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An Exploratory Analysis of Legal Abortion Access in Oaxaca, Mexico, Three Years Post-Decriminalization

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Abstract

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By Netra Anand

In 2019, the state of Oaxaca became the first state, and second federal jurisdiction, in Mexico to decriminalize voluntary abortion within the first trimester of a pregnancy. Nearly three years later, however, there is limited data to suggest that access to legal abortion services (knows as *Interrupción Legal de Embarazo*, or *ILE*) has improved. This objective of this study was to qualitatively describe the experiences of women who have utilized *ILE* services in the past and the self-perceived barriers of women who may avail of services in the future. The research team conducted nine qualitative interviews with women in Oaxaca City and the rural community of Santo Domingo Tonalá, ages 21 to 37 years. Participants described a limited availability of trained abortion providers across the state and inconsistencies in the quality of medical care from public and private healthcare facilities. Outside of abortion care, there were several accounts of overbearing and assertive contraceptive counseling. Abortion stigma appeared to be pervasive at a cultural, religious, and interpersonal level. Findings from this exploratory study provide valuable first-hand accounts of utilization and perceptions of safe, legal abortion services in Oaxaca and serve as a foundation for future interdisciplinary research on reproductive healthcare in the region, as well as to inform policy and structural interventions to improve health outcomes for millions of women in Oaxaca, Mexico.

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This project was conducted by a multidisciplinary team from Mexico and Emory University. I have immense gratitude and respect to my co-investigators, who worked tirelessly and with great passion to build this project from the ground up: Mauricio Ramos Cruz, Ana Raquel Chávez Solano, Zenaida Martínez Blanco, Stella Zhang, and Gabrielle Jones. I also thank the feminist advocacy organizations and Brenda Olivera Solano from the *Instancia Municipal de la Mujer* for supporting the team with our community outreach and participant recruitment efforts. I also would like to express my gratitude to the nine women who participated in this study and shared their insights and experiences with the team.

I offer my sincere and eternal gratitude to Dr. Roger Rochat for the constant encouragement, inspiration, guidance and mentorship that he has provided to me throughout my time at Rollins School of Public Health. His commitment to improving access to safe and legal abortion and mentoring the next generation of public health researchers inspired me to pursue this project.

Finally, I thank my friends, family and mentors who have shown me so much love and support throughout this journey. I would not be where I am today without you.

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Chapter 1: Introduction

Rationale:

In 2019, the state of Oaxaca became the first state, and second federal jurisdiction, in Mexico to decriminalize voluntary abortion within the first trimester of a pregnancy (1,2). As part of the constitutional reform, all individuals are guaranteed a right to reproductive healthcare (3). Nearly three years later, however, there is limited data to suggest that access to legal abortion services (knows as *Interrupción Legal de Embarazo*, or *ILE*) has improved. As of November 2021, the state health authorities had reported only 92 cases of *ILE* in one of only three public facilities in the entire state with trained abortion providers (4,5). Moreover, state health records from Ciudad de Mexico, where *ILE* was decriminalized in 2007, report nearly 50 cases of *ILE* performed for women who travelled from Oaxaca to the city from 2019 to 2022 (3,6). The data suggest that women in Oaxaca may still be encountering barriers to accessing legal abortion services in the state.

Problem Statement:

With no published research on abortion access and limited quantitative data on *ILE* utilization, the impact that the *ILE* program in Oaxaca has had is unclear. Furthermore, no study has evaluated what barriers, if any, impact a woman's experience and access *ILE* services.

Purpose Statement:

This study aims to qualitatively describe the experiences of women who have utilized abortion services before, or the self-perceived barriers of women who may avail of abortion services in the future.

Significance Statement:

Investigating these attitudes would provide a more deta*ILE*d understanding of abortion access across the state and, eventually, inform policy and structural changes to improve health outcomes for millions of women.

Chapter 2: Comprehensive Review of Literature

Global Abortion Overview

An estimated 73 million induced abortions occur worldwide each year, and six out of 10 unintended pregnancies end in an induced abortion (7). The WHO classifies comprehensive abortion care, which includes "provision of information, abortion management and post-abortion care", as an essential health care service (7). However, nearly 45% of all induced abortions are deemed unsafe, defined as "an abortion performed by somebody without adequate skills (including the woman herself) and/or outside of an environment conforming to minimal medical standards" (7).

Abortion policies range from total prohibition to abortion without restriction. The legal status of abortion not only dictates whether women and girls have the right to decide to terminate a pregnancy, but also predicts the likelihood she will have financial security, complete her education, participate in public life, or die from an unsafe clandestine abortion (7,8). Currently, 36% of women of reproductive age worldwide live in a country that permits abortion upon request (8). A majority of these countries limit voluntary induced abortions to up to 12 weeks of gestation. The WHO also states that a medical abortion can be safely self-managed by the pregnant person within the first 12 weeks of the pregnancy (7).According to Singh et. al., however, legal status alone does not guarantee access to safe abortion (9). Political bodies and healthcare providers must come together to ensure full implementation of the law and inform women of their reproductive choices.

Abortion in Latin America and the Caribbean (LAC) and the Green Wave

Approximately one in four pregnancies in the Latin America and Caribbean region- which consists of the Caribbean, South and Central America- end in an induced abortion (10). In the Central American region, the share of unintended pregnancies that terminated in an abortion rose to 46% by 2019. Across the region, an estimated 1,100 women die each year due to unsafe abortions, and 12% of all maternal deaths can be attributed to unsafe abortion-related complications (11). The legal landscape for abortion access in the region is extremely variable. Until 2020, nearly 97% of women in Latin America lived in countries where abortion was restricted (12). Nicaragua, El Salvador, Haiti, Honduras and the

Dominican Republic are home to some of the most restrictive abortion bans in the world- the penalty for obtaining an abortion in El Salvador is up to 40 years of imprisonment (13). Conversely, Cuba, where abortion has been legal since 1965, has one of the highest abortion rates in the world (11). However, the abortion rate has steadily decreased in the past two decades, coinciding with decreasing fertility rates across the region, due to a rise in contraceptive prevalence (11,14). Three of the most populous countries, Argentina, Colombia, and Mexico, have decriminalized abortion. This era of progressive legislation comes with a sweeping abortion rights activist movement known as *La Marea Verde* (Green Wave). The movement began in Argentina in 2005 as a grassroots feminist mobilization, organized by the National Campaign for the Right to a Safe, Legal and Free Abortion, and grew into a transnational movement to call for both legal action and challenge social stigma against abortion and reproductive rights (13,15). The movement is contrasted by the Pro-Vida (pro-life) movement to maintain the illegal status of abortion and preserve the right to life from conception. In a predominantly Catholic region, where over 70% of people self-identify as strongly Catholic, there is considerable social and political pushback to the Marea Verde (13). Abortion has become a political bargaining chip for leaders balancing the support of the conservative sector and Catholic Church (11). Even in countries that have legalized abortion, healthcare providers reserve the right to refuse providing abortion services on grounds of religious, moral, or ethical belief (16). A provider's conscientious objection to providing abortion care thus poses a significant barrier to women who seek to terminate their pregnancy.

Regardless of legal status, access to safe abortions are situated within numerous structural and social inequalities (11). Women with the financial means can circumvent restrictions to seek out high quality and discreet care in private clinics, or can travel to areas where abortion is legal. Poor, young, and/or marginalized women, however, cannot afford to do so, even if abortion is legal where they reside.

Mexican Healthcare Systems

Mexico consists of 32 federal entities- 31 states and Mexico City, known as *el Distrito Federal (D.F.)*- each with their own governing body and constitution. In 1995, the federal government shifted to decentralizing healthcare spending to the local level, leaving

individual states to oversee the public healthcare system (17). Additionally, policy decisions, such as those pertaining to legal abortion, were left up to the state governments.

Mexico operates an expansive public healthcare system under which all residents are eligible to receive healthcare through one of several systems based on employment status (18). Public-sector employees receive coverage through the Institute for Social Security and Services for State Workers (ISSSTE). The state-run petroleum industry, PEMEX, covers employees through a state-run plan, as do the armed forces (SEDENA). Private-sector formal employees can opt for coverage through the Mexican Social Security Institute (IMSS) and all those who are not eligible for coverage through employment can receive health insurance through the federal IMSS-Bienestar program (formally known as INSABI and Seguro Popular). Any individual also has the option to obtain care from a private clinic for an out-of-pocket cost. The COVID-19 pandemic brought forth a significant decrease in public healthcare usage, and 7 of 10 Mexicans resorted to private clinics for their needs (18).

Reproductive Health Estimates in Mexico

With an estimated population of 126 million, 51.2% of whom are female, Mexico is the 10th most populous nation in the world (19,20). The birth rate has steadily decreased since 1960 to 1.9 births per woman, reaching replacement-level (21,22). The most recent 2022 estimate for maternal mortality is 30.4 deaths per 100,000 live births, which marks a 37.8% decrease from the previous year (23). The most common cause of death shifted from COVID-19 infections, which had been the leading cause of death in 2020-2021 and contributed to a 56.8% increase in overall maternal deaths , to obstetric hemorrhage and hypertensive disorders (23,24). Death due to an abortion makes up 7.1% of all reported maternal deaths in 2022 (23). Importantly, however, this statistic does not distinguish induced voluntary abortions from spontaneous abortions, or miscarriages.

Accurate incidence measurements of voluntary abortion are difficult to estimate due to the fragmented legal landscape of abortion in the country and inconsistent hospital data reporting systems (25).In 2009, approximately 55% of all pregnancies were unintended. Of these unintended pregnancies, more than half were estimated to end in an induced abortion (10). At the time of the 2009 study, induced abortions upon request were illegal in

all 32 states, except for the Federal District of Mexico City (D.F.). Government data from 2009 indicated that 159,000 women were hospitalized in public-sector hospitals for complications due to unsafe abortions, and the Guttmacher Institute estimates that 10 times as many obtained a clandestine abortion (10).

Decriminalization of Abortion in Mexico City

In April 2007, the Mexico City legislature passed landmark legislation to decriminalize abortion upon request in the first twelve weeks of pregnancy (26),.Mexico City followed Uruguay as one of the first regions in Latin America to take a step towards abortion decriminalization since Cuba did so in 1965 (10,11,26). Under this policy, elective abortion services upon demand of the pregnant individuals in the first trimester were titled *Interrupción Legal del Embarazo* (Legal Interruption of Pregnancy), or *ILE*. Termination of a pregnancy after 13 weeks of gestation were renamed as abortions and maintained status as a criminal offense (27). The Ministry of Health of Mexico City (MOH-DF) mandated that public *ILE* clinics be set up to provide services free of charge for residents of Mexico City and for a small fee for non-residents (26). The policy change also inspired changes in the delivery of *ILE* services across the city. A shift from surgical abortions (i.e. dilation & curettage) to safer medicated abortion or manual vacuum aspiration methods enabled the program to expand patient volume (26). Moreover, in 2011, mifepristone was commercially registered in Mexico, allowing women to self-manage abortions in a safe manner. The shift to medicated abortions was critical to meeting the high demand for abortions in the country by increasing the client capacity and safety of the *ILE* program (26,28). The 2007 reform also integrated sexual and reproductive healthcare and post-abortion family planning into primary healthcare services (28).

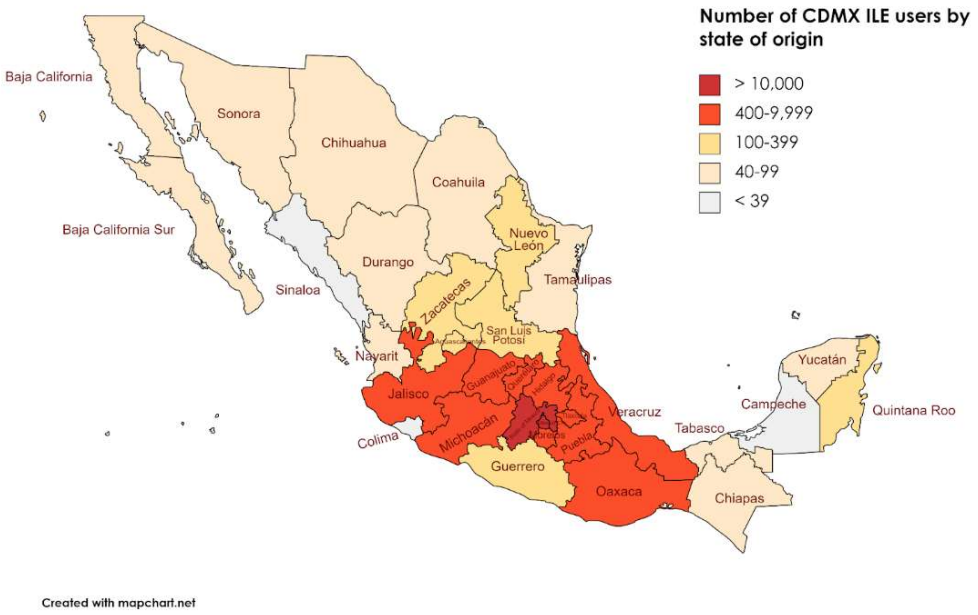
Since 2007, the *ILE* program has provided 256,665 legal terminations of first-trimester pregnancies (6). The program has not registered a single death due to a legal *ILE* procedure (29). This statistic, however, only reflects services conducted through the state-run public *ILE* clinics. Data from private clinics or clandestine abortions are often not reported. As such, state-published data on abortion incidence and fatality are often severely under-reported.

Abortion Travel

Response to the 2007 policy was mixed. Immediately following the decriminalization of abortion in Mexico City, conservative political parties nationwide united with the dominant Catholic Church to pass constitutional reforms to affirm the right to life from conception (30). Eighteen of 32 states saw changes made to the state constitution, changes that were largely closed to public participation (30,31). The issue of conscientious objection was also brought up, and many healthcare providers within Mexico City refused to offer *ILE* services on moral or ethical grounds. The MOH-DF responded to this problem by clarifying the guidelines for the *ILE* program such that public hospitals were mandated to hire non-objecting providers, and that entire healthcare institutions cannot claim conscientious objection (26,27).

The MOH-DF has reported 256,665 legal abortions since 2007 (6). Of them, nearly 31% of cases were for women who were not residents of Mexico City and traveled to the district to obtain an abortion. A majority of these women were from the state of Mexico, where abortion is still illegal. Due to its geographic location within the state of Mexico and in the center of the country, Mexico City is often referred to as an "island of liberties" in the larger "fractured abortion landscape" of the country (32). In what Singer calls "abortion ex*ILE*", women from all across the country were forced to navigate restrictive abortion laws in their own state, financial burdens, stigma from their own communities, and fear of not finding non-objecting providers and travel to Mexico City to terminate an unwanted pregnancy. The term ex*ILE* highlights the exclusion of reproductive health and rights from social and political arenas. It also brings to attention the inequity of safe abortion in Mexico. Results from the National Demographic Survey in 2006 found that higher rates of unsafe abortions were found among women of low socioeconomic status, of indigenous origin, and with low levels of education (33).

Figure 1: State of Origin, *ILE* Users April 2007-December 2022- Secretaría de Salud de la Ciudad de México



Decriminalization of Abortion in the Other Parts of Mexico

In 2012, the Convention on the Elimination of all Forms of Discrimination Against Women expressed concern over inconsistencies in abortion legislation across the 32 states in Mexico, and urged the federal and state governments to extend access to safe and legal abortion (34). In 2021, the Mexican Supreme Court unanimously ruled it unconstitutional to criminalize abortion and established that local governments cannot grant the status of personhood to the embryo or fetus (26,35,36). These rulings came in response to two attempts in the states of Coahuila and Sinaloa to restrict access to voluntary induced abortions. As such, this decision confirmed the constitutional protection of an individual's right to reproductive autonomy (37).

Since 2007, ten states have now decriminalized abortion upon request up to 12 weeks gestation (38,39). In the other 22 states, the right to a voluntary abortion is only protected in certain cases, such as rape, risk to the mother's health or insemination without consent.

Figure 2: Federal Entities with legal abortion upon request up to 12 weeks gestations, 2022

Overview of Sexual and Reproductive Health Needs in Oaxaca, Mexico

The state of Oaxaca is situated in the southwestern region of Mexico and has a population of over 4.1 million inhabitants, 52.2% of whom are women (40). The state is home to thirteen native indigenous communities, the most of any state in Mexico, and over 43% of Oaxacans identify as a member of one of these communities. 3 out of 10 Oaxacans over three years of age speak an indigenous language, and of them, 13.4% do not speak Spanish (40).

The total fertility rate in Oaxaca is estimated to be 2.16 births per woman, slightly lower than the global TFR (2.2) and higher than the national estimate (1.9) (22,41). 19% of all births recorded in 2019 were to women below 20 years, 3% of which were women between 9 and 14 years (41).

The contraceptive prevalence rate among women ages 15 to 49 is 65.0%, much lower than the national prevalence rate of 73.1% (41). Some studies have attributed this

difference to the lack of adequate state-run family planning programs in rural, hard-to-reach parts of the state (41,42). 51% of the total population of Oaxaca reside in rural communities, beyond the extensive mountain ranges that run through the north and south of the state. Nationwide, access to healthcare services has decreased since 2018, moreso in rural communities than urban regions. 30.5% of the rural population encounter inadequate or a complete lack of healthcare services in their communities. Furthermore, 36.9% of Oaxacans were identified as not being affiliated with any state-run healthcare system. The unmet need for contraception among indigenous women and girls is nearly double the rate for women in the rest of the state. Moreover, women in rural-indigenous communities are "nine times more likely to die during pregnancy or childbirth than in less isolated communities" (41,42). As such, rural women encounter dual barriers to adequate healthcare: geographic isolation and a lack of trained providers who speak local languages (42).

Decriminalization of Abortion in Oaxaca

On September 25th, 2019, Oaxaca made history as the first federal state in Mexico to decriminalize abortion upon request up to 12 weeks gestation (2). Similar to the legal process that occurred in D.F. over a decade before, the penal code was reformed to redefine abortion as the termination of a pregnancy after 12 weeks gestation, and *ILE* as the termination of a pregnancy before 12 weeks. Following the Mexican Supreme Court's 2021 decision to rule the criminalization of abortion unconstitutional, the Oaxacan Supreme Court also reformed the state constitution to guarantee the right to reproductive healthcare, including *ILE* (3). The "right to life from conception" provision that was added to the constitution following the decriminalization of abortion in D.F. was replaced with the protection of life from birth (3). Furthermore, the constitutional amendment mandated that all reproductive healthcare services and materials should be provided in the language(s) that are spoken in the community of service provision. The State Ministry of Health (Secretaria de Salud) was responsible for maintaining a deta*ILE*d registry of legal abortion services that are provided in public clinics and provide trainings to providers both in the public and private sectors. Lastly, public clinics are mandated to provide *ILE* services within three days from the patient's initial request.

Currently, there are nine state-run *ILE* clinics that operate in the state. Outside of the public sector, there are private clinics that provide *ILE* services for a cost, ranging from upwards of 3000 MXN (165 USD, April 10, 2023) for a medicated abortion (43). The most recent report for abortions conducted in state-run clinics estimates 379 cases from September 2019 to 2020, 344 of which were *ILE* cases and 35 related to pregnancies over 12 weeks gestation (3). However, for every registered case, it is estimated that there are 4 unregistered cases, likely clandestine and unsafe. Some official estimates calculate between 2300 to 9200 clandestine abortions carried out annually (43).

With just nine clinics in the entire state that provide free, safe and legal abortion services, it is clear that many women still struggle to exercise their right to safely terminate an unwanted pregnancy. The State Ministry of Health estimates that to establish at least one *ILE* clinic in each of the six health jurisdictions in the state will cost 4.6 million MXN per jurisdiction (3).

Gaps in the Literature:

Over three years since the decriminalization of *ILE* in Oaxaca, there has been no research into the quality of *ILE* services, accessibility, or patient/provider attitudes towards the policy and its impact. Furthermore, unlike in D.F., reporting mechanisms for *ILE* in Oaxaca are not complete or publicly available, creating an unclear and outdated picture of the abortion (both legal and clandestine) landscape in the state. A greater understanding of the barriers, facilitators and disparities to accessing safe, free and legal abortion services is essential to identifying areas for improvement and ensuring that women in Oaxaca have the opportunity to exercise their right to reproductive autonomy.

Chapter 3: Manuscript

An Exploratory Analysis of Legal Abortion Access in Oaxaca, Mexico, Three Years Post-Decriminalization

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Contributions of the Student

My involvement with this project began in December 2021 when I met with Dr. Roger Rochat to propose a study on abortion access in Oaxaca, Mexico. I served as the lead investigator and project coordinator and am the primary author of the paper. I designed all study materials and conducted two-thirds of the qualitative interviews. After the data collection period, I performed data analysis, designed the qualitative codebook, conducted all background research, and presented the study and initial findings at research symposiums.

Abstract:

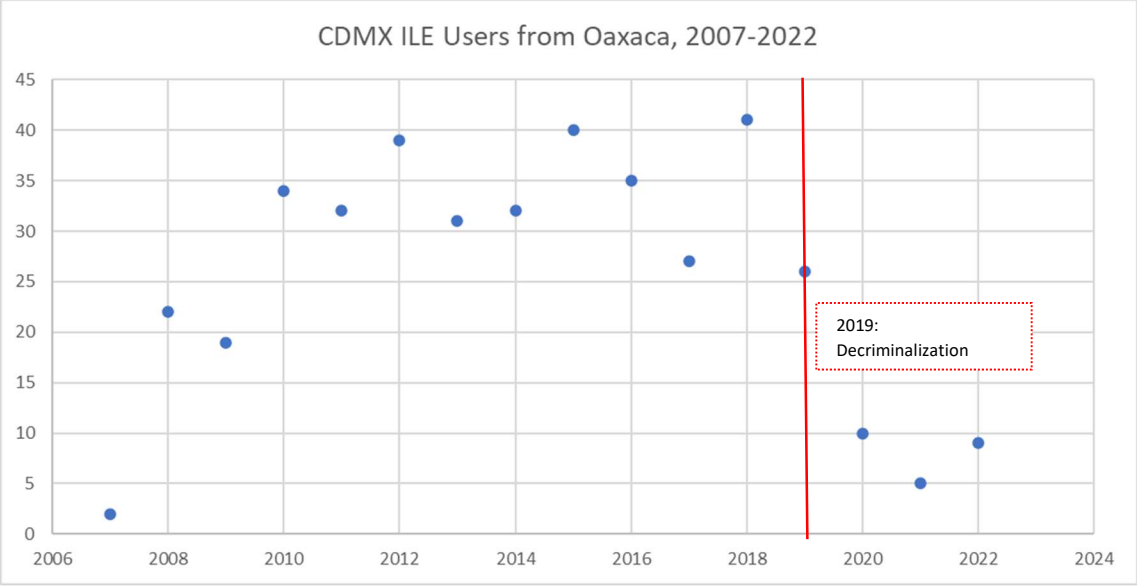
In 2019, the state of Oaxaca became the first state, and second federal jurisdiction, in Mexico to decriminalize voluntary abortion within the first trimester of a pregnancy. Nearly three years later, however, there is limited data to suggest that access to legal abortion services (knows as *Interrupción Legal de Embarazo*, or *ILE*) has improved. This objective of this study was to qualitatively describe the experiences of women who have utilized *ILE* services in the past and the self-perceived barriers of women who may avail of services in the future. The research team conducted nine qualitative interviews with women in Oaxaca City and the rural community of Santo Domingo Tonalá, ages 21 to 37 years. Participants described a limited availability of trained abortion providers across the state and inconsistencies in the quality of medical care from public and private healthcare facilities. Outside of abortion care, there were several accounts of overbearing and assertive contraceptive counseling. Abortion stigma appeared to be pervasive at a cultural, religious, and interpersonal level. Findings from this exploratory study provide valuable first-hand accounts of utilization and perceptions of safe, legal abortion services in Oaxaca and serve as a foundation for future interdisciplinary research on reproductive healthcare in the region, as well as to inform policy and structural interventions to improve health outcomes for millions of women in Oaxaca, Mexico.

Introduction:

Access to safe and legal abortions is critical to reduce maternal mortality and adverse reproductive health outcomes among women. Across Latin America, the abortion landscape has undergone dramatic changes over the course of the past two decades. Until 2020, nearly 97% of women in Latin America lived in a country where abortion was restricted[1,2]. Regardless of legal status, however, access to safe abortions is situated within numerous structural and social factors that disproportionately limit poor, young, indigenous, or other marginalized women from exercising their right to health.

In 2019, the state of Oaxaca became the first state, and second federal jurisdiction, in Mexico to decriminalize voluntary abortion within the first trimester of a pregnancy. As part of the constitutional reform, all individuals are guaranteed a right to reproductive healthcare[3]. Nearly three years later, however, there is little evidence to suggest that access to legal abortion services (knows as *Interrupción Legal de Embarazo*, or *ILE*) has improved. As of November 2021, the state health authorities had reported only 92 cases of *ILE* in one of only three public facilities in the entire state with trained abortion providers[4,5]. Moreover, state health records from Ciudad de Mexico, where *ILE* was decriminalized in 2007, report nearly 50 cases of *ILE* performed for women who travelled from Oaxaca to the city from 2019 to 2022[3,6] (Figure 1).

Figure 1



The data suggest that women in Oaxaca may still be encountering certain barriers to accessing legal abortion services in the state. With no published research on the topic of abortion in Oaxaca, it is unclear whether provider and community attitudes toward abortion and the understanding of the 2019 policy play a role in the uptake of *ILE* services in the state. This study aims to address that gap with a preliminary exploration of the self-perceived barriers to legal abortion services using qualitative interviews with women of diverse backgrounds in Oaxaca, Mexico. Understanding these attitudes would provide a more deta*ILE*d understanding of abortion access across the state and, eventually, informing policy change to improve health outcomes for millions of women.

Methods

Since there is no published literature about the self-perceived barriers to legal abortion access in this region, we chose to conduct an exploratory analysis using qualitative interviews to gather diverse perspectives and experiences. Over the course of eight weeks in Summer 2022, the study team conducted:

1. Nine in-depth individual interviews with women of reproductive age in Oaxaca City and the rural community, Santo Domingo Tonalá.
2. Seven key informant interviews with government stakeholders, healthcare providers, and leaders of abortion advocacy organizations.

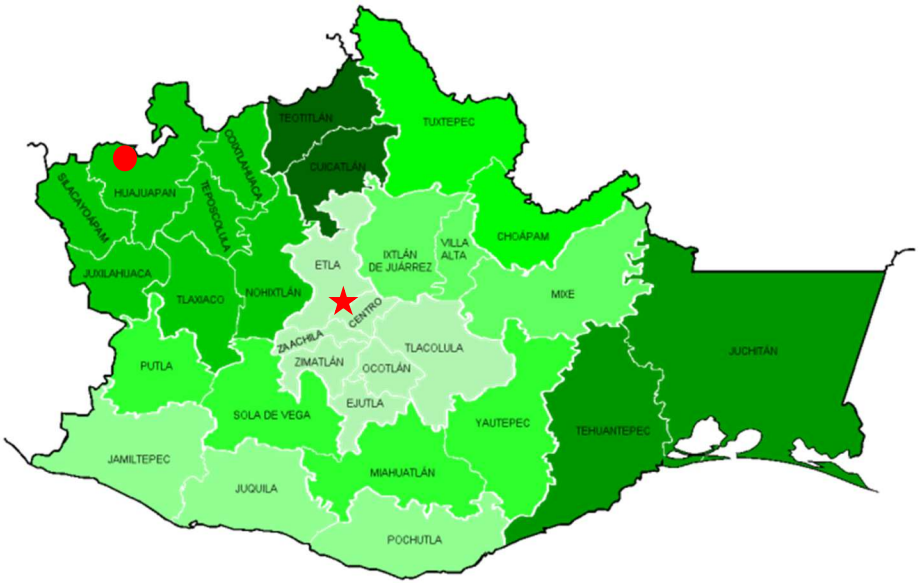
This analysis will focus on the results from part 1 of the study. For part 1, the study team drew from the London Measure for Unplanned Pregnancy and existing literature to develop a semi-structured interview guide. The interview questions probed perceptions and experiences in accessing general sexual and reproductive health care, such as pregnancy care and family planning services, before narrowing the conversation to a discussion on abortion and *ILE* services. This funnel-like approach allowed participants to develop trust in the study investigators before opening up to discuss more personal anecdotes. We collected demographic data, such as age, type of health insurance coverage, and contraceptive method use at the beginning of the interview. The study team also engaged in daily debriefing sessions and weekly planning sessions to discuss emerging themes, revisions to the interview questions, and any other issues of concern.

All interviews were conducted entirely in Spanish. Wh*ILE* all study team members are fluent Spanish-speakers, we chose to have one native Mexican member and one non-native member from Emory University co-lead each interview. The Mexican investigator would be able to probe cultural and structural nuances that a non-native may not have captured. All interviews were conducted face-to-face in a private location selected by the participant.

Study Site

Data collection occurred in Oaxaca de Juarez (Oaxaca City), the capital city of Oaxaca, and Santo Domingo Tonalá, a rural municipality in the northwest region of the state between June and July 2022. Santo Domingo Tonalá is one of 570 municipalities in the state of Oaxaca and is situated in the rural Mixteca region. The municipality has a total population of 7393 inhabitants, 52.8% of which are female and 19.5% of whom speak a language other than Spanish. The municipality consists of 11 communities. Due to the geographic terrain, some communities are cut off from the central municipal government, and instead are overseen by independent municipal agents. The study team selected this municipality to be the rural site for the investigation due to an existing connection to municipal government authorities and strong understanding of the region, which facilitated participant recruitment for data collection.

Figure 2: Map of Oaxaca, Mexico



Participants

The investigators utilized a mixture of convenience and purposive sampling methods to recruit women of reproductive age. In Oaxaca City, we contacted local feminist advocacy organizations to find women who had had an abortion through the *ILE* program. These organizations offer financial, legal, and even emotional assistance to women who seek abortion services and were able to refer two women to the study. The third participant was recruited after hearing about the study from the investigator at her workplace.

In Santo Domingo Tonalá, the study team adapted the recruitment strategy to the cultural nuances of the community. The team partnered with the director of the Municipal Authority for Women (*Instancia Municipal de las Mujeres*), an administrative office of the municipal government that oversees programs for women's rights, equality, discrimination, and the elimination of gender-based violence. The director aired public announcements for study and organized informal recruitment events for community members to meet the study team and volunteer to participate in interviews. The director advised the study team of the stigmatized nature of the research topic and warned the team of possible reticence from study participants. As such, the team made the decision to alter the interview guide to probe on access to general sexual and reproductive health care.

The study received ethical approval from the Institutional Review Board of Emory University, which determined the study to be exempt from additional review under 45 CFR 46.104(d)(2). Per the Mexican study team members, no further approval was required from an ethics board in Oaxaca.

Before beginning the interview, the study team explained the objectives of the project to the participant and obtained written and verbal informed consent. Interviews were approximately 45 minutes long and participants were not compensated for their time.

Data Analysis

After obtaining participant consent, the study team recorded the interviews on multiple mob*ILE* phones to ensure completeness and transcribed the audio in Spanish

using Sonix. We stored all transcripts and audio recordings on an encrypted cloud drive that could only be accessed by the investigators. Data were uploaded to MAXQDA 22.4 and analyzed in Spanish. This was done to preserve any linguistic nuances that would have been lost if translated to English. The primary and secondary investigators reviewed the interview questions to develop a preliminary codebook of deductive themes. To complement these *a priori* themes, the authors also integrated the AAAQ framework to analyze the various factors of access to *ILE* services that the participants described. The AAAQ framework was developed by the Committee on Economic, Social, and Cultural Rights and established four key essential elements that a service must meet to uphold the Right to Health: 1) Availability, 2) Accessibility, 3) Acceptability, 4) Quality. These four elements aligned appropriately with the interview guides and have been used extensively in prior research on perceptions, behaviors and access to health care. The study investigators proceeded to review all interview data using this codebook to examine common themes that resonated across interviews. Data were contextualized based on the location of the interview to identify differences between rural and urban settings.

Results

From June to July 2022, the study team conducted nine interviews with 3 women in Oaxaca City, designated as an urban setting, and Santo Domingo Tonalá, designated as a rural setting. Of the nine participants, all three women in the urban setting disclosed that they had a voluntary abortion. Two of the three accessed abortion services after the decriminalization of voluntary abortion in 2019, wh*ILE* the third woman had an abortion in 2013. One of the six women from the rural setting disclosed having had a spontaneous abortion (miscarriage), and none of the women shared ever voluntary terminating a pregnancy. Seven women previously or currently used a modern contraceptive method, the most common method being the contraceptive injectable. Four of the nine women had public health insurance through the Mexican Institute of Social Security (IMSS), and one participant received health insurance through the Institute for Social Security and Services for State Workers (ISSSTE) because she worked as a nurse for a public hospital. Participants ranged in age from 18 to 37 years. From these interviews, we identified five common themes describing the current landscape of legal abortion access in Oaxaca.

Decision to seek care from a public or private clinic

As part of the 2019 decriminalization of voluntary first trimester abortion, three public healthcare facilities were designated as public *ILE* clinics, where women could receive abortion care free-of-cost from a provider who was not a conscientious objector to abortion. Two of the three clinics are located in Oaxaca City: Hos*pital General "Dr. Aurelio Valdivieso*", a large general hospital that serves patients without health insurance coverage, and *La Clínica de la Mujer*, a municipal health clinic established in 2016 to provide primary and specialized gynecological care to women. Women may also choose to seek care from a private gynecologist in an independent clinic (*una clínica particular*), some of which are operated by a non-profit organization, such as Marie Stopes International.

Of the three participants from Oaxaca City who had terminated their pregnancy, one had done so through a private provider in 2013 (when voluntary abortions were still illegal), one had done so through the *Hospital General ILE* clinic in 2021, and one had gone to two clinics, one private and one public, in 2021. Wh*ILE* public clinics offered the financial benefit, participants described long wait times at these clinics, both to secure an appointment and to be seen by a provider. For one woman, the decision to go to a public clinic to terminate her pregnancy came down to a financial decision. Whereas the private gynecologist would charge her upwards of 1800 MXN ($99.79 USD, April 4, 2023) for a consultation, not including the additional cost of the medications, the hospital would do both for no charge.

Participants in Santo Domingo Tonalá affirmed these comments when discussing their experiences going to the local *centro de salud* (community health clinic) for general primary care. Participants highlighted the lack of specialized healthcare providers in the village. There is only one *centro de salud* that operates in the municipality and provides primary care for a low cost. Some of the participants shared that there is only one doctor who works at the clinic, and that she is working there just to reach the requirements for a retirement pension. When the doctor is not available, there is no one to provide care at the clinic, and the nurses tell patients to come back another day.

Many women shared that they prefer going to see a private doctor for specialized care, such as prenatal visits and gynecological care. Even there, the doctors lack adequate support staff and resources to meet the demand. For any inpatient care, one must travel to the nearest hospital in Huajuapan de Leon- a city that lies 50 kilometers to the north of Tonalá. The journey to Huajuapan de Leon takes over an hour by car, and individuals must obtain a referral and voucher from the *centro de salud* to go to the hospital- the cost for transportation, 800 MXN ($43.85 USD, April 4, 2023), is not included in the voucher.

Quality of counseling was inadequate and biased

All three women in Oaxaca City first found out about their pregnancy after seeing a private gynecologist. For them, the convenience of making a same-day appointment to a clinic near your house often outweighed the cost difference. Upon learning of their diagnosis, the women asked about the option to terminate the pregnancy, and were met with mixed reactions. One woman recalled that the doctor seemed irritated, saying:

> She (the doctor) was not in favor (of abortion). So she said "Look, I don't agree with this, but I'll help you anyway *(Oaxaca City, Age 37)*

The provider wrote her a prescription for misoprostol and instructed her to take two pills under the tongue for half an hour and two pills vaginally after two hours. One week later, she returned to the clinic and was told that the product was still there, and that the fetus now had a heartbeat.

She continued that she confided in her aunt, who worked for GESMujer, a feminist advocacy organization that accompanies women to access *ILE* services. Her aunt informed her that the doctor gave her the wrong prescription- mifepristone was also necessary to prevent the pregnancy from continuing. At this point, the aunt recommended that she go to *La Clínica de la Mujer* instead of a private clinic. She went to the new clinic and received another prescription, this time for both misoprostol and mifepristone, and after a couple of weeks, she returned for a follow-up appointment and was told that the abortion had been successful.

The other two women had similar stories of receiving insufficient counseling on the abortion procedure from a private gynecologist. One participant mentioned that she had reached out to a feminist advocacy group, *Consorcio Oaxaca*, via Whatsapp for information on clinics to go to for *ILE* services and advice on properly self-managing her abortion. Following the procedure, she discovered a Facebook group for women who were looking for resources or information on abortion services in the city.

Providers Insistent on usage of long-term contraception

In contrast to the limited counseling on abortion, all the participants shared that after completing their abortion, they were pressured by the provider to immediately start using a long-term contraceptive method. One woman recounted the following encounter at the end of the follow-up appointment for her abortion:

> They told me I didn't have any residues anymore, that I was clean, and they gave me an injection….They told me "Or do you want to get pregnant?" I told them "No, that's what I came here in the first place", and they told me that they did not want to see me here again (for another abortion)(*Oaxaca City, Age 37).*

She recalls the provider asking if she wanted to get a tubal ligation instead and provided her with information on clinics where she could go to get it done. At this point, she was unsure if she would want to follow through with the permanent method, but:

> They convinced me that it was for my own good…they told me that it was important that I have the ligation because the uterus serves two purposes: to have babies and to have cancer *(Oaxaca City, Age 37).*

Women who had not had an abortion also had similar experiences of assertive and persistent contraceptive counseling from a provider immediately after giving birth. Many recalled that they did not want to use any contraceptive method and were planning to have more children in the future, however, the providers tried to convince them to use a long-term method, like the contraceptive injection or complete tubal ligation, citing that they were too young to be a mother or did not have a partner to help take care of a child.

Multiple levels of stigma impact decision to have an abortion

Women described multiple levels of stigma surrounding the topic of abortion that not only affected their decision to proceed with the abortion, but also their decision to not have another one in the future.

Most of the women self-identified as Catholic and described abortion to be something that was not accepted by the Catholic Church. Some women shared that they were told that abortion, in any case, was a sin in the eyes of God. Others described the topic as too taboo to even be discussed in the Church. The religious discourse often seeped into cultural and family attitudes towards abortion. One woman recalled discovering that her mother was part of a group of older women who would wait outside a local private abortion clinic to "pray for the children" and attempt to convince the women who go to the facility to not proceed with the abortion.

Women also described feelings of guilt and religious repentance after terminating their pregnancy. One participant shared:

> I cried a lot, I think I fell into a depression. It was always the same, I would ask God to forgive me. Forgive me for what I did, forgive me for what I did, but I didn't feel forgiven *(Oaxaca City, Age 36)*

After almost a year, she confessed to her mother she had had an abortion. She recalled her mother telling her:

> The true repentance is when you decide that you will not do it [have an abortion] ever again (*Oaxaca City, Age 36)*

The fear of seeking help, or even to access information on how to get an abortion, without encountering judgment was cited as a key barrier by all three women when recounting their experience having an abortion. Outside of the Church, participants described a similar culture of shame and judgment in the community and within their own families. All three women from Oaxaca City did not share their decision to have an abortion with their family, noting a fear of being judged. This fear extends beyond the home and

follows women throughout the abortion process. One woman shared the following encounter when she arrived to the *ILE* clinic for her appointment:

> In the beginning, I registered with the nurses…and I felt a little bit uncomfortable, perhaps because, we all know that here in Mexico and in Oaxaca it still isn't a very open topic. It's not like one arrives at the hospital and says "I am here to have an abortion", no? It is a little difficult, sometimes, to express it *(Oaxaca City, Age 21)*

The culture of s*ILE*nce she describes was also seen in Santo Domingo Tonalá. When probed on the types of discussions that they had with their friends and families about abortion, many responded that this was not something that they ever talked about. They characterized the older generation as quiet, traditional, and private when it came to talking about sexual and reproductive health. Moreover, one participant recalled feeling ashamed to go to the *centro de salud* because she was worried someone would see her and spread gossip. Many participants shared that in Tonalá, children were taught to associate reproductive health, such as puberty, menstruation, and even the names of their reproductive organs, with shame.

At the individual level, a majority of the participants in Santo Domingo Tonalá expressed that they were not in favor of legal abortion. One woman shared her concern that young girls were using abortions in place of other contraceptive methods:

> I knew a cousin or niece who had aborted three or four times…but if you don't want it (a child) why are you having sexual relations knowing that there are (contraceptive) methods…If you are not ready to have a family or a baby, why? (*Santo Domingo Tonalá, Age 27)*

Others were hesitant to disclose their stance on abortion, sharing what their family or community says about the topic but never clearly sharing their personal opinion.

Awareness of policy is limited

Six of the nine participants were not aware of the abortion policy in Oaxaca. Two were unaware that abortion was decriminalized, and one believed that abortion was only legal in cases of abuse or rape. Only one woman was able to define decriminalization or the

instances under which abortion was permitted. Of the women who were familiar with the policy, two indicated that they found out through social media. One participant mentioned that she knew about the policy because she and her classmates had conducted an independent research project on the policy (she is a law student). She recalled:

> We got together to research (the policy)...and we saw that, since it was decriminalized, only one person had obtained an abortion in the hospital that I went to and that surprised me because…well, it's a public service, no? And you would assume that they should be…well it's a service meant for many people *(Oaxaca City, Age 21)*

None of the participants indicated receiving information on the abortion policy from healthcare providers or seeing announcements from the government. When probed on why that was, one participant shared:

> It is a lack of information from the doctors… because I don't think that they say "No, this (abortion) is okay", right? If it's because of ethics, or whatever you say, they have to provide this information, no? So I believe that it is because of a lack of awareness of the doctors themselve*s (Santo Domingo Tonalá, Age 29)*

Others reiterated the lack of public health campaigns and materials on abortion, compared to other healthcare services:

> It's not like I go to a hospital and I will find a brochure about abortion. It's more of, I don't know, any other type of disease or problem. You can find more available information on that than on abortion *(Oaxaca City, Age 21).*

Discussion

This exploratory analysis is the first of its kind to examine legal abortion access in Oaxaca nearly three years after decriminalization. The common experiences and perceptions fit into the four essential elements of the right to health set forth by the AAAQ framework and indicate key weakness points of the *ILE* program that require attention.

Availability and Accessibility

Lack of clinics or trained providers to seek abortion services was not described as a major issue for the participants in Oaxaca City but poses a possible barrier for women in Santo Domingo Tonalá. Wh*ILE* none of the participants in the rural setting explicitly shared concerns over the availability of *ILE* care near them, there were concerns over the limited availability of specialized care, gynecological care, and trained specialists in the municipality. As of March 2023, there are nine public health facilities that offer *ILE* services in Oaxaca, six of which are in the capital city and none in the north-west region of the state, where Santo Domingo Tonalá is located. The nearest facility where a woman could go for free abortion care is in Oaxaca City, over 200 km away in distance, or a journey of nearly four hours. Although abortion upon request is legal in the entire state, there is a persisting issue of limited availability of services and providers, compounded by an issue of physical accessibility. This finding is consistent with findings in other studies on abortion access in Mexico City, one which determined that an additional 15 minutes of travel time can be associated with almost two-thirds reduction in utilization of *ILE* services[7,8]. Rural-urban healthcare disparities in Oaxaca are also well-established in the literature [9,10].

Another commonly described theme across the study sample was a lack of familiarity with the legal status of abortion in Oaxaca. None of the participants reported hearing about the 2019 decriminalization policy from healthcare providers or seeing public health campaigns or commercials from the government. Of the few women who were aware that abortion had been decriminalized in Oaxaca, many of them found out through word-of-mouth and social media. This finding contrasts the situation in Mexico City, where public awareness about the *ILE* program and policy is high [11,12]. This points to an existing knowledge gap among the general population, further exacerbated in rural settings, and an urgent need for more health campaigns to disseminate information about the *ILE* program.

Acceptability

All participants commented on the stigma associated with abortion, either exerted by external actors or internally perceived. The investigators categorized stigma into three levels: cultural/religious, family, and personal beliefs. There is extensive research on the

relationship between abortion stigma and religiosity, specifically within the context of Catholicism in Mexico [13,14]. The findings from this study reinforce this relationship- the Catholic Church's perspective on abortion was mentioned by nearly all the women. When probed on their personal beliefs about abortion, however, less than half of the participants shared the same unfavorable perspective as the Church. This divergence between cultural and personal beliefs has been explored in some studies, with particular focus on the age, marital status, and education level as determinants of perceived abortion stigma[13,15–17]. Of the nine participants interviewed, those who opposed legal abortion were generally older, married, and had children. Abortion stigma could have also had an impact on the sample size of the study- it is possible that women who had an abortion refused to participate in this study due to an unwillingness or fear to disclose their abortion. Stigma had an impact on abortion access at every point of the abortion journey- from the decision to terminate a pregnancy to the outcome of the procedure[17]. Two participants shared feelings of religious guilt and remorse during and after having an abortion. Wh*ILE* this study did not collect data from healthcare providers, some of the accounts from the participants who sought abortion care indicated abortion stigma from healthcare providers.

Abortion policies largely exclude the discussion of morality from their language, instead focusing on the service from a criminal standpoint [18]. These findings suggest that despite the legality of abortion, abortion stigma appears to be pervasive in Oaxaca. As such, any effort to improve access to *ILE* services in the state must also consider a need for broader de-stigmatization and cultural changes.

Quality

A recurring theme from the participant interviews was the perceived difference in the quality of care received between private and public healthcare providers. All three women in Oaxaca City first sought abortion services from a private clinic, and shared negative experiences with the provider. Two of the three decided to seek a second-opinion from a public *ILE* clinic instead, and expressed satisfaction with the services they received and the providers they saw. The third woman was unable to do the same because of the time period in which she had the abortion (pre-decriminalization). The factors associated

with satisfaction, such as low cost and the quality of counseling that they received about the procedure, are consistent with findings from similar studies conducted in Mexico City [11,14]. The two women noted supportive and non-judgmental attitudes from the medical and reception staff at these clinics. In comparison, one participant recalled the private gynecologist that she first saw explicitly stating that she was not in favor of abortion but that she would help her anyway. All public *ILE* clinics are required to hire providers who are not conscientious objectors to abortion, so as to prevent a situation in which a patient would be turned away for service.

The quality of post-abortion contraception counselling was also brought up in many interviews. There is significant research on an extremely high level of post-abortion contraception uptake in Mexico City[14]. One such study found that 82% of women in their sample opted for a contraceptive method following their abortion [19]. The high uptake, however, may not accurately reflect the true experiences of contraception counseling. The findings from this study provide such perspectives. Overall, participants expressed feeling obligated or pushed to use a long-acting contraceptive method after their abortion. Two participants even recall their providers being insistent that they undergo tubal ligation. The timing of counselling is also important to note. The time following an abortion can be especially emotional for women, and in this emotionally vulnerable state, they may be unable to adequately advocate for themselves when making decisions on their reproductive health[20–23]. Women in Santo Domingo Tonalá commented on similar experiences with contraceptive counselling postpartum. These qualitative findings align with quantitative data on contraceptive utilization among women after an obstetric event that were published by the Ministry of Health in 2019. 54% of women who gave birth in a public facility were discharged with a contraceptive method. Similarly, 30% of women who were attended at a public hospital for an abortion received a contraceptive method. Among both groups, the most commonly used methods were the intrauterine device (IUD), the subdermal implant, and tubal ligation- all three are long-acting contraceptive methods [10]. These findings suggest that family planning service provision and counselling in the public sector are not prioritizing the patient's reproductive autonomy. Future research can build

upon these initial findings to evaluate quality and respect for human rights in reproductive healthcare. [24-25]

The small sample size and convenience sampling strategies used in this study limit the ability for any of the findings to be generalized to a larger population context. The choice of only two settings, Oaxaca City and Santo Domingo Tonalá, also limits the generalizability of the results to other parts of the state, especially regions with a strong presence of indigenous populations or non-Spanish speaking communities. The benefit of an exploratory analysis such as this, the first qualitative investigation on abortion access in Oaxaca, is that we have identified several areas for future research. Having analyzed the self-perceived barriers to abortion services using the AAAQ framework, these finding can be used to inform future research and policy to ensure the right to abortion for all women in Oaxaca.

The testimonies shared by the nine participants in this study suggest that there is much work to be done to facilitate expansive and equitable access to safe and legal voluntary abortion for women in Oaxaca. Policymakers and government stakeholders will need to dedicate more resources to increase the availability of trained abortion providers and disseminate information on the *ILE* program across the state. Advocacy groups that have been providing financial, social and informational support to abortion seekers for years must continue their work and reach out to the marginalized poor, rural and indigenous communities that have long been overlooked.

Manuscript References:

1. Explainer: Abortion Rights in Latin America. AS/COA. Published June 28, 2022. Accessed February 8, 2023. https://www.as-coa.org/articles/explainer-abortion-rights-latin-america

2. Abortion in Latin America and the Caribbean. Guttmacher Institute. Published July 27, 2016. Accessed March 30, 2023. https://www.guttmacher.org/fact-sheet/abortion-latin-america-and-caribbean

3. *Interrupción Legal Del Embarazo: A Tres Años de Su Despenalización En El Estado de Oaxaca*. CEMPAG: Centro de Estudios de las Mujeres y Paridad de Género; 2022. https://congresooaxaca.gob.mx/docs65.congresooaxaca.gob.mx/centros_estudios/CEMPAG/investigacion/3_Interrupcion_legal_del_embarazo_a_3_anios_de_su_despenalizacion_en_Oaxaca.pdf

4. Sarabia D. Despenalización del aborto en Oaxaca: solo dos clínicas y sin atención a mujeres indígenas. Yahoo Finance. Published December 15, 2021. Accessed March 27, 2023. https://es-us.finanzas.yahoo.com/noticias/aborto-oaxaca-cl%C3%ADnicas-atenci%C3%B3n-mujeres-123612851.html

5. Espinosa Gutierrez A. A 2 años de despenalización de aborto en Oaxaca mujeres aún enfrentan dificultades. GESMujer. Published September 30, 2021. Accessed March 27, 2023. https://www.gesmujer.org/sitio/a-2-anos-de-despenalizacion-de-aborto-en-oaxaca-mujeres-aun-enfrentan-dificultades/

6. *INTERRUPCIÓN LEGAL DEL EMBARAZO (ILE)*.; 2023.

7. Ona Singer E. Abortion ex*ILE*: navigating Mexico's fractured abortion landscape. *Cult Health Sex*. 2020;22(8):855-870. doi:10.1080/13691058.2019.1631963

8. Friedman J, Saavedra-Avendaño B, Schiavon R, et al. Quantifying disparities in access to public-sector abortion based on legislative differences within the Mexico City Metropolitan Area. *Contraception*. 2019;99(3):160-164. doi:10.1016/j.contraception.2018.11.012

9. Kothari S. A Legal Victory for Abortion, but Out of Reach for Indigenous Women in Oaxaca. PAI. Published October 18, 2019. Accessed January 16, 2022. https://pai.org/resources/a-legal-victory-for-abortion-but-out-of-reach-for-indigenous-women-in-oaxaca/

10. *Información Básica Del Estado de Oaxaca: Salud Reproductiva*. Ipas Mexico; 2021. https://ipaslac.org/documents/IpasMx2021-Oaxaca.pdf

11. van Dijk MG, Arellano Mendoza LJ, Arangure Peraza AG, Toriz Prado AA, Krumholz A, Yam EA. Women's Experiences with Legal Abortion in Mexico City: A Qualitative Study. *Studies in Family Planning*. 2011;42(3):167-174. doi:10.1111/j.1728-4465.2011.00278.x

12. Making Abortion Services Accessible in the Wake of Legal Reforms: A Framework and Six Case Studies. Published online April 1, 2012. Accessed March 22, 2023. https://www.guttmacher.org/report/making-abortion-services-accessible-wake-legal-reforms-framework-and-six-case-studies

13. McMurtrie SM, García SG, Wilson KS, Diaz-Olavarrieta C, Fawcett GM. Public opinion about abortion-related stigma among Mexican Catholics and implications for unsafe abortion. *International Journal of Gynecology & Obstetrics*. 2012;118(S2):S160-S166. doi:10.1016/S0020-7292(12)60016-2

14. Olavarrieta CD, Garcia SG, Arangure A, et al. Women's experiences of and perspectives on abortion at public facilities in Mexico City three years following decriminalization. *International Journal of Gynecology & Obstetrics*. 2012;118(S1):S15-S20. doi:10.1016/j.ijgo.2012.05.005

15. Díaz Olavarrieta C, Bonifaz Alfonzo L, Sanhueza-Smith P, et al. Twelve years after abortion decriminalization in Mexico City: Can we still remain an island of liberties? *Best Practice & Research Clinical Obstetrics & Gynaecology*. 2020;62:63-78. doi:10.1016/j.bpobgyn.2019.07.009

16. Sorhaindo AM, Juárez-Ramírez C, Olavarrieta CD, Aldaz E, Mejía Piñeros MC, Garcia S. Qualitative Evidence on Abortion Stigma from Mexico City and Five States in Mexico. *Women & Health*. 2014;54(7):622-640. doi:10.1080/03630242.2014.919983

17. Seewald M, Martin LA, Echeverri L, Njunguru J, Hassinger JA, Harris LH. Stigma and abortion complications: stories from three continents. *Sex Reprod Health Matters*. 27(3):75-85. doi:10.1080/26410397.2019.1688917

18. Institute G. Making Abortion Services Accessible in the Wake of Legal Reforms: A Framework and Six Case Studies.

19. Mondragón y Kalb M, Ahued Ortega A, Morales Velazquez J, et al. Patient characteristics and service trends following abortion legalization in Mexico City, 2007-10. *Stud Fam Plann*. 2011;42(3):159-166. doi:10.1111/j.1728-4465.2011.00277.x

20. Brandi K, Woodhams E, White KO, Mehta PK. An exploration of perceived contraceptive coercion at the time of abortion. *Contraception*. 2018;97(4):329-334. doi:10.1016/j.contraception.2017.12.009

21. Sheeran N, Vallury K, Sharman LS, et al. Reproductive coercion and abuse among pregnancy counselling clients in Australia: trends and directions. *Reprod Health*. 2022;19:170. doi:10.1186/s12978-022-01479-7

22. Acre VN, Dijkerman S, Calhoun LM, Speizer IS, Poss C, Nyamato E. The association of quality contraceptive counseling measures with postabortion contraceptive method acceptance and choice: results from client exit interviews across eight countries. *BMC Health Serv Res*. 2022;22(1):1-15. doi:10.1186/s12913-022-08851-0

23. Yee LM, Simon MA. Perceptions of Coercion, Discrimination and Other Negative Experiences in Postpartum Contraceptive Counseling for Low-income Minority Women. *Journal of Health Care for the Poor and Underserved*. 2011;22(4):1387-1400. doi:10.1353/hpu.2011.0144

24. Holt K, Dehlendorf C, Langer A. Defining quality in contraceptive counseling to improve measurement of individuals' experiences and enable service delivery improvement. *Contraception*. 2017;96(3):133-137. doi:10.1016/j.contraception.2017.06.005

25. Holt K, Zavala I, Quintero X, Hessler D, Langer A. Development and Validation of the Client-Reported Quality of Contraceptive Counseling Scale to Measure Quality and Fulfillment of Rights in Family Planning Programs. *Studies in Family Planning*. 2019;50(2):137-158. doi:10.1111/sifp.12092

Chapter 4: Conclusion and Public Health Implications

There is no published research on the topic of abortion- both legal and clandestine- in Oaxaca, Mexico. Much of the existing literature on abortion access in Mexico focuses on the capital city, with little mention of the sociocultural and structural nuances that exist in other parts of the country. This study aims to address that gap with a preliminary exploration of the self-perceived barriers to legal abortion services using a human rights framework. The AAAQ framework was developed by the Committee on Economic, Social, and Cultural Rights and established four key essential elements that a service must meet to uphold the universal right to health: Availability, Accessibility, Acceptability and Quality.

The findings from this study indicate that women in Oaxaca encounter barriers to accessing *ILE* services at each of the four levels. There are a limited number of public facilities that are equipped to provide abortion care across the state. Understanding of the abortion policy is severely inadequate, both among the public and healthcare providers. Despite the legal status of abortion, it is evident that abortion stigma continues to be pervasive at a cultural, interpersonal, and individual level, impacting abortion access at every point of the abortion journey. The quality of abortion care is inconsistent between public and private facilities, and post-abortion contraceptive counselling is described to be overbearing and insistent. The participants in the study confronted multiple of these barriers, the compounding effects of which impacted their experience obtaining an abortion or precluded them completely.

Wh*ILE* this study was limited by its sample size, the results can serve as a starting point for further research into abortion access and the needs of the population in Oaxaca. Whereas this study focused on the experiences of *ILE* users, future investigations could examine provider perspectives to identify weak points in the *ILE*. Moreover, there is a need for accurate quantitative data to complement qualitative descriptions of *ILE* utilization.

The testimonies shared by the nine participants in this study suggest that there is much work to be done to facilitate expansive and equitable access to safe and legal voluntary abortion for women in Oaxaca. Policymakers and government stakeholders will

need to dedicate more resources to increase the availability of trained abortion providers and disseminate information on the *ILE* program across the state. Advocacy groups that have been providing financial, social and informational support to abortion seekers for years must continue their work and reach out to the marginalized poor, rural and indigenous communities that have long been overlooked.

References:

1. Oaxaca C. Consorcio Oaxaca celebra Reforma Constitucional que elimina la protección de la vida desde su fecundación [Internet]. Consorcio Para el Diálogo Parlamentario y la Equidad Oaxaca. 2021 [cited 2023 Feb 25]. Available from: https://consorciooaxaca.org/2021/10/consorcio-oaxaca-celebra-reforma-constitucional-que-elimina-la-proteccion-de-la-vida-desde-su-fecundacion/

2. Mexico's Oaxaca State decriminalizes abortion and makes history [Internet]. Ipas. 2019 [cited 2023 Feb 25]. Available from: https://www.ipas.org/news/mexicos-oaxaca-state-decriminalizes-abortion-and-makes-history/

3. Interrupción Legal del Embarazo: a tres años de su despenalización en el Estado de Oaxaca [Internet]. CEMPAG: Centro de Estudios de las Mujeres y Paridad de Género; 2022 Oct. Available from: https://congresooaxaca.gob.mx/docs65.congresooaxaca.gob.mx/centros_estudios/CEMPAG/investigacion/3_Interrupcion_legal_del_embarazo_a_3_anios_de_su_despenalizacion_en_Oaxaca.pdf

4. Sarabia D. Despenalización del aborto en Oaxaca: solo dos clínicas y sin atención a mujeres indígenas [Internet]. Yahoo Finance. 2021 [cited 2023 Mar 27]. Available from: https://es-us.finanzas.yahoo.com/noticias/aborto-oaxaca-cl%C3%ADnicas-atenci%C3%B3n-mujeres-123612851.html

5. Espinosa Gutierrez A. A 2 años de despenalización de aborto en Oaxaca mujeres aún enfrentan dificultades [Internet]. GESMujer. 2021 [cited 2023 Mar 27]. Available from: https://www.gesmujer.org/sitio/a-2-anos-de-despenalizacion-de-aborto-en-oaxaca-mujeres-aun-enfrentan-dificultades/

6. INTERRUPCIÓN LEGAL DEL EMBARAZO (*ILE*). Ciudad de Mexico, Mexico; 2023 Jan.

7. Abortion [Internet]. World Health Organization. 2021 [cited 2023 Feb 25]. Available from: https://www.who.int/news-room/fact-sheets/detail/abortion

8. The World's Abortion Laws [Internet]. Center for Reproductive Rights. [cited 2023 Feb 8]. Available from: https://reproductiverights.org/maps/worlds-abortion-laws/

9. Singh S, Remez L, Sedgh G, Kwok L, Onda T. Abortion Worldwide 2017: Uneven Progress and Unequal Access. 2018 Mar 19 [cited 2023 Feb 25]; Available from: https://www.guttmacher.org/report/abortion-worldwide-2017

10. Juárez F, Singh S, Maddow-Zimet I, Wulf D. Unintended Pregnancy and Induced Abortion in Mexico: Causes and Consequences. 2013 Nov 1 [cited 2023 Feb 25]; Available from: https://www.guttmacher.org/report/unintended-pregnancy-and-induced-abortion-mexico-causes-and-consequences

11. Kulczycki A. Abortion in Latin America: Changes in Practice, Growing Conflict, and Recent Policy Developments. Studies in Family Planning. 2011;42(3):199–220.

12. Explainer: Abortion Rights in Latin America [Internet]. AS/COA. 2022 [cited 2023 Feb 8]. Available from: https://www.as-coa.org/articles/explainer-abortion-rights-latin-america

13. Dialogue L. The “Marea Verde” vs “Pro-Vida” movements: the fight over abortion rights in Latin America [Internet]. LatAm Dialogue. 2022 [cited 2023 Feb 25]. Available from: https://www.latamdialogue.org/post/the-marea-verde-vs-pro-vida-movements-the-fight-over-abortion-rights-in-latin-america

14. Bélanger D, Flynn A. The Persistence of Induced Abortion in Cuba: Exploring the Notion of an “Abortion Culture.” Studies in Family Planning. 2009;40(1):13–26.

15. Casas X. Opinion | How the ‘Green Wave’ Movement Did the Unthinkable in Latin America. The New York Times [Internet]. 2021 Nov 1 [cited 2023 Feb 8]; Available from: https://www.nytimes.com/2021/11/01/opinion/abortion-latin-america.html

16. Law and Policy Guide: Conscientious Objection [Internet]. Center for Reproductive Rights. [cited 2023 Feb 8]. Available from: https://reproductiverights.org/maps/worlds-abortion-laws/law-and-policy-guide-conscientious-objection/

17. Homedes N, Ugalde A. Twenty-Five Years of Convoluted Health Reforms in Mexico. PLoS Med. 2009 Aug 18;6(8):e1000124.

18. Infographic | How Do Mexicans Get Healthcare? | Wilson Center [Internet]. [cited 2023 Feb 25]. Available from: https://www.wilsoncenter.org/article/infographic-how-do-mexicans-get-healthcare

19. Población total (Número de habitantes) [Internet]. Cuéntame de México - INEGI. [cited 2023 Feb 25]. Available from: https://cuentame.inegi.org.mx/poblacion/habitantes.aspx?tema=P

20. Population, total - Mexico | Data [Internet]. [cited 2023 Feb 25]. Available from: https://data.worldbank.org/indicator/SP.POP.TOTL?locations=MX

21. Birth rate, crude (per 1,000 people) - Mexico | Data [Internet]. [cited 2023 Feb 25]. Available from: https://data.worldbank.org/indicator/SP.DYN.CBRT.IN?locations=MX

22. Fertility rate, total (births per woman) - Mexico | Data [Internet]. [cited 2023 Feb 25]. Available from: https://data.worldbank.org/indicator/SP.DYN.TFRT.IN?locations=MX

23. Informe semanal de notificación inmediata de muerte materna. [Internet]. Secretaria de Salud del Gobierno de Mexico; 2022. Available from: https://www.gob.mx/cms/uploads/attachment/f*ILE*/788958/MM_2022_SE52.pdf

24. Mendez-Dominguez N, Santos-Zaldívar K, Gomez-Carro S, Datta-Banik S, Carrillo G. Maternal mortality during the COVID-19 pandemic in Mexico: a preliminary analysis during the first year. BMC Public Health. 2021 Jul 2;21(1):1297.

25. Darney BG, Fuentes-Rivera E, Polo G, Saavedra-Avendaño B, Alexander LT, Schiavon R. Con la ley y sin la ley/With and without the law: Utilization of abortion services and case fatality in Mexico, 2000–2016. International Journal of Gynecology & Obstetrics. 2020;148(3):369–74.

26. Becker D, Díaz Olavarrieta C. Decriminalization of Abortion in Mexico City: The Effects on Women's Reproductive Rights. Am J Public Health. 2013 Apr;103(4):590–3.

27. Fuentes MLS, Paine J, Elliott-Buettner B. The Decriminalisation of Abortion in Mexico City: How Did Abortion Rights Become a Political Priority? Gender and Development. 2008;16(2):345–60.

28. Díaz Olavarrieta C, Bonifaz Alfonzo L, Sanhueza-Smith P, Fajardo Dolci GE, Guevara-Guzmán R, Aburto-Arciniega MB, et al. Twelve years after abortion decriminalization in Mexico City: Can we still remain an island of liberties? Best Practice & Research Clinical Obstetrics & Gynaecology. 2020 Jan 1;62:63–78.

29. El Aborto Como Un Asunto De Salud Pública [Internet]. Ipas Mexico; 2021. Available from: https://ipasmexico.org/pdf/IpasCAM-2021-ElAbortoComoUnAsuntoDeSaludPublica.pdf

30. Maier E. El aborto y la disputa cultural contemporánea en México. La aljaba. 2010 Dec;14:11–30.

31. Constituciones que Protegen la Vida desde la Concepción [Internet]. Información y datos sobre aborto legal en México, violencia obstétrica, muerte materna y otros. [cited 2023 Feb 25]. Available from: https://gire.org.mx/plataforma/constituciones-que-protegen-la-vida-desde-la-concepcion/

32. Ona Singer E. Abortion ex*ILE*: navigating Mexico's fractured abortion landscape. Cult Health Sex. 2020 Aug;22(8):855–70.

33. Sousa A, Lozano R, Gakidou E. Exploring the determinants of unsafe abortion: improving the evidence base in Mexico. Health Policy and Planning. 2010 Jul 1;25(4):300–10.

34. Concluding observations of the Committee on the Elimination of Discrimination against Women. [Internet]. United Nations; 2012 Jul. Report No.: CEDAW/C/MEX/7-8). Available from: https://www2.ohchr.org/english/bodies/cedaw/docs/co/cedaw-c-mex-co-7-8.pdf

35. Paso a paso: las sentencias de la Corte sobre aborto [Internet]. GIRE: Grupo de Informacion en Reproduccion Elegida; 2022 Nov. Available from: https://gire.org.mx/wp-content/uploads/2022/11/Paso-a-paso.pdf

36. Romo V. Mexico's Supreme Court Has Voted To Decriminalize Abortion. NPR [Internet]. 2021 Sep 7 [cited 2023 Feb 25]; Available from: https://www.npr.org/2021/09/07/1034925270/mexico-abortion-decriminalized-supreme-court

37. Sobol V. Mexico Supreme Court Recognizes a Constitutional Right to Abortion [Internet]. Center for Reproductive Rights. 2021 [cited 2023 Feb 25]. Available from: https://reproductiverights.org/mexico-supreme-court-decriminalizes-abortion/

38. Mexico's border state Quintana Roo becomes 11th to allow abortion | Reuters [Internet]. [cited 2023 Feb 25]. Available from: https://www.reuters.com/legal/mexicos-border-state-quintana-roo-becomes-11th-allow-abortion-2022-10-26/

39. Quintana Roo y la ola verde: ya son 11 estados que despenalizan el aborto en México [Internet]. [cited 2023 Feb 25]. Available from: https://www.eleconomista.com.mx/politica/Quintana-Roo-y-la-ola-verde-ya-son-11-estados-que-despenalizan-el-aborto-en-Mexico-20221027-0050.html

40. Número de habitantes. Oaxaca [Internet]. [cited 2023 Feb 25]. Available from: https://cuentame.inegi.org.mx/monografias/informacion/oax/poblacion/

41. Información Básica del Estado de Oaxaca: Salud Reproductiva [Internet]. Ipas Mexico; 2021 Jul. Available from: https://ipaslac.org/documents/IpasMx2021-Oaxaca.pdf

42. Kothari S. A Legal Victory for Abortion, but Out of Reach for Indigenous Women in Oaxaca [Internet]. PAI. 2019 [cited 2022 Jan 16]. Available from: https://pai.org/resources/a-legal-victory-for-abortion-but-out-of-reach-for-indigenous-women-in-oaxaca/

43. Carpeta Informativa: Interrupcion Legal del Embarazo. CESOP: Centros de Estudios Sociales y de Opinion Publica;

Appendix 1: Semi-Structured Interview Guide (Spanish)

GUÍA DE ENTREVISTA SEMI ESTRUCTURADA

Gracias por su valioso tiempo destinado a esta entrevista. A continuación 2 entrevistadores (presentación) realizarán 10 preguntas abiertas.

Antes de comenzar es importante mencionar que se le otorgará a usted "el consentimiento informado", donde puede elegir ser anónima. Cabe mencionar que la siguiente entrevista es con fines académicos y queda exenta de intereses políticos, ideológicos, sociales etc.

También, nos permite grabar la entrevista? Vamos a borrar el audio después del análisis.

Comenzaremos con datos sociodemográficos y generales sobre su persona:

DATOS GENERALES DE LA MUJER ENTREVISTADA

Edad: _____	Escolaridad: _____	Lugar de origen: _____
Religión:_____	Estado Civil _____	¿Es usted hablante de alguna lengua indígena? Si ___ Cuál _____ No ___
¿Es derechohabiente de algún sistema público de salud (por ej. IMSS, ISSSTE, SEDENA, PEMEX)? Si ___ Cuál _____ No ____ ¿Es usuaria de algún sistema privado de salud? Si ___ Cuál_____ No ____	¿Ha estado embarazada? Si ___ ¿Cuántos años tenía usted cuando se embarazó por primera vez?_____ No____	¿Cuántos embarazos ha tenido? _____ ¿El/los embarazos fueron concluidos? _____

¿Ha tenido abortos? Si___ No_____ ¿Cuántos? _____ Cuándo fue (mes y/o año)? _____	¿Ha migrado alguna vez? Si___ a dónde:___ No_____ A qué edad migró: _____ ¿Cuánto tiempo vivió en donde migró? _____	¿Actualmente usa algún anticonceptivo? Si___ No_____ ¿Cuál? _____ ¿Cuándo comenzó a usar anticonceptivos?

Preguntas de la entrevista Mujeres

Panorama General

¿En su opinión, como es la atención que reciben las mujeres en los centros de salud de la comunidad? (personal de salud, administrativo, farmacia, seguridad, etc.)

¿Cree que existe el personal médico suficiente para atender a los servicios de salud reproductiva/sexual de las mujeres en el estado de Oaxaca?

¿Cómo ha sido su experiencia con los métodos anticonceptivos? (adquisición, accesibilidad, costos,etc.)

¿Has recibido educación sexual, quién se la ha proporcionado?

¿Sabe cuáles son los derechos sexuales y reproductivos de las mujeres? ¿Ha visto/escuchado/leído campañas que promocionen y/o proporcionen información sobre los derechos sexuales y reproductivos de las mujeres?

¿En dónde cree que se puede conseguir más información?

***Si ella responde "SI" a la pregunta sobre aborto, sigue esta sección*

Experiencias con servicios del aborto:

¿Puedes describirme tu experiencia con el servicio del aborto?

Probes:

¿Me podría comentar cómo accedio el aborto (tomó medicamentos, asistió a una clínica, otros métodos naturales/tradicionales)?

¿Qué dificultades tuvo para acceder al servicio de aborto? (enfatizar en economía, ubicación geográfica, apoyo social, información,etc.)

¿Asistió a una clínica pública o privada para esté servicio?

¿Fue acompañada por alguien?(pareja, familiares, amistades, alguna organización)

¿Cuánto le costó el servicio y/o consultas de seguimiento?

¿Cuántas semanas de embarazo tenía cuando realizó el aborto?

¿Nos puede compartir que le llevó a tomar la decisión de abortar?

¿Tuvo alguna consulta médica y/o habló con alguien antes de tomar la decisión?

¿Cómo se sintió cuando descubrió que estaba embarazada?

¿Cómo fue la información que le dieron los proveedores del aborto? ¿Fue clara, suficiente, insuficiente, confusa, etc.?

¿Cómo se sintió después de abortar? (tranquila,triste,inquieta, feliz, etc)

¿Usted le compartió a alguna persona (familia, amistades, conocidos) sobre su aborto?

¿Cómo se imagino el procedimiento del aborto?

¿Fue como usted lo imaginaba?

¿Qué apoyo adicional le hubiera gustado tener al obtener un aborto?

¿Qué desafíos, si hubo alguno o enfrentó cuando abortó?

¿Que hubiera hecho si le negaran hacer el aborto y/o no podría encontrar a un servicio?

Percepciones y Creencias respecto al servicio del aborto

¿Ha tenido conversaciones con sus amistades/familiares/religión etc, sobre el aborto? ¿Qué piensa usted de estas conversaciones?

¿Cree usted que las mujeres de su comunidad reciben información suficiente sobre el tema del aborto?

¿Qué desafíos cree usted que tienen las mujeres para acceder a un aborto legal y seguro en su comunidad?

¿Qué conoce sobre la Ley que despenalizó el aborto en Oaxaca?

Conclusión:

Agradecimiento:

Muchas gracias por tomar tiempo para apoyar con esta información. ¿Tiene usted algún comentario pregunta? También si tiene preguntas en el futuro, nos puede comunicar aquí

_____

Al concluir el proyecto, vamos a borrar la grabación de esta entrevista después de hacer el análisis. Su nombre y datos privados *no* van a aparecer ni en el análisis ni en cualquier documento. Entendemos que este tema puede causar emociones negativas o debilitantes. Si necesita tiempo y espacio,, le podemos dejar este espacio para usted. También si cree que le

ayudará la atención psicológica, podemos conectarle con un miembro del grupo que le puede ayudar.

El equipo de Emory Global Health Institute le agradece su atención prestada!

Appendix 2: Translated Quotations

Participant ID- Position	Spanish	English Translation
MO-1, Pos. 94	Que no está de acuerdo. Pues y me dijo "Mira, no estoy de acuerdo, pero te voy a ayudar" dijo.	She (the doctor) was not in favor (of abortion). So she said "Look, I don't agree with this, but I'll help you anyway "
MO-1, Pos. 131-139	..Me dijo que ya no tenía yo residuos, este que este estaba limpio y ya me pusieron una inyección… me dijo "¿o quieres embarazarte?" Y le dije No, si por eso vine le dije, y me dice no te quiero volver a ver aquí, de que…que vas a volver…pues me imagino otro aborto ¿no?	They told me I didn't have any residues anymore, that I was clean, and they gave me an injection….They told me "Or do you want to get pregnant?" I told them "No, that's what I came here in the first place", and they told me that they did not want to see me here again (for another abortion)
MO-1, 145,194	Me convencí de que es por mi bien… Me dijeron que era importante que me ligara porque la matriz o sea es servía más para dos cosas para tener bebés y para este para tener cáncer.	They convinced me that it was for my own good…they told me that it was important that I have the ligation because the uterus serves two purposes: to have babies and to have cancer
MO-2, Pos. 47	Lloraba mucho, creo que caí en depresión siempre era lo mismo que pedía perdón a Dios. Perdóname por lo que hice, perdóname por lo que hice, pero yo no tenía esa capacidad, no me sentía perdonada.	I cried a lot, I think I fell into a depression. It was always the same, I would ask God to forgive me. Forgive me for what I did, forgive me for what I did, but I didn't feel forgiven.
MO-2, Pos.108	El verdadero arrepentimiento es cuando decides ya no volver a hacerlo.	The true repentance is when you decide that you will not do it [have an abortion] ever again
MO-3, Pos.126	En un principio me registré con las enfermeras…yo llegué como sintiéndome un poco incómoda, quizás porque, sabemos que aquí en México y en Oaxaca no es como un tema muy abierto todavía. Entonces no es como llegar al hospital y decirles "ahí yo voy a abortar". No? Es un poco difícil, yo creo a veces como expresarlo.	In the beginning, I registered with the nurses…and I felt a little bit uncomfortable, perhaps because, we all know that here in Mexico and in Oaxaca it still isn't a very open topic. It's not like one arrives at the hospital and says "I am here to have an abortion", no? It is a little difficult, sometimes, to express it.
MT-6, Pos.72	Fue una prima o una sobrina que se ha abortado como tres o cuatro veces… ¿Si no lo quieres para que vas a tener relaciones sabiendo que existen métodos? ¿Si no estaban decididos en	I knew a cousin or niece who had aborted three or four times…but if you don't want it (a child) why are you having sexual relations knowing that there are

	formar una familia o tener un bebe para que?	(contraceptive) methods…If you are not ready to have a family or a baby, why?
MO-3, Pos.63	Recuerdo que nos pusimos a investigar porque si nos llaman mucho la atención como el tema de los abortos y vimos que nada más, o sea desde que se despenalizó, que fue en el 2019 hasta el 2020, nada más una persona se lo había realizado en el hospital al que yo fui y me sorprendió mucho porque... Pues es un servicio público, ¿no? Se supone que debe de haber...Pues es servicio para mucha gente.	We got together to research (the policy)...and we saw that, since it was decriminalized, only one person had obtained an abortion in the hospital that I went to and that surprised me because…well, it's a public service, no? And you would assume that they should be…well it's a service meant for many people
MT-5 CLEAN, Pos. 108	Pues yo creo que es falta de información de los doctores, porque no creo que por ellos diga no está bien, no? Que sea por ética, por lo que ustedes quieran, tienen que brindar esa información, no? Entonces este yo creo que es por falta de conocimiento de los mismos doctores.	It is a lack of information from the doctors… because I don't think that they say "No, this (abortion) is okay", right? If it's because of ethics, or whatever you say, they have to provide this information, no? So I believe that it is because of a lack of awareness of the doctors themselve*s*
MO-3, Pos. 138	No es como que voy a ir al hospital y voy a encontrar un folleto informativo precisamente del aborto. Es más como de, no sé, cualquier otro tipo de enfermedad o problema. Puedes encontrar más accesibilidad a eso que a un folleto de información de un aborto	It's not like I go to a hospital and I will find a brochure about abortion. It's more of, I don't know, any other type of disease or problem. You can find more available information on that than on abortion