of accompaniment that rests on a foundational belief in the power of the people they support.

Centring emotional support during accompaniment

In describing how they provided later abortion accompaniment, across the interviews, participants underscored how, at each stage of the accompaniment process, providing emotional support to the accompanied person was imperative. Accompaniers considered emotional support a fundamental – and even foundational – element of the accompaniment process and understood their role as not just to provide information or physical presence, but to create a space where the accompanied person felt safe and confident. One explained that,

"Not only the presence of the accompaniers that have information, or more information, about an abortion process in the same place where the woman is having the abortion, but also everything that is happening around that, like creating a caring and trusting environment, for me, that is essential." (Paula, Argentina)

The care that accompaniment represented, in other words, was not simply material or practical. Emotional support was woven into each stage of the process, an integral complement to the provision of more medical aspects of care such as monitoring symptoms and managing pain. One accompanier explained,

"I feel that what I always try to boost is courage, like, 'you are doing great, you are tough, you are strong, you are doing well, breathe, you are doing excellent.' Like encouraging her at the end, like being an abortion cheerleader there in the bathroom, trying to improve the girl's morale and reduce the anxiety and obviously the fear, like saying: 'Darling, you are doing excellent. Connect with yourself and keep on doing it like you've been doing.'" (Celeste, Chile)

Describing herself as an abortion cheerleader, Celeste understood accompaniment as helping the accompanied person learn to trust in themselves, to raise their spirits, ease their fears and encourage them to take charge of their own abortion experience. Accompaniment was not just about ending a pregnancy, it was about emotional safety and empowerment.

This construction of what accompaniment meant operated in contrast to the public health system. Participants described accompaniment as creating a loving, caring emotional bond, whereas the public health system, as one accompanier described it, was a difficult place, particularly for vulnerable populations,

"The public health system we have is awful and for all working-class people it is a problem to have to resort to these health services, and then, and even more so for if the people from the working class are women, or even worse if they are transvestites or lesbians." (Paula, Argentina)

Further, accompaniers located their focus on supporting the accompanied person as not only in contrast to systems that devalue vulnerable populations but as an intentionally activist orientation. They saw listening to the accompanied person, witnessing their emotions and validating any emotional expression that arose, as an act of encouraging self-care and empowering them. One accompanier explained,

"Like what to do when they cry, that is, all those emotions they feel, knowing that they are legitimate and listening, accompanying is a lot of listening, a lot, a lot, so like … paying attention, and knowing, and reacting based on that too, right? But, yes, it's also not coming from a place of like, 'Oh, poor you,' but rather … listening to your peer, that, of course, she is the one who is going to abort, you are giving her information but now she also has that information, which means that all you are doing is guiding and answering questions, if she has any, and accompanying." (Angie, Ecuador)

Angie echoes the sentiment of many other accompaniers as they described themselves as a guide for the accompanied person, and highlights the fundamental concept of this model of accompaniment, that the accompanier and the accompanied are equals. Accompaniers see their role as one of empowering the accompanied person by sharing all the necessary information with them and allowing them to take control of their own bodies and reproductive autonomy, rendering accompanied abortion a supported self-care practice.

Discussion

Drawing on in-depth interviews with 28 accompaniers from abortion accompaniment collectives in Argentina, Chile and Ecuador, we describe a feminist collective-led model of abortion self-care for people aborting with medication beyond 17 weeks of gestation without clinical supervision. We describe this model of care, and in so doing, underscore how a feminist, rights-based, orientation to abortion care is central to this work. In addition to highlighting the logistical considerations and safety mechanisms put in place to ensure favourable abortion outcomes, we show how providing supportive care, that takes into consideration both physical and emotional needs of the accompanied person, is fundamental to this model.

The current literature on accompaniment, or hotline, models for self-managed abortion care, both globally and in Latin America specifically, primarily focuses on virtual accompaniment and on abortion in the first trimester.[20–23] This paper contributes to a growing body of evidence that medical abortion is safe and effective beyond 12 weeks gestation and, in fact, beyond 17 weeks gestation, and describes a unique model of care that is tailored for medical abortion at later gestations. Further, our analysis demonstrates that this model of feminist collective-facilitated self-care holds lessons for other self-care models in sexual and reproductive health, particularly in terms of its ability to expand access to needed health care.

This analysis makes several contributions to the conceptualisation of self-care. Centrally, this

model of supported self-care challenges the idea that "self-care" necessarily means "solo care," or care that happens alone. Within the accompaniment model described here, individuals who seek accompaniment care are empowered to be active participants in their own abortion; they take the pills themselves and make choices about how their care is delivered, shaping their own abortion experiences. However, they are also supported in this self-care act by feminist peers who help them manage the physical and emotional aspects of the experience. They also benefit from the full support of accompaniers who are acting on the wisdom and experience gained through their feminist collectives. Thus, this model presents an example for a self-care intervention that is not "solo care."

In addition, the feminist collective-facilitated self-care intervention illustrates a response to legal restrictions on vital reproductive health services that is also a part of a broader movement of abortion rights activism. In the study contexts, the individual aborting might face criminalisation should they seek an abortion within the healthcare system. This particular model of care provides what is often the only opportunity for many marginalised individuals to receive abortion care at all. In many such legally restricted contexts, these feminist collectives enable individuals not only to access needed care but to do so in a supported, compassionate, and empowering environment. Furthermore, a central part of many accompaniers' identity is their role as activists in the fight for reproductive rights. Abortion accompaniment is one expression of this activism and is part of a broader movement of social and political change to expand access to abortion beyond the institutionalised medical system. Abortion accompaniment does this by increasing access to and de-medicalising the use of pharmaceuticals to allow any person to engage in an autonomous health action.[24] Supported self-care practices such as the abortion accompaniment model described here help expand our understanding of the role that organisations outside the healthcare system, such as feminist collectives, can play in creating access to health services that are legally restricted within the healthcare system and pave the way for broader social acceptance as well as legalisation of these services.

Finally, the ways in which the accompaniers centre the accompanied person represent an example of how a supported self-care intervention not only increases access to health services, but also can be of higher quality than care provided in the healthcare system. Despite research demonstrating the value of emotional support in patient-provider interactions,[25,26] this aspect of care is not always prioritised within clinical abortion care, and yet providing such emotional support and comfort for people aborting could greatly improve their abortion experience.[27,28] As this analysis demonstrated, the accompaniers centre the accompanied person and their emotional needs by serving as both guides and companions during their abortions. The concept of accompaniment in health care is not unique to abortion, and accompaniment in other areas of health care has been shown to promote high-quality person-centred care and favourable health outcomes, including treatment adherence, in areas such as human immunodeficiency virus (HIV)[29,30] and tuberculosis (TB) care.[31] Although the type of abortion care described in this study arose in response to legal restrictions in the three documented countries, the value of emotional support and centring of the accompanied person of this model is not limited to legally restrictive settings.

Of note, the accompaniment model of care does not only use pharmaceuticals for pain management, but rather incorporates a variety of non-pharmaceutical techniques and prioritises pain management tools that most resonate with the accompanied person. While the focus of pain management for surgical abortions has largely been on analgesics,[32,33] incorporating non-pharmaceutical techniques from the accompaniment model (such as hot water bottles, essential oils, herbal teas, etc.) into clinical abortion care may both have lower costs and be an additional point in care where the accompanied person has agency and choice, helping to empower them and improve their overall experience of care. In countries like the United States, nearly all abortions beyond 17 weeks take place in clinical settings. Yet, this in-person accompaniment model highlights an alternative and more expansive vision of what later abortion care could be – a model that abortion providers globally should consider. Additionally, while the model does require support from trained individuals, it has lower medical resource needs, which could help reduce the strain on health systems that are overburdened as a result of the global COVID-19 pandemic.

As with all research, this study has limitations. While a strength of our study was that we completed interviews with people from three different legal contexts, by combining these interviews into a single analysis, we do not offer precision on how specific legal, social, and cultural context mattered. Additionally, because many of the interviews were conducted by an interviewer with a personal relationship to the participant, there may have been aspects of their accompaniment experiences they did not feel comfortable disclosing. As noted in the Methods, we judged the ability of interviewers to gain participants' trust outweighed this risk. For our purposes here, moreover, we have very low concern that any disclosure hesitancy would impact what participants shared about the model of care itself. These limitations are balanced by strengths. The data presented here provide one of the first, and most comprehensive, descriptions of a model for the provision of self-managed medical abortion with in-person accompaniment support beyond 17 weeks gestation. Further, data collected for this study emerged from a novel, research-activist partnership built over years of collaboration that enabled access to accompaniers willing to share their perspectives and experiences.

Conclusion

This study provides a comprehensive description of a collective-facilitated model of self-managed abortion beyond 17 weeks of gestation based on data from three accompaniment groups in Argentina, Chile and Ecuador. This model is unique in its feminist rights-based approach to facilitating abortion self-care via comprehensive, peer-to-peer emotional and physical support. This model of feminist collective-facilitated self-care emerged in order to expand access to later abortion care for people seeking abortions within legally restrictive contexts. Both the model of care itself, including a focus on peer-to-peer education about the medical technology and its impact on the body, as well as the model for the provision of emotional support and empowerment, could be scaled and replicated within other abortion care models – inclusive of the clinical setting. Future research is needed to understand the accompanied person's experience of self-managed abortion at these later gestations as well as the pathways to, and experiences of, accompaniment as an activist practice. Additional research should also explore how the unique elements of this model contribute to the high effectiveness and safety seen in prior research,[14] and the extent to which adaptation of this model of care across additional cultural and legal contexts might be possible or of interest.

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Appendix

Location in Results Section	Spanish	English
Note: for context, some of the English surrounding the quotes is presented below.		
1	One accompanier, for example, described the experience of accompanying as "de haber entrado al feminism, de haber conocido el feminism popular" (Paula, Argentina). Accompaniment, for Paula, was rooted in an understanding of the vulnerable, particularly those at risk of dying of an unsafe abortion, " … de haber podido sentarme a discutir con las compañeras de los barrios, que es donde más vulnerabilidades hay, que son las primeras que corren el riesgo de morirse en un aborto clandestino o de estar forzadas a una maternidad obligatoria, donde las iglesias han hecho mierda toda la capacidad de libertad y autonomía de la femineidades." (Paula, Argentina)	One accompanier, for example, described the experience of accompanying as "having become part of feminism, getting to know popular feminism" (Paula, Argentina) Accompaniment, for Paula, was rooted in an understanding of the vulnerable, particularly those at risk of dying of an unsafe abortion, " … of being able to sit down and discuss with fellow women from the neighborhoods, where the most vulnerabilities exist, and whom are the first to run the risk of dying as a result of a clandestine abortion or of being forced into obligated motherhood, where the churches have destroyed any chance of freedom and autonomy for women." (Paula, Argentina)
2	"Siempre pienso como el acompañamiento es una de las estrategias que tenemos para luchar por ejercer nuestros derechos digamos. Entonces, para mí es como un poquito de ampliar el acceso a ese derecho de la manera más segura, de la manera más cuidada y de la mejor manera posible, es acompañando." (Juliana, Argentina)	"I always think that accompaniment is one of the strategies we have in our fight for our rights, let's say. So, for me, it is like the safest way, the most cared for way and the best possible way to improve access to that right, is through accompaniment." (Juliana, Argentina)
Screening for in-person accompaniment		
3	An accompanier explained why it is important to have an ultrasound, "tienen que tener un eco para saber la ubicación de la placenta y saber que no haya peligro que tenga placenta previa que puede generar una hemorragia durante el expulsivo que eso sí es peligroso" (Vanessa, Ecuador).	An accompanier explained why it is important to have an ultrasound, "they have to have an ultrasound to know the location of the placenta and to know there is no risk of having a placenta previa which may cause bleeding during the expulsion because that is really dangerous" (Vanessa, Ecuador).
4	"Yo trato de informar mucho a la mujer sobre lo que va a suceder … me gusta hablarles mucho del tema emocional, de que si ella está segura de este procedimiento va a ser mucho más fácil. Nosotras apoyamos la decisión de la mujer sea cual sea, pero nos hacemos cargo solo en el caso de que ella decida abortar." (Johana, Chile)	"I try to inform women a lot about what is going to happen … I like to talk to them a lot about the emotional aspect, that if she is sure about the process then it will be much easier for her. We support the woman's decision no matter what she chooses, but we only take part in it if she decides to abort." (Johana, Chile)

Preparation for the in-person accompaniment		
5	For instance, one accompanier in Argentina emphasized that the space was not simply functional but, in contrast to clinical settings, it also needed facilitate an ambiance of harmony and comfort, "Que el clima sea de armonía, que si hay una música que sea una música baja, que haya la mayor penumbra posible, de respetar los momentos de silencio y de descanso de esa otra" (Paula, Argentina)	For instance, one accompanier in Argentina emphasized that the space was not simply functional but, in contrast to clinical settings, it also needed facilitate an ambiance of harmony and comfort, "that there is an atmosphere of harmony, if there is music that it be quiet music, that the lights can be dimmed, to respect the moments of silence and the moments of rest for that person" (Paula, Argentina).
Day of in-person accompaniment		
Arriving at the site		
6	The in-person accompaniments (outlined in Figure 2) usually began in the morning to ensure that both the accompanied person aborting and the accompaniers were well rested and able to put all of their energy into the process, "tenemos que empezar a la mañana, porque la mujer tiene que haber descansado … que ella haya dormido muchas horas y nosotras también" (Claudia, Argentina).	The in-person accompaniments (outlined in Figure 2) usually began in the morning to ensure that both the accompanied person aborting and the accompaniers were well rested and able to put all of their energy into the process, "we have to begin in the morning because the woman has to have rested … . to ensure that she has slept many hours and so have we" (Claudia, Argentina).
7	As one accompanier described it, "tomamos desayuno, si es que ellas no han tomado, tomamos todas juntas, así conversamos un poquito, vemos cómo se sienten, hablamos un poco de ellas, y ahí ya partimos con la dosis" (Johana, Chile).	As one accompanier described it, "we have breakfast, if they have not had it yet, we have it all together, that way we talk a little, we see how they are feeling, we talk a bit about them and then we start with the dose" (Johana, Chile).
Passing time, monitoring symptoms and managing pain		
8	After taking the first dose of misoprostol, there were generally a few hours of wait time. Accompaniers took advantage of this time to further build a personal connection with the accompanied person and empower them as the protagonists of their own abortions by sharing personal stories and experiences of other people's abortions, "buscamos empatizar con ellas, decirles la verdad, hablarles de nosotras como mujeres, contarles lo que nos pasó a nosotras, lo que les ha pasado a otras mujeres, decirles, recordarles en el fondo que las mujeres hemos parido y hemos abortado en la casa durante toda la historia de la humanidad" (Valentina, Chile).	After taking the first dose of misoprostol, there were generally a few hours of wait time. Accompaniers took advantage of this time to further build a personal connection with the accompanied person and empower them as the protagonists of their own abortions by sharing personal stories and experiences of other people's abortions, "we try to empathize with them, to tell them the truth, to talk to them about us as women, to tell them what has happened to us, what has happened to other women, to tell them, to remind them that women have given birth and have aborted at home throughout the entire history of humanity" (Valentina, Chile).
9	Accompaniers catered to their needs and desires, as one accompanier described, "a ver si tiene ganas más de charlar, si tiene ganas de que la escuches, si tiene ganas de ver la tele o no tiene ganas de nada, de leer e irse a la pieza con el celular" (Andrea, Argentina).	Accompaniers catered to their needs and desires, as one accompanier described, "we see if she feels like chatting, if she just feels liked being listened to, if she feels like watching TV or feels like doing nothing, or reading or just going to into a room with her cell phone" (Andrea, Argentina).

10	"En todo ese proceso que siempre en general siempre hay muchas molestias, siempre hay mucho dolor […] Entonces solemos generar bolsitas de agua caliente, masajes detrás de la espalda […] tranquila con voz muy suavecita como darle contención, pero a su vez tampoco generarle mucha ansiedad a ella: "ya va a pasar". Como eso, generar sobre todo un ambiente tranquilo y cálido para las mujeres y que si hay un momento de tensión lo llevemos adelante y que ella pueda relajarse y pueda volver a concentrarse en ella." (Mónica, Argentina)	"During all that process in which there is always, generally always, great discomfort, there is always a lot of pain […] So we usually prepare hot water bottles, give them back massages […] calmly and with a very soft voice so that she feels supported, but at the same time, trying not to make her anxious, "you will get through this." Like that, mainly to create a relaxed and warm atmosphere for the women, and if there is a moment of tension, she knows we will get through it and she can just relax and focus on herself again." (Mónica, Argentina)
11	As one explained, "el masaje en la parte de la espalda baja, y también como al inicio del coxis con aceites de ruda, por ejemplo, aceites así … que puedan calentar el cuerpo, pero creo que el que más hemos usado es como masajes en los pies" (Paola, Ecuador)	As one explained, "a massage to the lower back, and also like at the beginning of the coccyx with Rue oil, for instance, oils like that … that can warm up the body, but I think the technique we have used the most is, like, foot massages" (Paola, Ecuador).
12	"Cuando ya están con mucho dolor empezamos a probar técnicas, si el guatero ya no funciona, empezamos a hacer ejercicio, masajes en la cola, en la espalda, o en la cara, como para relajar si es que están muy nerviosas. Hacemos terapia como de respirar y que ella vaya sintiendo su cuerpo." (Johana, Chile)	"When they are already feeling a lot of pain we start trying some techniques, if the hot water bottle no longer works, we begin to do exercises, to give low back massages, face massages, so as to relax them if they are really nervous. We do like a breathing therapy so that she can begin to connect with her body." (Johana, Chile)
The expulsion		
13	"Una ya se va dando cuenta de cuánto va a faltar para el momento de la expulsión. Me parece que se les nota en la cara, se les nota en el cuerpo, en los síntomas, te describen el dolor y vos te vas dando cuenta que el dolor va encaminado o no hacia la expulsión también" (Juliana, Argentina).	"You start to learn how much longer it will take for the expulsion to happen. I think you can see it in their faces, you can see it in their bodies, in the symptoms, they describe the pain they are feeling and you start noticing that the pain is increasing, or not, leading up to expulsion too." (Juliana, Argentina)
14	"El expulsivo es cuando todo está siendo mucho más fuerte. La mayoría de mujeres que hemos acompañado, sienten un dolor tan fuerte que es como, 'ya no más'. Hay unos gritos de dolor terribles pero lo clave es que en todo ese momento preparatorio, profiláctico y de manejo de dolor las mujeres van entendiendo su cuerpo y lo van conociendo." (Amelia, Ecuador)	"The moment of expulsion is when everything is much stronger. Most women we have accompanied, feel a pain that is so strong that it is like, "no more, please." There are some awful cries of pain, but the key is that during all the moments of preparation, prophylactic and pain management the women get to understand their body and get to know it." (Amelia, Ecuador)
15	"Yo digo que en el baño parece como si hubiera como un mundo aparte. Todo alrededor no importa nada más … es como en ese momento la mujer y la socorrista que está ahí apretándole la mano, diciéndole que todo va a salir bien, o acariciándole la espalda digo, como. Es eso, es como ellas dos solas en el mundo sin nadie más alrededor." (Verónica, Argentina)	"I say that there seems to be a world of its own in the bathroom. Nothing around us matters any more … it's like at that moment the woman and the accompanier, who is holding her hand, telling her that everything will be okay, or rubbing her back, it's like, I mean. It's that, it's like they are the only two people in the world without anyone else around." (Verónica, Argentina)

Hours, days and months post-abortion		
16	After expelling the products of conception, accompaniers described their observation that relief and gratitude washed over people, "Yo veo que las mujeres tienen alivio porque ya termina todo este proceso de dolor, se dan cuenta que no pasó nada más, se alivian todos sus miedos" (Vanessa, Ecuador). She continued, noting that people typically recognized the key role that accompaniers played in enabling them to complete their abortion, "Ese momento cuando ya todo salió bien muchas nos abrazan y agradecen, sobre todo. Esa parte es súper gratificante" (Vanessa, Ecuador).	After expelling the products of conception, accompaniers described their observation that relief and gratitude washed over people, "I see that women are relieved because this whole painful process is over, they realized that nothing bad happened, all their fears are relieved" (Vanessa, Ecuador). She continued, noting that people typically recognized the key role that accompaniers played in enabling them to complete their abortion, "At that moment when everything turned out fine, many of them hug us and, above all, they thank us. That part is extremely gratifying" (Vanessa, Ecuador).
17	Another accompanier described a similar overwhelming feeling of gratitude and relief after the abortion is complete, "Hay un montón de gratitud de parte de las mujeres, en el momento en que ya terminó todo, es como la cara se nos transforma a todas, se respira otro aire, abrimos las ventanas, comemos algo y ese momento también, es como una enorme devolución a todas las horas previas." (Juliana, Argentina)	Another accompanier described a similar overwhelming feeling of gratitude and relief after the abortion is complete, "There is a lot of gratitude from the women, at the moment when everything is over, it is like all of our faces change, we breathe a different air, we open the windows, we eat something, and at that moment also, is like a huge return on all those previous hours." (Juliana, Argentina).
19	"Si las chicas se quieren dar una ducha como que se den una ducha, siempre hay comida preparada para cuando ellas ya están con deseos de comer. Les recomendamos siempre como que se queden recostadas por lo menos una hora antes de su casa, si es que se quieren ir a sus casas inmediatamente. Y cuando ya ellas se sienten en condiciones de poder levantarse, caminar, ponerse su ropa y regresar a sus lugares, también nosotras las acompañamos hasta cuando ellas se van, hasta el colectivo, hasta la micro si es que hay que acompañarlas." (Ailén, Chile)	"If the girls want to take a shower they can take a shower, there is always food ready for when they feel like eating. We always recommend that they lay down for at least an hour before going home, if they are wanting to go home right away. And when they feel ready to get up, to walk, to put on their clothes and go back home, we also accompany them until they leave, to the bus stop, to take the minibus, if there is any need for us to accompany them." (Ailén, Chile)
20	During the hours and days after the abortion, accompaniers continued to monitor for warning signs for possible adverse events, "vamos tratando de recaudar información respecto como a su salud, por ejemplo síntomas que ellas vayan teniendo, para que evitemos infecciones, o podamos detectar hemorragias" (Antonela, Chile).	During the hours and days after the abortion, accompaniers continued to monitor for warning signs for possible adverse events, "we try to collect information about their health, for instance, symptoms that they might be having, so that we avoid infections or we can detect hemorrhages" (Antonela, Chile).
21	People expressed a range of interest in ongoing communication with their accompaniers: "Hay mujeres que terminan el proceso y quieren cerrar una puerta y no quieren volver a hablar del asunto. Y hay otras mujeres que pasa un mes, dos meses y siguen llamándonos" (Valentina, Chile).	People expressed a range of interest in ongoing communication with their accompaniers: "There are some women who finish the process and they want to close the door and they never want talk about it again. And there are others who after a month, two months, they keep calling us" (Valentina, Chile).

22	Another accompanier described this, "a veces se generan vínculos súper grandes, entonces te están escribiendo, te mandan saludos por navidad o por año nuevo" (Marta, Ecuador)	Another accompanier described this, "sometimes a great relationship is formed, so they keep writing to you, they send you Christmas or New Year's greetings" (Marta, Ecuador).
23	"[…] hay algo de la cosa ahí efímera e íntima que se construye ahí … que es eso, no tiene como otra definición. No es una confianza, una amistad, es una cosa de saber que están las acompañantes y de ellas sí de entregarse, pero a la vez hay una entrega de las acompañantes también ahí, hay un punto de vulneración de las dos ahí. Porque ella está muy vulnerable, ofreciéndote todo porque ya no sabe más qué hacer, y a la vez una ahí está también como vulnerable de 'bueno, sólo te puedo sostener, como en la escucha y en la mirada y sosteniéndote la mano, no puedo hacer otra cosa.'" (Andrea, Argentina)	"[…] there is something a bit ephemeral and intimate that is created there … it is just that, there is no other definition. It's not a trust, a friendship, it's knowing that the accompaniers are there and that the woman can give herself over, but at the same time the accompaniers give themselves over to her too, there is like a moment of vulnerability for both of them there. Because she is very vulnerable, offering you everything because she does not know what else to do, and at the same time you are also vulnerable, like 'well, I can only hold you, like, in the way I listen to you and look at you and hold your hand, there is nothing else I can do.'" (Andrea, Argentina)
24	"No solamente la presencia de las socorristas que tienen información o más información sobre un proceso de aborto en el mismo lugar que esa mujer que está abortando, sino todo lo que ocurre alrededor, cómo generar un espacio de cuidado y de confianza, eso para mí es fundamental." (Paula, Argentina)	"Not only the presence of the accompaniers that have information, or more information, about an abortion process in the same place where the woman is having the abortion, but also everything that is happening around that, like creating a caring and trusting environment, for me, that is essential." (Paula, Argentina)
25	"Yo siento que lo que yo trato de estimular siempre es la valentía, como: 'lo estás haciendo muy bien, eres seca, tienes mucha fuerza, vas bien, respira, lo estás haciendo bacán.' Como alentando al final como siendo una porrista del aborto ahí en el baño tratando de subirle un poco la moral a la chica y bajar la ansiedad obviamente y el miedo, como decirle: 'Amiga lo estás haciendo bacán. Conéctate contigo y sigue haciéndolo tal como lo estabas haciendo.'" (Celeste, Chile)	"I feel that what I always try to boost is courage, like, 'you are doing great, you are tough, you are strong, you are doing well, breath, you are doing excellent.' Like encouraging her at the end, like being an abortion cheerleader there in the bathroom, trying to improve the girl's morale and reduce the anxiety and obviously the fear, like saying: 'Darling, you are doing excellent. Connect with yourself and keep on doing it like you've been doing.'" (Celeste, Chile)
26	"El sistema de salud público que tenemos es un garrón y que para todas las clases populares nos resulta un problema tener que recurrir al servicio de salud, y entonces, y sobre todo si estas clases populares son mujeres, peor, o travas, o lesbianas." (Paula, Argentina)	"The public health system we have is awful and for all working class people it is a problem to have to resort to these health services, and then, and even more so for if the people from the working class are women, or even worse if they are transvestites or lesbians." (Paula, Argentina)

28	"Como qué hacer cuando lloran, o sea, todas esas emociones que ellas sienten, saber que son legítimas y escuchar, es como mucho escuchar el acompañamiento, mucho, mucho, entonces como … atentamente, y saber, y reaccionar en base a eso también, ¿no? Pero, sí, o sea tampoco desde, así como … 'Ay, pobrecita,' sino como … Escuchar a tu par, que, claro, ella es la que va a abortar, tú le estás dando la información pero ahora ella también tiene la información, entonces tú lo que estás haciendo es medio guiando y resolviendo dudas si es que las tiene y acompañando" (Angie, Ecuador).	"Like what to do when they cry, that is, all those emotions they feel, knowing that they are legitimate and listening, accompanying is a lot of listening, a lot, a lot, so like … paying attention, and knowing, and reacting based on that too, right? But, yes, it's also not coming from a place of like, 'Oh, poor you,' but rather … listening to your peer, that, of course, she is the one who is going to abort, you are giving her information but now she also has that information, which means that all you are doing is guiding and answering questions, if she has any, and accompanying." (Angie, Ecuador)

Résumé

En Argentine, au Chili et en Équateur, l'avortement à un stade avancé de la grossesse est limité par la loi. Dans ces contextes, les groupes féministes aident les femmes avec un avortement médicamenteux autogéré en dehors du système de soins de santé. Le modèle d'accompagnement personnel de l'avortement représente une occasion d'examiner une pratique d'auto-prise en charge qui remet en question et réinvente les conditions de l'avortement. Nous avons mis en place une collaboration fondée sur un engagement de partage du pouvoir et de la prise de décision entre des chercheurs et des partenaires. Nous avons mené 28 entretiens auprès d'informateurs clés avec des accompagnantes en Argentine, au Chili et en Équateur en 2019 sur leur modèle d'accompagnement personnel de l'avortement à un stade avancé de la grossesse. Nous avons codé les transcriptions de manière itérative à l'aide d'une approche d'analyse thématique. Les accompagnantes basaient leur action sur un cadre de travail de militantisme féministe qui conçoit l'accompagnement comme une façon de corriger les inégalités et d'élargir les droits, spécialement pour les populations historiquement marginalisées. Par une description détaillée du processus d'accompagnement personnel, nous montrons que le modèle, y compris les considérations logistiques et les mécanismes de sécurité mis en place pour garantir une issue favorable de l'avortement, insiste sur les soins physiques et affectifs de soutien prodigués de pair à pair à la personne accompagnée. Ce modèle représente ainsi une auto-prise en charge assistée qui place les femmes au centre comme protagonistes de

Resumen

En Argentina, Chile y Ecuador, el aborto a una edad gestacional más avanzada está restringido por la ley. Las colectivas feministas en estos contextos apoyan a las personas por medio del aborto con medicamentos autogestionado fuera del sistema de salud. El modelo de acompañamiento presencial durante el aborto representa una oportunidad para examinar una práctica de autocuidado que cuestiona y reimagina la prestación de servicios de aborto. Formamos una asociación colaborativa bajo el compromiso de compartir el poder y la toma de decisiones con investigadores y socios. En 2019, realizamos 28 entrevistas con informantes clave acompañantes en Argentina, Chile y Ecuador acerca de su modelo de acompañamiento presencial durante el aborto a una edad gestacional más avanzada. Codificamos las transcripciones de manera iterativa utilizando el enfoque de análisis temático. Las acompañantes establecieron su trabajo en un marco de activismo feminista que define el acompañamiento como el abordaje de desigualdades y la ampliación de derechos, especialmente para las personas marginadas históricamente. Con una descripción detallada del proceso de acompañamiento presencial, mostramos que el modelo, que incluye las consideraciones logísticas y los mecanismos de seguridad establecidos para garantizar resultados favorables del aborto, hace hincapié en la prestación de servicios entre pares que brinden atención física y emocional con apoyo a la persona acompañada. Por consiguiente, representa el autocuidado apoyado por medio del cual cada persona desempeña un papel central como protagonista de su propio aborto, a la vez que

leur propre avortement, tout en étant accompagnées par des pairs féministes. Ce modèle d'auto-prise en charge assistée remet en question l'idée que « l'auto-prise en charge » signifie nécessairement une « prise en charge solitaire » ou des soins qui se produisent seuls. Par son orientation sur le transfert de connaissances de pair à pair, sur l'octroi d'un soutien affectif et sur la place centrale de la personne accompagnée, le modèle élargit l'accès à l'avortement, mais représente aussi un type de pratiques axées sur la personne qui pourraient être étendues et imitées dans d'autres contextes.

es acompañada por pares feministas. Este modelo de autocuidado apoyado cuestiona la idea de que el "autocuidado" necesariamente significa cuidado a solas. El enfoque del modelo en la transferencia de conocimientos entre pares, brindando apoyo emocional y poniendo en el centro a la persona acompañada no solo amplía el acceso al aborto, sino que también representa prácticas centradas en cada persona que podrían extenderse y replicarse en diferentes contextos.