“I felt singled out, a bad mother, a bad woman”: Exploring violence in abortion trajectories in Uruguay 10 years after legal reform

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RESUMEN

A pesar de las medidas legislativas progresistas implementadas en Uruguay para salvaguardar la autonomía reproductiva y abordar la violencia obstétrica, persisten importantes vacíos en la comprensión de las experiencias de las personas que acceden a los servicios de aborto tras la reforma legal. Este estudio busca llenar esos vacíos mediante la investigación de las trayectorias de acceso al aborto y la identificación de posibles casos de violencia obstétrica dentro del sistema de salud uruguayo.Utilizando entrevistas cualitativas con informantes clave y una encuesta cuantitativa realizada entre enero y febrero de 2023, la investigación explora las experiencias de las personas en el acceso a los servicios de aborto, incluidas las interacciones con los profesionales médicos, los períodos de espera, las estrategias de manejo del dolor y la difusión de información. Al centrarse en las experiencias de violencia obstétrica durante la atención del aborto, este estudio arroja luz sobre los desafíos actuales en el sistema de salud y destaca la necesidad urgente de transformaciones que protejan los derechos y la dignidad de las personas a lo largo del continuo de atención del aborto en Uruguay. Los hallazgos de este trabajo contribuyen al creciente cuerpo de literatura sobre salud reproductiva en contextos post-reforma, ofreciendo perspectivas que pueden guiar futuros esfuerzos para mejorar la calidad de la atención y garantizar la justicia reproductiva.

PALABRAS CLAVE:

ABORTO, URUGUAY, VIOLENCIA OBSTETRICA, CALIDAD DEL CUIDADO, TRAYECTORIAS DE ACCESO AL ABORTO, DERECHOS SEXUALES Y REPRODUCTIVOS

RESUMO

Apesar das medidas legislativas progressistas implementadas no Uruguai para salvaguardar a autonomia reprodutiva e enfrentar a violência obstétrica, persistem lacunas significativas na compreensão das experiências das pessoas que acessam os serviços de aborto após a reforma legal. Este estudo busca preencher essas lacunas por meio da investigação das trajetórias de acesso ao aborto e da identificação de possíveis casos de violência obstétrica dentro do sistema de saúde uruguaio. Utilizando entrevistas qualitativas com informantes-chave e uma pesquisa quantitativa realizada entre janeiro e fevereiro de 2023, a investigação explora as experiências das pessoas no acesso aos serviços de aborto, incluindo interações com profissionais de saúde, os períodos de espera, as estratégias de manejo da dor e a disseminação de informações. Ao focar nas experiências de violência obstétrica durante o atendimento ao aborto, este estudo lança luz sobre os desafios atuais no sistema de saúde e destaca a necessidade urgente de transformações que protejam os direitos e a dignidade das pessoas ao longo do contínuo de cuidado do aborto no Uruguai. Os resultados deste trabalho contribuem para o crescente corpo de literatura sobre saúde reprodutiva em contextos pós-reforma, oferecendo perspectivas que podem orientar esforços futuros para melhorar a qualidade do atendimento e garantir a justiça reprodutiva.

PALAVRAS-CHAVE:

ABORTO, URUGUAI, VIOLÊNCIA OBSTÉTRICA, QUALIDADE DA ATENÇÃO, TRAJETÓRIAS DE ACESSO AO ABORTO, DIREITOS SEXUAIS E REPRODUTIVOS

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Abstract

Despite progressive legislative measures in Uruguay aimed at safeguarding reproductive autonomy and addressing obstetric violence, significant gaps remain in understanding the lived experiences of individuals accessing abortion services after legal reform. This study addresses these gaps by investigating the trajectories of abortion access and identifying potential instances of obstetric violence within Uruguay's healthcare system. Through qualitative interviews with key informants and a quantitative survey conducted between January and February 2023, the research examines individuals' interactions with medical professionals, waiting periods, pain management strategies, and the availability of information. By focusing on people's experiences of obstetric violence during abortion care, this study illuminates the ongoing challenges within the healthcare system and the urgent need for transformation to protect the rights and dignity of individuals throughout the abortion care continuum in Uruguay. The findings contribute to the growing body of literature on reproductive health in post-reform contexts and offer insights that can inform future efforts to improve the quality of care and ensure reproductive justice.

I. Introduction

In 2012, Uruguay made headlines by enacting one of the most progressive abortion laws in the region (Uruguay, 2012). From 2013—the first full year of the law's implementation—until December 2021, 85,228 abortions were performed in Uruguay within the institutional health system, according to records from the Ministry of Public Health (MSP). The average is around 9,400 abortions per year, placing Uruguay among the nations with the lowest annual abortion rates in Latin America and the Caribbean (Demirdjian, 2022). This rate aligns Uruguay within the average range observed among European countries (United Nations Population Fund, 2023).

The country's progressive stance on reproductive health is further reflected in its comprehensive legal framework addressing various aspects of reproductive health and gender-based violence. Since 2001, Uruguay has had a Law on Accompaniment during Childbirth (Uruguay, 2001). In 2008, the Law on Sexual and Reproductive Health (Uruguay, 2008) was enacted, defining the right to humanized childbirth. Further progress was made in 2012 and 2013 with the passage of the laws on Voluntary Interruption of Pregnancy (Uruguay, 2012) and Assisted Human Reproduction (Uruguay, 2013), respectively.

The remarkable progress in legal safeguards for sexual and reproductive rights is exemplified by Law 19.580, which comprehensively addresses obstetric violence (Uruguay, 2017). This legislation defines obstetric violence as any conduct, whether an action, omission, or pattern of behavior, exhibited by healthcare professionals during reproductive processes, which infringes upon a woman's autonomy to freely determine decisions regarding her body or involves the misuse of invasive techniques and procedures. Law 19.580 extends its protection beyond explicit forms of violence, acknowledging that it can manifest in various dimensions such as institutional, physical, emotional, and financial. Additionally, the law upholds individuals' entitlement to respect and protection of their sexual and reproductive rights, including the full exercise of rights enshrined in the laws governing sexual and reproductive rights and abortion discussed above.

Furthermore, Law 19.580 extends its protection beyond explicit forms of violence, acknowledging that it can manifest in various dimensions such as institutional, physical, emotional, and financial. This broad understanding underscores the law's commitment to safeguarding individuals' rights and dignity throughout the reproductive journey. Additionally, the law upholds individuals' entitlement to respect and protection of their sexual and reproductive rights, including the full exercise of rights enshrined in the laws governing Sexual and Reproductive Health (Uruguay, 2008) and Voluntary Interruption of Pregnancy (Uruguay, 2012).

While the enactment of a robust legal framework on sexual and reproductive rights represents a significant milestone, understanding their implementation and people's trajectories to care is equally vital. Despite the commendable steps forward, there exists a scarcity of comprehensive data on the laws' implementation and individuals' experiences within this context.

The most recent data collected in the National Survey on Prevalence of Gender-Based Violence included a question related to violence during the abortion access process (Instituto Nacional de Estadística, 2019). The survey examined different experiences such as being pressured to continue the pregnancy, making the person feel guilty, having received offensive or disqualifying

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comments, receiving insinuations about her ability to make decisions, threats of not respecting the confidentiality of the consultation, and others. The results show that 54.4% of women aged 15 or over who decided to undergo an abortion process after passing the law state that they have experienced some of the abovementioned violent situations during this process. A more recent study about obstetric violence done by the National Observatory on Gender and Sexual and Reproductive Health found that 53% of the people who participated in the survey were forced to look at ultrasounds, 25% were made to listen to them, and 11% received derogatory comments from medical professionals during the exam (Mujer y Salud en Uruguay, 2022). Additionally, research from the field shows how health professionals generally display paternalistic, disciplinary, or condemnatory attitudes toward women seeking abortion services (Labandera et al, 2016). Some even publicly declare their desire to show sonograms or speak to their patients about the "right to life" (Muñoz, 2018). Yet there is a dearth of disaggregated data on abortion and in particular on people's trajectories to access care and their experiences in the process.

Obstetric violence has been recognized as a form of gender and racial violence (Cohen, 2015; Davis, 2018) that women and birthing people in the context of their sexual and (non) reproductive trajectories. The term is used to describe practices of "structural modes of violence" that reflect the "deeper patterns of inequality" (Zacher, 2015). It encompasses a wide range of abusive and disrespectful behaviors, such as verbal abuse, physical abuse, forced interventions, neglect, and humiliation, that occur in the context of reproductive and non-reproductive care. As described in the current laws on obstetric violence, this kind of action leads to the pathologization of pregnant people's bodies, the medicalization of their reproductive processes, and dehumanizing treatment that is detrimental to their integrity (Bellón, 2015).

Of all forms of gendered violence, this form of violence remains one of the most underexplored and invisible iterations. It was, for a long time, a problem with no name where a socio-structural "edifice of ignorance"—borrowing the words of Code—was built around the very fact and ubiquity of this form of violence (Code, 2009). This form of violence operates subtly, veiled within societal norms surrounding sexuality and reproduction, whether it be in the context of (non) reproductive decisions, the perceived best interests of patients or infants, or justified under the guise of medical and professional expertise. Often, it is perceived as inherently well-intentioned and therefore not recognized as "violence" (Chadwick, 2023).

Despite the prevalent understanding of obstetric violence as a pervasive infringement upon women's rights during pregnancy and childbirth, it is imperative to acknowledge its presence within other realms of women's (non) reproductive experiences, notably during abortion care. Authors have documented and analyzed different manifestations of this phenomenon like the rate of c-sections (Cóppola, 2015; Colomar et al, 2022)[1] and violence during birth (Magnone, 2011, 2017), together with efforts to highlight the institutional or system nature of this matter—rather than (only) interpersonal or attitudinal (Farías y Magnone, 2022). While extensive research has shed light on obstetric violence within the contexts of pregnancy and childbirth, scant attention has been paid to the experiences of mistreatment and dehumanization encountered during abortion access processes, with only a handful of studies documenting such occurrences (Tobasía et al, 2019). Larrea, Assis, and Mendoza (2021) studied testimonials of individuals who had experienced abortion-related obstetric violence in Brazil, Ecuador, and Chile and Araújo Moreira et al (2023) explored obstetric violence in the abortion process in Brazil.

This aspect warrants closer examination, particularly given the substantial social stigma surrounding abortion (Berro, 2019). The importance of an intersectional perspective is underscored, echoing the insights of Farías (2014), as it acknowledges that pregnancies and reproductive choices are intricately interwoven with an individual's socio-historical, cultural, and racial context.

Employing a combination of qualitative and quantitative methodologies, this research draws upon data collected through interviews with key informants and a survey administered between January and February 2023. The study examines individuals' experiences as they navigate the trajectory to access abortion services. This encompassing exploration includes interactions with medical professionals, waiting periods, access to information, and other relevant dimensions.

This study aims to fill a significant gap in the existing literature by examining the trajectories of access to abortion services for women and people with gestational capacity in Uruguay. Specifically, our objective is to analyze the obstetric violence experienced in people's trajectories

[1] The international healthcare community considers the ideal rate for caesarean sections to be between 10% and 15%. However, in Uruguay, the overall caesarean section rate exceeds 45%.

to care. Through this analysis, we aim to contribute to a deeper understanding of the challenges faced by individuals seeking reproductive autonomy in Uruguay, with the hope of inspiring actions that prioritize the well-being and rights of all individuals involved in the abortion care continuum.

II. Methods

Our methodology is rooted in feminist principles aimed at rendering visible the dynamics of power—be they structural, relational, or manifest—while prioritizing the narratives and perspectives of women (Nandagiri, 2017). Doing feminist research on abortion necessitates a critical interrogation of what is considered 'normal' or 'invisible', thereby re-conceptualizing experiences traditionally marginalized as mere 'side effects' of womanhood as human rights violations. Indeed, as Tickner (2005) observes, the hallmark of feminist research lies in its distinctive methodological perspective, one that fundamentally challenges the pervasive yet often unnoticed dynamics of power[2]. For that reason, we use in this study the term obstetric violence. In this sense, we follow Chadwick's (2016) analysis of how choosing the term "obstetric violence" over more neutral labels such as "mistreatment" is "part of a deliberate move to confront problematic practices, which have often been hidden, invisible and unacknowledged, as forms of violence" (Chadwick, 2016, pp 423).

Primary data were collected through semi-structured interviews with key informants and an online survey. We conducted interviews with seven key informants purposively sampled from known organizations and collectives working on abortion; all respondents were over the age of 18 and no gender conditions were placed on project participation.

All of the interviews were conducted in Spanish between March and May 2022, involved two interviewers, and were guided by a question guide developed by the authors. All interviews were conducted over Zoom. Both Principal Investigators were involved in each interview to facilitate a conversation-like encounter with each interviewee.

The interviews provided valuable information that was used to design an online questionnaire survey. We fielded an anonymous online survey that was open from 1 February to 15 de March 2023. The survey was designed to be answered by people who accessed or tried to access an abortion in formal healthcare since Nov 2012 and were able to give informed consent. We only included completed responses in the analysis.

Ethics review was completed at the Human Research Ethics Committee of the Faculty of Psychology of the University of the Republic (Uruguay). Translations were done by the research team using deepl.com and originals can be made available upon request.

III. Results

In this section, we will present the findings of the survey both quantitative and qualitative. The study design aimed to minimize the number of qualitative questions in the survey to streamline data collection and analysis. However, despite the limited number of open-ended questions, respondents often provided extensive and detailed responses. While some of the answers go well beyond the questions asked, the responses in the open-ended qualitative questions provide a unique opportunity to highlight the different forms of violence that might not be adequately captured by the quantitative questions in the survey.

III.i. Limitations

It is important to note several limitations of this study. First, owing to the selection of non-probability sampling, our sample may not be representative of the broader population (Lefever et al, 2007). However, our online recruitment approach granted us access to a diverse spectrum of individuals hailing from every province of the country (departamento) in Uruguay and spanning various age groups.

Second, another limitation of this study is the possibility of selection bias within the final sample. It's plausible that participants who willingly engage in internet-based research might differ systematically from those who abstain. However, existing research suggests that internet-driven recruitment methods do not inherently introduce more bias than conventional approaches and do not automatically yield biased associations (Upadhyay et al, 2022).

[2] As explained by Bartlett (2018, pp 837) "In law, asking the woman question means examining how the law fails to take into account the experiences and values that seem more typical of women".

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Thirdly, since all survey respondents are, prima facie, eligible for accessing abortion services in Uruguay, our study did not capture information about individuals who may not be eligible (because of citizenship/residency reasons).

III.ii. Demographic information

In total, 258 responders from all departamentos provided their consent to participate and responded to the survey. Respondents ranged in age from 18-66 years old.

99.2% identify themselves as women (n=256), one person identifies as non-binary and one as "other". 81% of the survey respondents declared having a tertiary level or higher degree (university, non-university tertiary, and postgraduate). 82% identify as heterosexual, 15.5% as bisexual, 0.4% as gay or lesbian, and 2.3% other. In terms of marital status, 37% reported to be single, 37% to live in a couple, 17% in a non-cohabiting couple, and the remaining 7% were married.

We had at least one response from all departments, 58% Montevideo, 14% Canelones, 5% Maldonado, and the rest divided among the rest of the departments. 87% reported living in an urban area, 10% suburban and 2% rural area.

99% of survey respondents identified themselves as Uruguayan citizens, while 1% reported being legal residents. Notably, none fell into the category of residents with less than one year of residence in the country, a requirement for accessing the service. In essence, those who participated in the survey are generally eligible to access abortion services in Uruguay.

67% of respondents accessed their abortions through the private sector (mutualista), while 29% utilized the State Health Services Administration (ASSE) as their provider. The remaining 3% selected "Other" in response.

84.5% of the respondents reported having undergone one abortion, while 13.6% indicated they had experienced two abortions. Additionally, 2% of respondents stated they had undergone three abortions, representing the highest number of abortions reported among our participants.

III.iv. Knowledge of the law and the abortion process

When asked about their familiarity with the law, 98.5% responded affirmatively. However, regarding knowledge of the specific procedures outlined in the law, 41.5% acknowledged awareness, 31.5% stated they were unaware, and 27% provided a response indicating uncertainty.

In terms of how our respondents gained knowledge of the law and the process to access abortion services, 26% of respondents indicated that it was through the healthcare system, 28% through the education system, 43% through friends, 15% through family, 38% through social media, and 47% through traditional media outlets.

When asked whether they had connected with any networks, NGOs, or collectives to obtain information or support in accessing the service, 91% responded negatively, while 9% answered affirmatively. Among the organizations mentioned were Las Lilas (4 people), Mujer y Salud en Uruguay (2), telephone services of ASSE (4), friends (2), and Mujeres en el Horno (7).

III.iv. Experiences in the abortion processes

We asked our respondents how long it took them to attend the first consultation (time elapsed between requesting the appointment, scheduling it, and attending the consultation). 27,5% did the process in less than 24 hours, 38,4% in less than 72 hours, 27,1% in less than a week, and for the remaining respondents (7%), it took them longer than 15 days to have the first consultation.

When asked about the quality of the care provided in this first consultation, 24.4% responded it was poor and very poor, 29.5% fair and 46.1%. answered good and very good.

99,7% continued the process after this first consultation and 3% didn't. Of that 3%, 1 answered that it was a personal decision, and 1% that they were not within the limits of the law [more than 12 weeks pregnant].

The Uruguayan law grants the pregnant person the option to involve the other 'progenitor' in the abortion process (Art. 4, lt. b). 54% of our respondents chose to involve the other parent, while 47% opted not to. In the survey, we asked respondents to briefly explain how this decision-making process unfolded, and we received 195 qualitative responses. In addition to detailing

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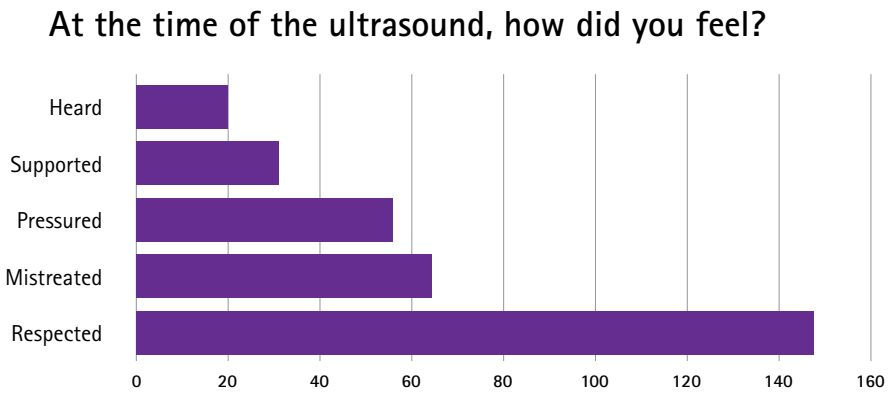
their decisions regarding the involvement of the other parent, our respondents provided extensive narratives about their experiences. These responses provide important insights into the trajectories and will be discussed below in Section III.v.

When asked about the quality of the care provided during the ultrasound, 30.3% responded it was poor and very poor, 25,6% fair and 44,2%. answered good and very good

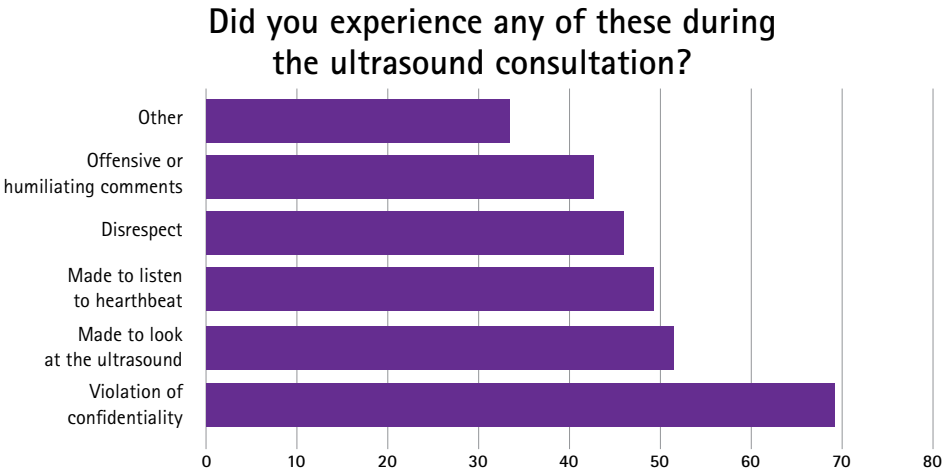
Figure 1 - Feelings at the time of the ultrasound



Graphic produced by the research team based on the study results.

We asked about the time elapsed between the first consultation and the ultrasound and the answers varied. 12,6% answered that it only took them one day to get the ultrasound, 10% two days, 16,4% three days, 14% four days, 6,8% six days while 16,8% waited for a week and 23,2% more than a week.

Figure 2 - Experiences during ultrasound consultation



Graphic produced by the research team based on the study results.a

Based on a total of 258 reported cases, the data shows that 26.74% of individuals experienced a violation of confidentiality during abortion care. Additionally, 20.54% were made to look at the ultrasound, while 18.60% were made to listen to the heartbeat. Instances of disrespect were reported by 17.83% of the individuals, and 16.67% faced offensive or humiliating comments. Other negative experiences were reported by 12.79% of the respondents. These percentages highlight the prevalence of various negative experiences during the abortion process.

As part of our survey, we provided an answer box for respondents to share additional insights and experiences related to their ultrasound appointments. From this initiative, we garnered a significant response, receiving 89 submissions. As described above these qualitative responses provide important insights on the experiences of people and in this case, they also go well beyond

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what was specifically asked. The next section presents these responses together with the 195 responses described above.

III.v. Experiences in the abortion processes: qualitative responses

Our respondents share a wide range of emotions and reasons for having abortions. While some emphasize that the decision to undergo an abortion was emotionally challenging, with conflicting feelings and uncertainties, others assert that they were resolute and self-assured in their choice.

However, amidst these varied experiences, there appears to be a widespread agreement that the difficulty primarily stemmed from the process surrounding abortion itself. While for the majority of the respondents, the decision to have an abortion might have been clear, the process was marred by negative interactions with healthcare providers. In this regard, they share

> "My decision was clear from the beginning, I did not hesitate much, the process was difficult ... I felt a lot of pain and guilt from the doctors, there was always the feeling of guilt for comments, they told me things like "have it, you are young" "Don't you feel sorry?, babies feel" "You will regret it"."
>
> "It was a joint decision with a quick process but with the worst medical care from the gynecological team."
>
> "It wasn't difficult to decide to have an abortion...What was terrible was how the gynecologist treated me after my miscarriage."

Similarly, other respondents express

> "It was a simple decision...The process was horrible for me".
>
> "Confident decision and process was lengthy"
>
> Other respondents refer to the process as "cumbersome and very painful, both psychologically and physically", "painful, and embarrassing" and "traumatic" and the care received as "very bad and very inhumane". They explain that the process was "horrible, I felt very judged, and they were questioning me all the time".

One of the respondents expressed

> "At the [provider] I felt singled out, a bad mother, a bad woman, everyone made me feel irresponsible and that kind of thing with different comments and actions. At [name of provider] I experienced the worst because the nurse who called me shouted out loud that it was a termination of pregnancy and all the time she treated me badly while I was waiting for the medication and asking me questions. I felt like a criminal".

For many of our respondents, navigating the logistical, financial, and social aspects of obtaining an abortion posed significant hurdles. They speak for example of the barriers posed by conscientious objection:

> "When I consulted my gynecologist at the time, she refused to give me the abortion form because she was an objector, shouted at me and my partner at the time, and referred us."

The barriers posed by conscientious objection mean problems with logistics, having to disclose the abortion to work, and people, increased costs, and delays. For example, one of the respondents explain

> "I live in [city] and I was a member of the [provider], they do not accept it and they have the right of conscience so they make you travel to [different city] to see the doctors there, and then travel to the hospital in [another different city] to get the medication. At that time I was not working and I was affiliated with the [provider] because of my mother, so all the costs I had to pay, I sold some things or borrowed money"

Many respondents shared their experiences with the process of obtaining an abortion, highlighting various challenges and deficiencies they encountered along the way.

> "The process is difficult; the healthcare system has many deficiencies regarding the implementation of IVE and especially in dealing with people."
>
> "I remember that from the moment I had to take blood tests, the nurse started to ask me why I was doing that, that I was young, that I was going to regret it, I was afraid... I feel that there was a lack of support from the medical team and a lack of information at the national level."

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Similar to the experiences recounted above, when asked specifically about the ultrasound respondents offer detailed information on their interactions with the healthcare providers and their experiences and feelings in those interactions. Respondents emphasized the "Lack of empathy. Lack of information" and "Cruelty".

In the questions where we invited open answers, our respondents outlined a series of forms of violence that impacted their trajectories to abortion care. Some of them speak of interpersonal violence and some others of institutional violence. Firstly, many of our respondents recount being victims of psychological violence, which involves the use of verbal and non-verbal communication to inflict harm, control, and diminish a person's self-worth. They describe feeling judged, intimidated and undermined throughout their experiences. One respondent shares a distressing encounter:

> "The process was long and I had a hard time not being able to do the abortion immediately. The social worker asked my partner if I had ever cried because of my decision and the last doctor who did the ultrasound asked me if I wanted to listen to the embryo's heartbeat, both of which seemed very out of place."

Other respondents recount troubling experiences with different health providers:

> "I was seen by a gynecologist—a male gynecologist who actually treated me rather coldly and even subtly questioned why I had become pregnant"

One respondent expressed feeling a profound sense of isolation during their ultrasound experience

> "Although I did not feel that I was mistreated or that there was violence. I felt very lonely, there was absolutely no support at any time during the ultrasound before or after"
>
> "The way the ultrasound doctor treated me was very harsh, and I would have preferred a little more warmth"
>
> "They generated fears during the process, they did not provide me with correct information."

Respondents also report a series of breaches of what the law requires. For example, one of them shares "[t]hey wanted to bring the father into the consultation to hear his opinion." Others report "Inappropriate comments from the nurse such as "Do you want to listen to your baby?" and "They congratulated me [on my pregnancy]". Another respondent explains that the medical professionals made "[c]omments about the length of gestation "11 weeks for an IVE"[3] in a loud voice, in front of other users waiting for their ultrasound scan. Psychological mistreatment and humiliating and prejudiced comments inside the room.".

Incidents of verbal comments and questioning in medical settings can significantly impact individuals seeking abortion services. One individual recounted a particularly distressing experience:

> "The second time they condemned me for being the second time, they questioned my decision (why can't you have it?) etc. etc. It was in the [provider] where I felt violated."

Another individual shared their experience of encountering unsolicited personal opinions from medical staff: "They gave their personal opinion against abortion".

Furthermore, some patients face pressure to reconsider their decisions. One individual described their encounter:

> "The gynecologist, despite my firm decision, insisted that I should reconsider it, the social worker did not say anything, only the psychologist gave me support"

Additionally, incidents of being mocked by medical professionals further illustrate the violence some patients face. Instances of ridicule and insensitivity like the ones described below highlight a profound lack of empathy and understanding from medical professionals. For example, one respondent recounted,

> "I was questioned a lot, one person [doctor's name] from [provider] laughed in my face because I was crying for not having received attention in [city]"

Another individual described an experience with a gynecologist who made a flippant remark

> "When they explained to me what the process would be like. The gynecologist told me "you put the pills in and the party begins". I felt mocked, judged and punished"

Furthermore, feeling judged by healthcare personnel appears as a common and distressing experience among individuals seeking abortion services. One respondent vividly described their interaction with the interdisciplinary team:

> "It was horrible, it felt like a judge... The memory I have of that team deciding whether or not if I could go for an IVE was very painful."

[3] IVE is the acronym for Voluntary Interruption of Pregnancy in Spanish, where it stands for "Interrupción Voluntaria del Embarazo."

Other shares

> "I felt judged by the tone in which she spoke to me and the lack of closeness and warmth in the process."

Accounts of the process include a dismissive attitude towards the patients, sarcasm, and laughter in the interactions:

> "I explained the great pain I was in and the amount of blood that had frightened me, to which she replied 'you had an abortion, mamita, what did you expect? it not to hurt? And then he laughed at me, after checking me in a bad way and I still didn't understand much of what was happening, he asked me when I had been to 'the clinic' to which I asked 'which clinic', and he replied 'the woman's clinic, or on top of that you have it done clandestinely?"

Respondents highlight the negativity and coldness of the health care personnel, tone and manner of communication, and non-verbal cues of disapproval as profoundly impactful interactions. One respondent explains

> "The person who performed the ultrasound was quite negative about my decision and it showed. Despite the fact that I was alone and nervous, he showed coldness in the process and I felt quite guilty."

Others share

> "When the doctor asked me what the ultrasound was for, I told her it was for an IVE and it was a disapproving face and silence."
>
> "0 warmth, I felt judged and ignored, they talked amongst themselves about the fetus as if I wasn't there."
>
> "Also, in the second consultation with IVE, because I was "distressed" they sent me for a consultation with a psychologist. There were 3 consultations. I went to only one. The psychologist was not professional. She insinuated that I should not have an abortion."

The described experiences of condemnation, unsolicited opinions, pressure to reconsider decisions, and mockery fit within the spectrum of obstetric violence.

In Uruguay, the legal framework surrounding abortion mandates that an ultrasound be performed as part of the process. The law does not require healthcare providers to present the ultrasound image to the patient or provide a verbal description that includes details such as the identification of fetal parts, the heartbeat, or the fetus's current development stage (Upadhyay et al, 2017). However, our respondents indicate that doctors and technicians commonly show ultrasound images and provide detailed verbal descriptions.

Many respondents report being forced to watch the ultrasound:

> "They made me watch him move, and it broke my heart."
>
> "I requested the abortion at a gynecologist's appointment where I had an ultrasound scan to confirm the pregnancy and they made me look at the screen."
>
> "When I had the ultrasound scan the person made me look at the screen, then I asked her where I could get advice on abortion and she replied "I am pro-life"."

Others felt pressured to listen to the embryo's cardiac activity:

> "He asked me if I wanted to listen to the heartbeat. I told him he didn't have to ask that, I felt pressured, I said no. Cold and distant attitude."
>
> "The doctor pressured me to see if I wanted to hear the embryo's heartbeat"
>
> The provision of unsolicited information about the embryo further compounds this issue, contravening both legal stipulations and patient preferences. One respondent reported,
>
> "The doctor knowing that it was an IVE started to give me details of the foetus etc in order to create guilt or some kind of impact on the decision. It was horrible"
>
> "The sonographer told me: next time we will make a video for the father and gave me a picture of the embryo"
>
> "The sonographer insisted on giving me unrequested information about the embryo"

Additionally, several respondents have shared their harrowing encounters with physical violence during abortion-related procedures. One respondent writes: "Intravaginal violence with the device". This blunt and alarming statement highlights the physical pain and violence felt during the procedure. In a similar vein, other respondents state

> "[T]he sonographer stood between my thighs in a very unprofessional way while he was penetrating me with the sonographer"

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> "I asked if everything was OK and was told that it didn't matter for what I was doing. He told me very unkindly to take one leg out of my trousers and spread my legs and inserted the ultrasound machine inside without explaining much or being careful."
>
> Other recounts the refusal to provide pain relief during her abortion, highlighting that pain management was neither discussed as an integral component of a medication abortion nor provided when seeking emergency services.
>
> "That same day I put it on [misoprostol] and it started a very painful process in my case and I was frightened by the amount of blood, so when I contacted my doctor he told me to go to the emergency room so that they could give me a painkiller and I could cope better.
>
> From the moment I was admitted I was treated in a cold and arrogant manner, no questions were asked, no painkillers were given, I was simply left on a stretcher and they left"

Moreover, many respondents highlighted instances of institutional violence, where systemic issues within healthcare settings exacerbate the undue burdens and barriers for individuals. Institutional violence refers to the policies, practices, and norms within institutions that perpetuate harm, discrimination, and inequity.

One of the most prevalent issues respondents raise is the matter of time and the undue delays experienced

> "In [provider] they even stretched out the consultations and the psychologist told me you should tell your parents"
>
> "I was sure that I didn't want to continue the pregnancy, I was already 4 weeks pregnant and the pregnancy was confirmed and they forced me to wait until week 10 to give me the pills, it seems to me that they made the process very long when I acted from day one, I did the test and went immediately to the gynecologist they forced me to wait"
>
> "The process was very difficult because I found out I was pregnant for only a few weeks and first they had to rule out that it wasn't just a placenta. I had to have several ultrasounds until they saw the embryo and I was able to abort. The process was long and I had a hard time because I couldn't do the abortion immediately"
>
> "The process was interrupted by the easter holidays. The gynecologist said there was "no rush" as I was only a few weeks pregnant"

As this respondent explains these delays cause further costs and act as burdensome barriers to access. She reflects on how much she had to travel from one city to another and pay for private exams to be able to have timely access.

> "The process was quite fast because I moved around a lot, being in [city] there was no sexual and reproductive health clinic nearby, I had to go to [city] where they came once every 15 days or [city], one of the consultations I did in [city] and the ultrasound to confirm pregnancy I had a private ultrasound near where I live because there were no dates available soon in the clinic."
>
> The need to ameliorate the systemic delays also results in more costs
>
> "In my case, I had the ultrasound done in a private practice because my [provider] did not have an available date."
>
> One respondent also reports being required to pay for services and provide documentation that the law does not require like "[c]harging for the ultrasound scan and requiring FPP and obstetric card"

As it's possible to see also from the quantitative data shared in the section above, breaches of confidentiality within healthcare settings were highlighted by several respondents in our survey. Many of them shared distressing experiences where their confidentiality was compromised:

> "When they were scheduling me for the ultrasound they phoned my mother to tell them that I had coordinated an ultrasound, when I called to ask for explanations the administrator spoke to me very badly and told me that she was not the one doing anything wrong."
>
> "My gynecologist knew my ex-partner's family, so she disseminated information from my medical records without my consent"
>
> "I am a health worker and so is my mother. When the sonographer finished [the ultrasound] he said hello to your mother. I felt exposed"

The use of loud voices, disclosing patients' names, and sharing details of medical procedures in common spaces also appears recurrently in the responses

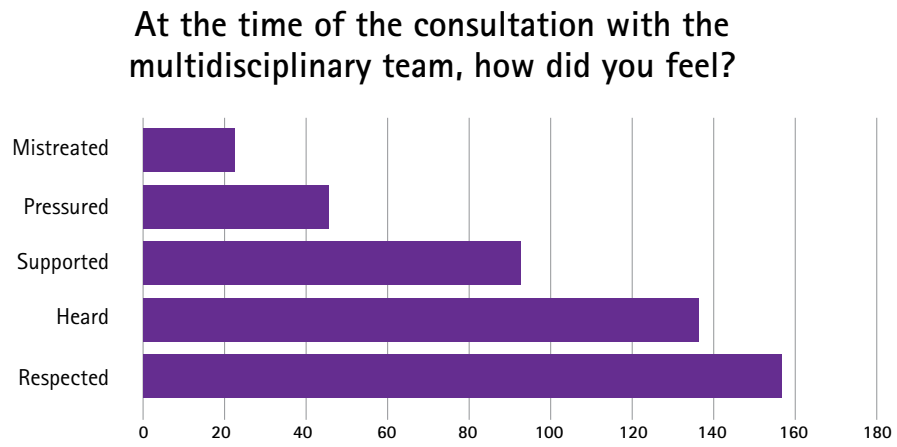
"In the waiting room, they shouted my name and the assistant said in front of everyone "She's coming for IVE".
"The medication was picked up by my mother and they asked her if it was for an abortion. In front of the whole pharmacy."
Another very recurrent matter is the refusal to provide abortion seekers with complete and thorough information about the process
"At home, I suffered because I didn't know what to expect, much had not been explained to me, my husband searched on Google... lack of support and information"
"It was a difficult process. The doctor was not very explicit about what you are going to see at the time of expulsion... I had more information from a friend who had gone through the same thing. The gynecologist was very ironic and violent in the consultations. I made a complaint to the [provider], I don't know what happened with that... he was the head of gynecology at the mutual insurance company"

The quote above also points to the failure to investigate and act on patients' complaints, perpetuating a culture of impunity and silence that denies patients the opportunity to seek redress and ensures that harmful practices continue unchecked. This issue transcends the actions of individual professionals and points to systemic failures in monitoring, evaluation, and responsiveness to patient complaints.

III.vi Mandatory waiting period and experiences with the multidisciplinary team

The majority of 68% of respondents rated the mandated five-day reflection period as unnecessary or entirely unnecessary, while a minority expressed different perspectives or experiences.

Figure 3 - Feelings at the consultation with the multidisciplinary team



Graphic produced by the research team based on the study results.

Our survey asked whether respondents have experienced any of the situations listed. 19% of people said they felt pressure to not continue with the abortion process, 20,9% received offensive comments, 4,5% felt that the team insinuated the respondent wasn't capable of deciding to have an abortion, 3,5% reported being made to feel like their information would be divulged in their communities, 3% reported that their information was shared in violation of confidentiality duties and 6,6% responded that they suffered "other" similar situations.

III.vii. Abortion methods

When asked about methods offered for the procedure, an overwhelming majority (92,6%) answered they were offered medication abortion with self-use of misoprostol at home. 12,4% reported being offered medication abortion with misoprostol use at the facilities of their provider and 5,8% were offered surgical options. None of the respondents was offered manual or electric

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vacuum aspiration as an option to terminate the pregnancy.
In the qualitative responses, there are various accounts of respondents being prescribed medication for abortion various times and offered curettage as an abortion method. One of them, when the abortion was incomplete recounts being offered only several rounds of misoprostol. Another one shares

> "They made me take the pill 3 times"

Many were offered or received curettage

> "It was a long process in which I had to take misoprostol 3 times, each time increasing the dose, the third was the last one before the curettage and it worked."
> "[B]ecause the abortion was not complete, and there were still rests, so I was once again given pills to take home, but the abortion was still not complete, which led to the curettage"

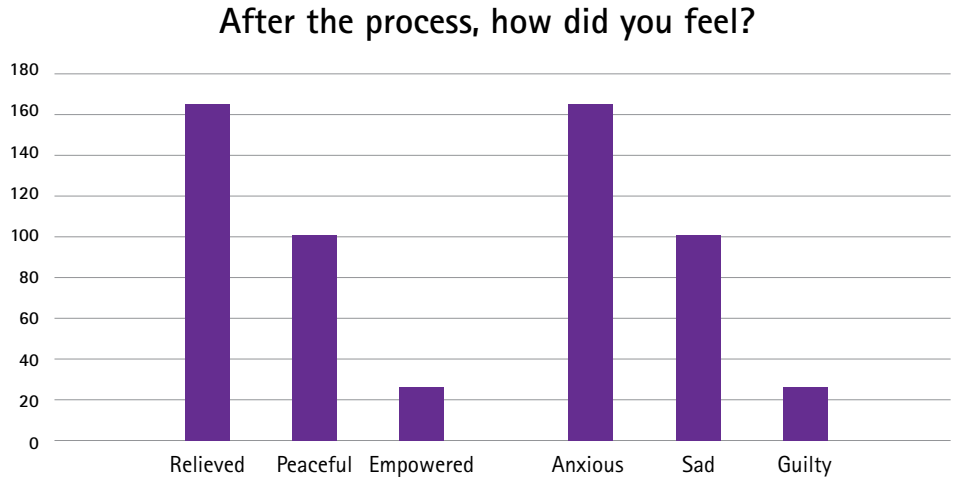
III.viii. Conscientious objection

83% of the respondents did not encounter conscientious objection in their trajectory to care while 17% did. Out of those that were faced with objectors 8% were referred to another professional in the same provider, 5% were referred to another provider institution, 3% had to travel to another departamento and 4% were offered other measures.

III.ix. Abortion at home and post-abortion consult

52% of the respondents sought support from individuals or institutions for the use of medication abortion at home and 48% did not. Out of those who sought support 26% did the process with their partners, 23% did it with friends, 14% with a family member(s) and 5% with the support of a collective or organization, 2,5% sought support from their therapists and 1% did it with the support of a doula.
When asked what they felt during the process, our respondents shared their feelings.

Figure 4 - Feelings after the abortion



Graphic produced by the research team based on the study results.

After the abortion, there is a post-abortion consultation mostly related to contraceptive uptake. 71% attended this consultation, and 39% didn't. People shared different reasons for not attending the consultation, and some of them spoke about the difficult experiences they faced during the process. One of the respondents explained

> "After the meeting with the multidisciplinary group, I had a consultation with the general practitioner who was the person in charge of giving me the pills to perform the IVE at home. The bad treatment I received from this person was very humiliating. I asked her to give me a few days rest at home to be able to do the IVE and I asked her not to tell the doctor the reason (in the first consultation I had I was told that this could be done) to which she replied

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that she was not going to lie for me and that I should take responsibility for what I was doing. If I had made the decision to have an abortion it was my responsibility and not hers to face up to what I was doing. So the "conversation" continued to become more violent as I kept repeating to myself that it was my fault and I had to face the consequences of my actions. I left in tears and distressed as ever… I decided not to go to the last consultation for fear that they would treat me the same way."

On a similar line, another respondent expresses:

"I was never told that such an instance [post-abortion contraceptive consultation] existed, and feeling so violated by the gynecologist on duty when I was admitted, I didn't want to go back."

Another respondent explicitly points to their experience with the process as a deterrent to seeking healthcare, leading to detrimental effects on their health:

"I didn't think it was necessary and no longer wanted another consultation because of the drain I felt. I ended up finding out after a few weeks of an advanced life-threatening infection"

Out of the 71% that attended the IVE 4 consultation, 25% felt forced to take contraception and 3% indicated they felt pressured to sign documents they didn't understand.

III.xi. Experiences with multiple abortions

Twenty-nine individuals responded that this was not their first abortion, and all of them reported being treated differently.

The subsequent interactions described by the respondent highlight a disturbing escalation in the level of violence and discrimination they faced during their abortion experiences. They noted that professionals began to regard them with more contempt, particularly emphasizing their inquiries into the respondent's sexual life, which felt intrusive and judgmental.

"In the following two interruptions, everything became more violent, the professionals looked at me in a more contemptuous way as it was not the first time and they always inquired a lot about my sexual life. In general, these situations occurred in different intensities but in all 3 interruptions"

"The first time the doctor told me that I should have thought about it before I opened my legs…the second time I went to the right place and everything flowed"

"I was scolded, that it couldn't be that I was pregnant again, lots of scolding and mistreatment."

Another respondent recalls that the personnel mentioned their age and the number of previous abortions, implying that their decisions are irresponsible and indicative of a failure to understand the seriousness of the situation.

"I felt that things were not explained to me as they were the first time. Also a lady, I don't remember what role she played, told me that I wasn't even 30 years old and I had already had 2 IVEs, that I should realize that this was not contraception."

Another respondent expressed hesitation in disclosing their previous abortion history out of fear of mistreatment

"As it was in another health service I did not say that it was my second IVE because I was unsure of how I would be treated. The first IVE I had at [provider] I had unpleasant experiences that I didn't want to go through again."

Notably, two respondents reported receiving better treatment and support for abortion care before its legalization compared to after.

"In my first IVE it was illegal but the doctors at [provider] were much nicer and didn't put any pressure on me"

"In my first experience, I only received counseling because it was before 2013. I had to do everything on my own, except for the consultation with the team at the hospital. That attention was very human and warm: I did not feel judged as I did later (and with the law in force) by the medical professional and the psychologist of the clinic of my private health service."

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IV. Discussion

The results of this study allow us to reflect on the violence experienced by women[4] during their trajectories to access abortions. We follow Pickles's proposal (Pickles, 2023) to think in terms of a 'continuum of violence' in reproductive healthcare to ensure different forms of obstetric violence are identified.

In this continuum, we were able to identify various manifestations of obstetric violence that we discuss in this section. But firstly, during our analysis, it became evident that abortion-related obstetric violence is frequently experienced but often normalized by those affected. The quantitative data in our study did not (and could not) capture the normalization of violence. Only when confronted with the responses on the qualitative open answers can the breadth of the violence can be analyzed. Many individuals undergoing the abortion process do not recognize or conceptualize their experiences as forms of violence, even though they may endure significant psychological and emotional distress. This disconnect often stems from the narrow definitions of violence typically used in society, which focus primarily on physical harm or overt abuse. As a result, the subtler, more insidious forms of violence that can occur within medical and institutional settings are frequently overlooked or dismissed. Furthermore, there is a distinct difference in how individuals perceive interpersonal violence compared to institutional violence in the context of abortion. Interpersonal violence, such as physical abuse or emotional coercion, is often more easily recognized and articulated by those affected. This type of violence is direct and personal, making it more visible and identifiable as harmful behavior. Even in these cases, our respondents use expressions like "inappropriate", and "out of place" to explain the nature of the interactions or words like "mistreatment" "traumatic" "painful" and feeling "humiliated" "judged" and "violated".

In contrast, institutional violence is perceived as more abstract and systemic, making it harder for individuals to pinpoint and name. This form of violence manifests in our sample through bureaucratic hurdles, such as delays in obtaining abortion services, a lack of available healthcare professionals, or being forced to travel long distances to access care and the limitation of available methods for termination. However, because this form of violence is embedded in the structures and policies of healthcare systems, it is less likely to be perceived as violence, even though its effects can be just as detrimental—or more.

In this sense, our study aligns with the existing literature that explores the experiences of people seeking abortion reproductive care (Afulani et al, 2019; Vedam et al, 2019) that shows that pregnant people may not recognize that certain actions or behaviors by healthcare providers constitute violence. Pregnant people may lack awareness of what constitutes high-quality care and/or that abortion can (and should) be a dignified and supported experience (Altshuler et al, 2017). As noted by Prandini and Larrea (2022), this normalization is partly due to social environments where structural violence is common, but in the case of abortion, stigma, and restrictive laws play a significant role. In the case of Uruguay, it is clear that these violent practices are informally used to punish those who defy norms surrounding sexuality and reproduction.

Our study reveals a significant disconnect between the decisiveness of individuals seeking abortions and the quality of care they receive. Many respondents reported that their decision to undergo an abortion was clear and resolute, indicating a strong sense of agency and self-assuredness in their choice. However, the process itself was often fraught with negative interactions with healthcare providers. We argue that the harm experienced by our respondents is predominantly rooted in the violence encountered during their journey to access care, and not on the abortion decision itself.

A recurrent theme among respondents was the lack of empathy and support from medical professionals. Instead of receiving compassionate care, many experienced different forms of violence. This exacerbated feelings of guilt and shame, even when the initial decision to have an abortion was made with confidence. Our respondents highlighted that these interactions were not isolated incidents but rather indicative of a broader systemic issue within the healthcare system.

Our findings further highlight the profound emotional and physical toll that abortion-related obstetric violence has on individuals. Many respondents described the process as cumbersome, painful, embarrassing, and traumatic, with the care received often characterized as very bad and inhumane.

[4] We use the word women because as detailed above 99,2% of the people who responded the survey identified as women.

The experience of being stigmatized and labeled as irresponsible or a "bad mother" by healthcare providers was a common theme (Kumar et al, 2009). The stigmatization of abortion appears to be deeply ingrained, with healthcare providers acting as gatekeepers, passing moral judgments on patients. This included unsolicited personal opinions against abortion, mocking remarks, and dismissive attitudes toward patients' pain and concerns.

Furthermore, our study reveals a troubling pattern of violence experienced by respondents during the ultrasound process. 1 in 5 of our respondents felt compelled to watch the ultrasound despite their discomfort, with some expressing significant emotional distress as a result. Similarly, others reported feeling pressured to listen to the embryo's cardiac activity, highlighting a disregard for patient autonomy and personal boundaries. Additionally, respondents recounted instances where healthcare providers went beyond their professional obligations by offering unsolicited and detailed information about the fetus. This included descriptions of fetal development and features, which seemed aimed at eliciting guilt or influencing the patient's decision. As Sanger (2017) puts it, these attitudes attempt to "produce a confrontation" between the pregnant woman and fetus, compelling a woman to recognize the life she would end in abortion and aiming to deter her from that.

The findings from our study also illuminate the deeply troubling reality of physical violence experienced by individuals seeking abortion services. The blunt description of "intravaginal violence with the device" by one respondent exposes the harsh and invasive nature of the procedures, underscoring the profound impact of such violence on individuals' bodies and well-being. The depiction of a sonographer adopting a stance perceived as invasive and unprofessional during the procedure is particularly distressing. Similarly, the failure to inquire about the patient's pain levels or provide pain relief highlights a disregard for the patient's autonomy and bodily integrity, perpetuating a culture of violence and medical paternalism that undermines patients' rights to dignified and respectful care further reinforcing the need for a closer look at people's experiences accessing abortion care.

Many respondents in our study highlighted instances of institutional violence within healthcare settings, where systemic issues exacerbate burdens and barriers for individuals seeking abortion services. One prevalent issue raised by respondents is the significant delays experienced in accessing abortion care. These delays, whether intentional or due to bureaucratic inefficiencies, prolong the process and impose undue burdens on individuals seeking timely care. The necessity to navigate through these delays often results in additional financial costs and logistical challenges, particularly for those living in areas with limited access to reproductive healthcare services. Moreover, breaches of confidentiality within healthcare settings were distressingly common among respondents; more than 1 in 4 of our respondents reported violations of confidentiality. Many recounted experiences where healthcare providers disclosed sensitive information to family members without consent or discussed patients' medical histories inappropriately. Disclosing patients' names and sharing details of medical procedures in common spaces further exacerbates the violation of patient privacy and confidentiality, contributing to feelings of shame, stigma, and mistrust in healthcare settings.

Additionally, respondents reported a lack of comprehensive information provided about the abortion process. This failure to adequately inform patients about what to expect during the procedure, potential side effects, and aftercare contributes to feelings of uncertainty and distress among individuals seeking abortion services. Furthermore, the failure to investigate and address patients' complaints points to systemic failures in healthcare institutions' responsiveness to patient concerns, perpetuating a culture of impunity and silence that allows harmful practices to persist unchecked.

The absence of options for manual or electric vacuum aspiration raises questions about the comprehensiveness of available abortion services and the extent to which individuals are informed about the full range of safe and effective abortion methods. Access to a variety of abortion methods is essential for ensuring that individuals can make informed choices based on their medical needs, preferences, and personal circumstances. Besides the limitation of the method that leads to people being prescribed multiple rounds of medication, there is also a worrisome use of dilation and curettage, an outdated abortion procedure no longer recommended by the World Health Organization (Leke et al, 2010; Romero et al, 2021; Küng et al, 2021). Not only does this deprive patients of a choice of method, but reveals systemic failures (training for doctors and purchase of equipment needed).

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The experiences shared by respondents who had undergone multiple abortions reveal a troubling pattern of escalating violence and discrimination. Despite seeking abortion services multiple times, they reported being treated differently each time, often with increased contempt and judgment from healthcare professionals. In particular, respondents noted intrusive inquiries into their sexual history, scolding, and mistreatment, which intensified with each subsequent abortion experience. One respondent vividly described feeling belittled by a healthcare provider who remarked on their age and previous abortions, insinuating irresponsibility and suggesting a lack of understanding regarding the seriousness of their decision.

Interestingly, some respondents noted disparities in treatment between their experiences before and after the legalization of abortion. Two individuals recalled receiving more compassionate care and support for abortion services when it was illegal, highlighting a paradoxical shift in healthcare attitudes following legalization. This raises questions about the impact of legal frameworks on healthcare practices and the role of stigma and discrimination within healthcare systems.

The reported emotional responses after an abortion are consistent with findings in the literature (Rocca, 2015). Research indicates that many individuals experience a mix of emotions following an abortion, with positive feelings often outweighing negative ones. Among the positive emotions, relief is the most prevalent, as reflected in the data where relief was reported by 167 individuals (65% of respondents). This predominance of relief aligns with numerous studies suggesting that, for many, the decision to have an abortion is accompanied by a sense of relief and peace. However, this prevalent feeling of relief reflects the resolution of an unwanted or unsupportable pregnancy rather than the quality of care received. The relief felt post-abortion highlights the complex social landscape where respondents feel that the abortion decision and its outcomes bring significant emotional ease, even when the trajectory to access was marred by violence. While much more research is needed to understand this, our data indicates that the negative feelings are more connected to the experiences in their trajectories to care than the abortion decision itself.

V. Conclusion

The findings of this study highlight the pervasive and multifaceted nature of violence experienced by pregnant people during their journeys to access abortion services in Uruguay. By applying Pickles' concept of a 'continuum of violence', we were able to identify various forms of obstetric violence, ranging from psychological and emotional to more systemic and institutionalized forms (Pickles, 2023; Freedman et al, 2014). We identify various types of obstetric violence, painting a broad picture of how abortion trajectories can be a damaging experience for some pregnant people even when they have access to the service. As our study shows, the obstetric violence suffered by abortion seekers encompasses a spectrum of behaviors ranging from severe violations to less extreme, though still harmful, instances of coercion and disrespect, manifesting also at the individual, structural, and policy levels.

Besides the ubiquity of abortion-related obstetric violence, a salient insight from our analysis is its normalization. This normalization impedes the recognition and acknowledgment of violence, as many affected individuals do not perceive their experiences as such, due to–for example–societal definitions of violence that predominantly emphasize physical harm, no conceptual work of what a quality abortion looks like, or expectations of bad treatment. Our qualitative data exposed the extensive nature of this issue, demonstrating that many people endure significant harm that often goes unrecognized and unreported.

These trajectories to care are not neutral. As Chadwick argues, these are not (only) issues of quality of care and the failure of evidence-based obstetric practice that can be addressed with information and training (Chadwick, 2016). They produce and reproduce relations of power, politics, economics, knowledge, and cultures, in the wide variety that society generates.

In this sense, our study also points to a significant challenge: the legalization of abortion represents a critical advancement in reproductive health and rights, yet it does not inherently guarantee that individuals will consistently receive dignified and respectful care throughout their healthcare experiences. Legal frameworks alone do not provide comprehensive safeguards against the diverse forms of violence—spanning from subtle forms of disrespect to overt instanc-

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es of coercion or physical mistreatment—that individuals accessing abortion services may confront. We have argued elsewhere that the Uruguayan legal frameworks on abortion and obstetric violence fail to address the fundamental causes and entrenched systems of power that underlie these issues (Berro, 2019; Farías y Magnone, 2022). These frameworks reinforce a medicalized perspective on abortion, without challenging the dominance of the medical system. Consequently, they simplify the problem by reducing violence to matters of care quality or individual attitudes, rather than recognizing it as a systemic and institutional issue. This narrow focus neglects the broader context of institutionalized power dynamics and the ways in which they contribute to and sustain obstetric violence. By not addressing these deeper issues, these legal frameworks fall short of effecting meaningful change ultimately failing to transform the structures of power necessary to create abortion trajectories that are truly autonomous, supported and respectful.

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Bibliography

Afulani, P. A., Phillips, B., Aborigo, R. A., & Moyer, C. A. (2019). Person-centred maternity care in low-income and middle-income countries: analysis of data from Kenya, Ghana, and India. The Lancet. Global health, 7(1), e96–e109. https://doi.org/10.1016/S2214-109X(18)30403-0

Altshuler, A. L., Ojanen-Goldsmith, A., Blumenthal, P. D., & Freedman, L. R. (2017). A good abortion experience: A qualitative exploration of women's needs and preferences in clinical care. Social science & medicine, 191, 109–116. https://doi.org/10.1016/j.socscimed.2017.09.010

Araújo, M., Santana, A., Moreira, P., Xavier, M., de Araújo, J., & Santos, P. (2023). Obstetric violence in the abortion process. Enfermería: Cuidados Humanizados, 12(2), e3166. doi: 10.22235/ech.v12i2.3166

Bartlett, K. (2018). Feminist legal theory: Readings in law and gender. Routledge.

Bellón, S. (2015). Obstetric violence from the contributions of feminist criticism and biopolitics. Dilemata, 18, 93-111.

Berro Pizzarossa, L. (2019). Women Are Not in the Best Position to Make These Decisions by Themselves': Gender Stereotypes in the Uruguayan Abortion Law. University of Oxford Human Rights Hub Journal, 1(), 25-54.

Chadwick R. (2016). Obstetric violence in South Africa. South African medical journal, 106(5), 5–8. https://doi.org/10.7196/SAMJ.2016.v106i5.10708

Chadwick, R. (2023). The Dangers of Minimizing Obstetric Violence. Violence against women, 29(9), 1899–1908. https://doi.org/10.1177/10778012211037379

Code, L. (2009). A New Epistemology of Rape?. Philosophical Papers, 38(3), 327–345. https://doi.org/10.1080/05568640903420897

Cohen, S. (2015). Making loud bodies "feminine": a feminist-phenomenological analysis of obstetric violence. Human Studies 39 (2), 231-47. https://doi.org/10.1007/s10746–015–9369-x

Colomar, Mercedes, Colistro, Valentina, Sosa, Claudio, de Francisco, Luis, Betrán, Ana Pilar, Serruya, Suzanne, & De Mucio, Bremen (2022). Cesarean section in Uruguay from 2008 to 2018: country analysis based on the Robson classification. An observational study. BMC Pregnancy and Childbirth, 22(1), 1–10. https://doi-org.proxy.timbo.org.uy/10.1186/s12884-022-04792-y

Cóppola, Francisco. (2015). Cesáreas en Uruguay. Revista Médica del Uruguay, 31(1), 07-14. http://www.scielo.edu.uy/scielo.php?script=sci_arttext&tpid=S1688-03902015000100002&lng=es&tlng=es.

Davis, D. (2018). Obstetric Racism: The Racial Politics of Pregnancy, Labor, and Birthing. Medical Anthropology, 38(7), 560–573. https://doi.org/10.1080/01459740.2018.1549389

Demirdjian, S. (2022, diciembre 22). Diez años de la ley de aborto en Uruguay: puesta a punto de las cifras y evaluación de protagonistas. La Diaria. https://ladiaria.com.uy/feminismos/articulo/2022/12/diez-anos-de-la-ley-de-aborto-en-uruguay-puesta-a-punto-de-las-cifras-y-evaluacion-de-protagonistas/

Farias, Carolina (2014.). Vivencias y significados de la cesárea para las mujeres que han pasado por la experiencia. [tesis de maestría, Facultad de Psicología, Universidad de la República, Uruguay]. https://hdl.handle.net/20.500.12008/4473

Farías, C., Magnone, N. (2022). Violencia Obstétrica en Uruguay. Desafíos para la protección de los derechos reproductivos de las mujeres. Musas, 7(2), 62-80. https://doi.org/10.1344/musas2022.vol7.num2.4

Freedman, L. P., Ramsey, K., Abuya, T., Bellows, B., Ndwiga, C., Warren, C. E., Kujawski, S., Moyo, W., Kruk, M. E., & Mbaruku, G. (2014). Defining disrespect and abuse of women in childbirth: a research, policy and rights agenda. Bulletin of the World Health Organization, 92(12), 915–917. https://doi.org/10.2471/BLT.14.137869

*i*GAL *Ius*Género América Latina
VOLUMEN III NUMERO 1
RECIBIDO: 26/06/2024 APROBADO: 13/09/2024 PUBLICADO: 24/09/2024
DOI: 10.58238/IGALV3I1.73 ISSN: 2835-687X

Instituto Nacional de Estadística (2019). Segunda encuesta nacional de prevalencia de violencia basada en género y generaciones. https://www.gub.uy/ministerio-desarrollo-social/sites/ministerio-desarrollo-social/files/documentos/publicaciones/Segunda%20encuesta%-C2%A0naciona.pdf

Kumar, A., Hessini, L., & Mitchell, E. M. (2009). Conceptualising abortion stigma. Culture, health & sexuality, 11(6), 625–639. https://doi.org/10.1080/13691050902842741

Küng, S., Ochoa, B., Ortiz Avendano, G., Martínez, C., Zaragoza, M., & Padilla Zuniga, K. (2021). Factors affecting the persistent use of sharp curettage for abortion in public hospitals in Mexico. Women's health, 17, 17455065211029763. https://doi.org/10.1177/17455065211029763

Labandera, A., Gorgoroso, M., & Briozzo, L. (2016). Implementation of the risk and harm reduction strategy against unsafe abortion in Uruguay: from a university hospital to the entire country. International journal of gynecology and obstetrics: the official organ of the International Federation of Gynaecology and Obstetrics, 134(1), 7–11. https://doi.org/10.1016/j.ijgo.2016.06.007

Larrea, S., Assis, M. P., & Mendoza, C. O. (2021). "Hospitals have some procedures that seem dehumanising to me": Experiences of abortion-related obstetric violence in Brazil, Chile and Ecuador. Agenda, 35(3), 54–68. https://doi.org/10.1080/10130950.2021.1975967

Lefever, S., Dal, M. and Matthíasdóttir, Á. (2007), Online data collection in academic research: advantages and limitations. British Journal of Educational Technology, 38: 574-582. https://doi.org/10.1111/j.1467-8535.2006.00638.x

Leke, R. J., de Gil, M. P., Távara, L., & Faúndes, A. (2010). The FIGO working group on the prevention of unsafe abortion: mandate and process for achievement. International journal of gynaecology and obstetrics: the official organ of the International Federation of Gynaecology and Obstetrics, 110, S20–S24. https://doi.org/10.1016/j.ijgo.2010.04.005

Magnone, Natalia (2011, setiembre). Derechos sexuales y reproductivos en tensión: intervencionismo y violencia obstétrica. X Jornadas de Investigación: derechos humanos, seguridad y violencia. Montevideo.

Magnone, Natalia (2017). Entre lo formal y lo sustantivo: la calidad de la asistencia al parto en el Uruguay. Sexualidad, Salud Y Sociedad, (27), 97–117. https://doi.org/10.1590/1984-6487.sess.2017.27.06.a

Mujer y Salud en Uruguay (2022). Violencia obstétrica en cifras: resultados de la encuesta. https://www.mysu.org.uy/multimedia/noticia/violencia-obstetrica-en-cifras-resultados-de-la-encuesta/

Muñoz, A. (2018, mayo 7). A cinco años de la aplicación de la Ley de Interrupción Voluntaria del Embarazo. La Diaria. https://ladiaria.com.uy/salud/articulo/2018/5/a-cinco-anos-de-la-aplicacion-de-la-ley-de-interrupcion-voluntaria-del-embarazo/

Nandagiri, R. (27 setiembre, 2018). Why feminism: some notes from 'the field' on doing feminist research. LSE Engenderings Blog. http://blogs.lse.ac.uk/gender/2017/10/12/why-feminism-some-notes-from-the-field-on-doing-feminist-research/>.

Pickles, C. (2023). "Obstetric Violence," "Mistreatment," and "Disrespect and Abuse": Reflections on the Politics of Naming Violations During Facility-Based Childbirth. Hypatia, 38(3), 628–649. doi:10.1017/hyp.2023.73

Prandini, M., & Larrea, S Exposing abortion-related obstetric violence through activism in Latin America and the Caribbean. Hill, N., & Castañed, A. N. (Eds.). (2022). Obstetric violence: realities, and resistance from around the World. Demeter Press.

Rocca, C. H., Kimport, K., Roberts, S. C., Gould, H., Neuhaus, J., & Foster, D. G. (2015). Decision rightness and emotional responses to abortion in the United States: a longitudinal study. PloS one, 10(7), e0128832. https://doi.org/10.1371/journal.pone.0128832

*i*GAL *Ius*Género América Latina
VOLUMEN III NUMERO 1
RECIBIDO: 26/06/2024 APROBADO: 13/09/2024 PUBLICADO: 24/09/2024
DOI: 10.58238/IGALV3I1.73 ISSN: 2835-687X

Romero, M., Gomez Ponce de Leon, R., Baccaro, L. F., Carroli, B., Mehrtash, H., Randolino, J., Menjivar, E., Estevez Saint-Hilaire, E., Huatuco, M. D. P., Hernandez Muñoz, R., Garcia Camacho, G., Thwin, S. S., Campodonico, L., Abalos, E., Giordano, D., Gamerro, H., Kim, C. R., Ganatra, B., Gülmezoglu, M., Tuncalp, Ö., ... Carroli, G. (2021). Abortion-related morbidity in six Latin American and Caribbean countries: findings of the WHO/HRP multi-country survey on abortion (MCS-A). BMJ global health, 6(8), e005618. https://doi.org/10.1136/bmjgh-2021-005618

Sanger, C. (2017). About Abortion: Terminating pregnancy in twenty-first. Century America. Belknap Press.

Tickner, J. (2005). What is your research program? Some feminist answers to international relations methodological questions. International Studies Quarterly, 49(1), pp.1-21

Tobasía-Hege, C., Pinart, M., Madeira, S., Guedes, A., Reveiz, L., Valdez-Santiago, R., Pileggi, V., Arenas-Monreal, L., Rojas-Carmona, A., Piña-Pozas, M., Gómez Ponce de León, R., & Souza, J. P. (2019). Irrespeto y maltrato durante el parto y el aborto en América Latina: revisión sistemática y metaanálisis. Revista panamericana de salud publica, 43, e36. https://doi.org/10.26633/RPSP.2019.36

United Nations Population Fund (2023). Uruguay es el país con menor prevalencia de abortos en América Latina y el Caribe ubicándose en el promedio de los países europeos. https://uruguay.unfpa.org/es/10-anos-de-la-ley-ive

Upadhyay, U., Kimport, K., Belusa, E., Johns, N., Laube, D., & Roberts, S. (2017). Evaluating the impact of a mandatory pre-abortion ultrasound viewing law: A mixed methods study. PloS one, 12(7), e0178871. https://doi.org/10.1371/journal.pone.0178871

Upadhyay, U. D., Cartwright, A. F., & Grossman, D. (2022). Barriers to abortion care and incidence of attempted self-managed abortion among individuals searching Google for abortion care: A national prospective study. Contraception, 106, 49–56. https://doi.org/10.1016/j.contraception.2021.09.009

Uruguay (2001). Ley Nº 17386 Acompañamiento a la mujer en el preparto, parto y nacimiento. https://www.impo.com.uy/bases/leyes/17386-2001

Uruguay (2008). Ley Nº 18426 Defensa de la salud sexual y reproductiva. https://www.impo.com.uy/bases/leyes/18426-2008

Uruguay (2012). Ley N° 18987 Interrupción voluntaria del embarazo. https://www.impo.com.uy/bases/leyes/18987-2012

Uruguay (2013). Ley N° 19167. Regulación de las técnicas de reproducción humana asistida. https://www.impo.com.uy/bases/leyes/19167-2013/7

Uruguay (2017). Ley Nº 19580 Violencia hacia las mujeres basada en género. https://www.impo.com.uy/bases/leyes/19580-2017

Vedam, S., Stoll, K., Taiwo, T. K., Rubashkin, N., Cheyney, M., Strauss, N., McLemore, M., Cadena, M., Nethery, E., Rushton, E., Schummers, L., Declercq, E., & GVtM-US Steering Council (2019). The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States. Reproductive health, 16(1), 77. https://doi.org/10.1186/s12978-019-0729-2

Zacher, D. (2015). Obstetrics in a time of violence: mexican midwives critique routine hospital practices. Medical anthropology quarterly, 29(4), 437–454. https://doi.org/10.1111/maq.12174

*i*GAL *Ius*Género América Latina
VOLUMEN III NUMERO 1
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