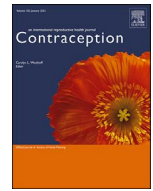




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Original research article

“Becoming the woman she wishes you to be”: A qualitative study exploring the experiences of medication abortion acompañantes in three regions in Mexico ☆☆☆

Suzanne Veldhuis^{a,*}, Georgina Sánchez-Ramírez^a, Blair G. Darney^{b,c}^a El Colegio de la Frontera Sur (ECOSUR), Carretera Panamericana y Periférico Sur s/n. Barrio de María Auxiliadora, México C.P.^b Oregon Health & Science University, Portland, Oregon, United States^c Centro de Investigación en Salud Poblacional (CISP), Instituto Nacional de Salud Pública (INSP), Cuernavaca, México

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ABSTRACT

Objectives: Acompañantes are activists who accompany women who have medication abortions outside of clinical settings. We describe models of accompaniment across 3 states in Mexico with diverse abortion laws, access, and acompañantes, and describe how acompañantes conceptualize the benefits and challenges of their work.

Study design: In this exploratory, qualitative study, we conducted semi-structured interviews with 14 participants about their experiences as acompañantes, in 2 states with restrictive abortion legislation (Baja-California, Chiapas) at the time of research and Mexico City, where abortion is legal upon request in the first trimester. We used a feminist ethnography approach and analyzed data using a priori categories which included perceived benefits of and challenges of the accompaniment model.

Results: Participants described similar steps and general characteristics of the accompaniment process regardless of the setting, supporting the concept of an overarching definition of the holistic accompaniment model for these acompañantes. Holistic accompaniment is a horizontal model that involves trusting women, not asking for the reasons for their abortion, preventing criminalization, economic support, respecting autonomy, emotional accompaniment, and being flexible. Participants described perceived advantages, including safety, even in settings otherwise unsafe, such as where women may be stigmatized and / or criminalized. Participants described benefits of autonomous abortion compared to in-clinic medication abortion or surgical abortion, and benefits specifically related to accompaniment, such as the potential to make the abortion a positive experience.

Conclusions: We describe components of a holistic accompaniment model in Mexico which has specific characteristics that may benefit women who opt for out-of-clinic abortion.

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1. Introduction

In Mexico, abortion is regulated at the state level and allowed only under narrow and unevenly implemented exceptions [1], restricting access to legal abortion [2,3]. By early 2020, first trimester abortion without restriction as to reason was decriminalized only

in 2 states: Mexico City (since 2007) and Oaxaca (since 2019) [1]. However, limited decriminalization does not imply widespread availability of services and there are still many obstacles that limit access to legal services, especially for the most vulnerable women¹ [4,5]. In Mexico, women (often with support from grassroots activists) increasingly use medication abortion (a safe and effective method [6]) outside clinical settings. This is often called self-managed medication abortion, and is an alternative to clinical services, or used when clinical services are limited or nonexistent [7].

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* Corresponding author.

E-mail address: suzanne.veldhuis@gmail.com (S. Veldhuis).

¹ We recognize that not all people who may have an abortion recognize themselves as “women”. However, in this article we chose to use this (and related) word(s), as all study participants refer to the people they accompany as such.

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| CLINICAL ABORTION | | | AUTONOMOUS ABORTION | |
|---|---|---|---|---|
| <i>Clinical providers</i> | <i>Telemedicine</i> | <i>Other providers</i> | <i>With acompañantes</i> | <i>Alone</i> |
| The mayor part of the process takes place in a clinical context with an in-person intervention of a professional health worker. Some tasks, such as the administration of the medication(s) or the assessment of completeness of the abortion are performed by the woman herself at home. | The process takes place at distance, partially or completely. The woman has contact with a professional health worker by means of telecommunication before, during or after the procedure, the medications are self-administered at home. | The process takes place inside or outside of a clinical context with support from lay health workers, and includes variable aspects of self-management. | The woman manages the whole process outside of a clinical context, accompanied in-person or virtually (by means of telecommunication) by trained lay activists. | The woman manages the whole process outside of a clinical context, without accompaniment or information provided by a trained person. |
| MORE MEDICALIZATION | | | LESS MEDICALIZATION | |

Fig. 1. Types of self-managed medication abortion translated from [11].

There is currently no consensus on the definition of self-managed medication abortion [8,9]. We refer to self-managed medication abortion as continuum that goes from minimally to highly medicalized [10], where one or more of the aspects of the process are self-led outside of a clinical setting [8]. We distinguish between *clinical* and *autonomous* self-managed medication abortion (Fig. 1) [11]. In the former, at least one of the steps takes place in a clinical context or involves a professional (in-person [12,13,42] or by telemedicine [14]) or other provider such as pharmacy workers or traditional midwives [12,15]. In autonomous medication abortion the whole process takes place outside of a clinical setting, and without the involvement of a healthcare provider [16]. It may be performed alone or accompanied by activists, often known in Spanish-speaking contexts as *acompañantes*. These *acompañantes* are not healthcare providers, but volunteers with training in safe medication abortion who provide evidence-based information, guidance, and support throughout the self-managed abortion process [16–22]. Accompaniment networks are increasingly common in Mexico [23], however, little is known about the experiences of *acompañantes* in this country. The purpose of this exploratory study was to describe models of accompaniment across 3 states in Mexico with diverse abortion law, access, and *acompañantes*, and to describe how *acompañantes* conceptualize the benefits and challenges of their work.

2. Methods

We conducted this qualitative study in 3 states in Mexico: Chiapas, Baja California, and Mexico City, representing different social, cultural, political, and legal settings. Both Chiapas and Baja California are conservative border states (to Guatemala and the United States, respectively) with restrictive abortion legislation at the time of this study (December 2019–February 2020) [1]. The population of the southern state of Chiapas is mainly poor, vulnerable, and rural. Chiapas also has a large Indigenous population [24]. In contrast, most of the population in Baja California, in the north, and Mexico City, in the center of the country, is neither poor nor vulnerable, and resides in urban areas [24]. Mexico City has had mostly liberal governments, although abortion stigma still exists [[4,25]. In Chiapas as well as in other states with restrictive legislation, levels of abortion stigma have been found to be much higher [25].

a. Data collection

We used a feminist ethnography approach, which aims to develop non-exploitative research relationships [26,27], and considers

study participants not only as informants but as creators of culture and knowledge. It is explicitly conducted to support positive change [27], in our case to improve access to safe abortion.

We identified participants using snowball sampling based on previous contacts that SV had with several *acompañantes*, activists who accompany women during autonomous abortions. We ensured a diverse sample by recruiting activists from feminist collectives and NGOs, as well as those operating individually. We provided the participants with a written explanation of the investigation’s purpose, which we described as to have a better understanding of the accompaniment model, its safety, possible benefits and challenges. All contacted *acompañantes* agreed to participate and provided written informed consent.

SV and GSR developed and then piloted the interview guide with one individual. Between December 2019 and February 2020, SV conducted 14 semi-structured interviews in Spanish in-person (Chiapas) or by videoconference (Baja California and Mexico City). Interviews lasted from 45 to 120 minutes. We recorded and transcribed all interviews. We assigned pseudonyms to each participant and omitted the names of the feminist collectives, organizations, and exact locations to preserve confidentiality. We asked the participants to describe a “typical” accompaniment process, their protocols, complications they have witnessed, perceived benefits, disadvantages, and challenges of the accompaniment-model, and their conception of its safety. Additionally, we asked them to describe possible reasons women opt for autonomous abortion instead of an abortion in a clinical and/or legal setting. In addition to the interview, we solicited sociodemographic information about the participants.

SV’s long experience working in Chiapas as an abortion provider and activist provided her with insider knowledge of the accompaniment-networks. This facilitated making contact and conducting the interviews, as trust was easily reached and participants felt confident to provide detailed descriptions (including sensitive information) of their experiences. SV’s identity as a physician (which was known to some but not all participants) and familiarity with the abortion process allowed participants to use shorthand and be understood. We ensured the quality of data collection by frequent discussions and feedback from GSR, who specializes in health research using a gender perspective, and BGD, a specialist in abortion research in Mexico. SV regularly shared transcriptions of the interviews with GSR and BGD to discuss findings and we reached data saturation after 14 interviews, 5 in Baja-California, 4 in Chiapas, and 5 in Mexico City. The Research Ethics Committee (CEI) of El Colegio de la Frontera Sur (ECOSUR), Chiapas approved this study.

Table 1
Selected characteristics of study participants, *acompañantes* in Mexico (N = 14)

| | |
|--|--------------|
| Median age, years (range) | 32 (25-65) |
| <i>State of residence</i> | |
| Baja California | 5 (36%) |
| Mexico City | 5 (36%) |
| Chiapas | 4 (28%) |
| <i>Type of acompañante</i> | |
| Feminist collective | 7 (50%) |
| NGO | 3 (21%) |
| Autonomous | 4 (29%) |
| Speaks indigenous language | 1 (7%) |
| Religious | 1 (7%) |
| Has children | 2 (14%) |
| In a relationship | 4 (29%) |
| <i>Employment status</i> | |
| Employed | 10 (72%) |
| Student | 3 (21%) |
| Retired | 1 (7%) |
| Median years of experience as <i>acompañante</i> (range) | 4 (0.5 - 12) |
| Mean years of experience as <i>acompañante</i> | 5 |
| Median number of accompaniments/year (range) | 19 (2 - 216) |
| Mean number of accompaniments/year | 65 |

b. Data analysis

We used a gender perspective and feminist ethnography approach to analyze our qualitative data [28]. Our positionality as researchers committed to the importance of access to safe abortion led us to focus the analysis on identifying the general characteristics of the accompaniment model, which was developed by the participants to benefit (based on their in-depth understanding of the (complex) experiences) women who seek an abortion.

We created a preliminary coding scheme guided by our research question, which included the exploring of perceived benefits, disadvantages of and challenges to the accompaniment model. We used a spreadsheet to organize relevant quotes by these categories, and added emergent themes as developed. SV coded the transcripts by means of an inductive process of adjusting, adapting, modifying, and creating of new categories and subcategories where necessary [29], and met frequently with GSR and BGD to discuss this process. When deemed necessary, we adapted the preliminary codebook. We compared findings by state to see if accompaniment models were different.

3. Results

The 14 participants, *acompañantes*, had a median age of 32 (range 25 - 65), were highly educated and identified as feminists and activists (Table 1). There was a wide range in the frequency of accompaniment, from 2 to more than 200 a year, with an average of 65 women accompanied per year across all participants. Those accompanying larger numbers of women usually formed part of a feminist collective or NGOs with high visibility on social networks. Participants who worked independently accompanied more sporadically and were identified via word-of-mouth. Participants in all 3 regions reported accompanying vulnerable women (e.g., adolescents, indigenous women, migrant women from Central America). They accompanied women from their own regions, as well as from other parts of the country or other countries in the Americas, including legal settings such as Mexico City and the United States.

All but one participant had attended at least one training on safe autonomous abortion care. Trainings included information on medical protocols as well as on a wide range of topics such as legal issues, feminist theory, and post-abortion accompaniment. All participants were routinely in contact with other *acompañantes* to share information and experiences at national and international meetings or through informal networks. All used protocols and materials received during trainings, created themselves (feminist collectives), which were provided (NGOs), or found on the internet (independent *acompañantes*).

a. The holistic accompaniment model

Asking *acompañantes* to describe a typical accompaniment experience gave rise to our principal finding: defining the components of a holistic accompaniment process. The participants described similar steps and general characteristics of the accompaniment process regardless the setting, supporting the concept of an overarching holistic model for these *acompañantes*. Holistic accompaniment is a horizontal model that involves trusting women, not asking for the reasons for their abortion, preventing criminalization, economic support, respecting autonomy, emotional accompaniment, and being flexible.

They talked about **trusting** the women and what they say, and **not asking for the reasons** for their abortion. "In our accompaniments, we never ask the women for the reason why they want to abort, that doesn't matter to us. They want to abort, and that's it" (Cloe - Chiapas). Participants reported forming an impression of the women's social context, discussing different safe options, and ruling out contraindications for medication abortion. They referred women to (allied) providers if they were not eligible or preferred one of the alternative options. If choosing medication abortion, they then provided detailed information about the procedure, how to access and use the medications, their adverse effects, what symptoms are to be expected, and signs of possibly serious complications, often using visual aids. Also, they shared strategies to **prevent criminalization**, such as avoiding the vaginal application of misoprostol (to prevent the detection of remains of the medication), and instructing on where to go and what to say if medical attention is needed. Clarisa (from Baja California) explains what to do in case of criminalization: "Do not say anything about the medication, there is no way that they will find something in your system, do not sign anything, any doubt or situation, call us".

Not only did they not charge for the accompaniment, they offered **economic support** to pay for medication or tests if necessary. Participants recommended a urine pregnancy test to confirm pregnancy, and an ultrasound² to determine gestational age and screen for ectopic pregnancy. However, they also proceeded without prior ultrasound and calculated gestational age based on the date of the last menstrual period, as they were aware of the possible financial and emotional impact.

I noticed that for some women it was difficult to have an ultrasound. Pregnancies are romanticized, they make them listen to the baby's heart... many have a hard time. So, I explain that it is not necessary, if they don't want to or are not able to, I will still accompany them (Aurora - Mexico City)

They described recommending accurate doses of the combined mifepristone-misoprostol³ or misoprostol alone WHO regimen, adjusted to gestational age. They also commented on recommending

² In Mexico, ultrasounds are typically made in private diagnostic centers by radiology-technicians without doctor's authorization (\$20-30USD), or in private clinics during a consultation (\$40-50USD).

³ Misoprostol is available over the counter at low cost in Mexico, but the sale of mifepristone is restricted. Most participants were in contact with an NGO that provided women with a mifepristone-misoprostol combination "kit" (\$25USD).

additional doses of misoprostol if needed until completion of abortion [13,38].

The accompaniment during the actual abortion could be virtual as well as in person. This depended on the location, wishes and needs of the accompanied woman, as well as the possibilities and preferences of the *acompañante*.

I meet them to go to their house, and there I will be accompanying them. They take the medications and I'm monitoring them. Sometimes I give them a massage, go for a glass of water, cook something... Sometimes we have dinner together before they take the medications. At all times, I am checking on how they feel, what is happening, whether they need anything... I think it is particularly important that they feel safe. (Aurora – Mexico City)

They monitored for warning signs and identified medical allies, who offered support in case of questions at any point during the accompaniment or in case of possible complications. All participants considered **respecting autonomy** and providing **emotional accompaniment** essential. The latter typically included activities to distract and relax the women, talking with women about their personal circumstances and emotions, and affirming their right to choose, during the entire accompaniment-process.

It's a personalized accompaniment. Besides the physical symptoms, we keep an eye on their mental health, make sure they feel comfortable, that it is a process filled with love. We try to make the process less traumatic, less painful, as far as possible, with full respect for the autonomy of the accompanied woman. (Andrea – Mexico City)

The participants recommended a range of methods to assess the termination of the pregnancy, such as an ultrasound or urine pregnancy test. They also assessed completion by the description of the expulsion of the gestational sac. The participants concluded the accompaniment when the woman decided to.

To me, it's not enough that she aborted, that she's physically healthy. I always try to find out how she is doing, what's going on, how she feels. Women themselves will tell you when it's over... there are women that as soon as they have had the abortion never again want to talk about it. (Ana – Mexico City)

Finally, as evidenced by this description of the accompaniment model, participants' recommendations and practices accompaniment were highly **flexible** and adapted to the preferences and circumstance of each individual woman.

b. Perceived benefits and challenges of autonomous abortion with acompañantes

We asked participants to describe perceived benefits, such as safety, and challenges of the accompaniment model. Emergent themes were benefits linked to the advantages of autonomous medication abortion compared to in-clinic medication or surgical abortion, and those specifically related to the accompaniment.

i. Perceived safety

All participants considered autonomous abortions with *acompañantes* as safe. Anahí from Chiapas affirms "Yes, it is safe, we use protocols that are endorsed by institutions⁴ that are experts on the issue": None reported having experienced serious complications. Ana (*acompañante* in Mexico City) shares: "In my experience, a well performed medication abortion usually does not present complications. The truth is that it is such an easy, such a noble procedure; women can do it at home"

Most participants described cases of non-medical complications due to unsafe social situations. They gave examples such as when

the violent husband found out the woman was having an abortion, the timely detection of ectopic pregnancies, or complications of unsafe abortions due to the lack of information and accompaniment.

They contacted me in the middle of the night. The chica had not followed any security protocol. She only knew she was pregnant because she stopped menstruating and her belly grew, I suspect that she was already in the second trimester. She had applied misoprostol and expelled [the pregnancy] but couldn't deliver the placenta. The boyfriend didn't know how to take her to a hospital, they lived in some remote village. The only thing I could think about was that she was going to die, and that I couldn't let that happen, so I told him to put 4 more tablets under her tongue, apply warm compresses and massage her. In the end, she delivered the placenta. Early next morning he took her to a clinic, they checked her and everything was fine. (Ofelia – Chiapas)

Participants noted that accompaniment offers protection in an unsafe environment. They considered that the holistic accompaniment model reduces internalized stigma and protects women from stigmatization from others such as providers and family members, as expressed by Clementina from Mexico City: "I think it is safer for them...prevents them from being stigmatized and criminalized, by having a network that takes care of them, an accompaniment that you will not find in a clinic or hospital. Security on a social and a physical level.". Participants also mentioned that it prevents criminalization in legally restrictive settings.

ii. Additional benefits of autonomous abortion with acompañantes

The participants expressed that self-management of medication abortion allows women to plan the timing of the abortion, and have the abortion, at a low cost, in the comfort and privacy of their own home. They often contrasted the comfort of a home abortion to a surgical intervention in a health facility. Aurora from Mexico City describes "You're in a familiar place, where you can create a moment of privacy, have control over the time, can decide when you are going to do it. It can be a more personal experience, someone in whom you trust can be there with you, you can eat something, listen to music, have the liberty to choose what you want to do during the process."

In participants' experience, a holistic accompaniment can make the abortion a positive, loving, empowering, and transformative experience. Participants described that autonomous abortions with *acompañantes* will always exist, because it offers something that a clinical abortion does not offer, even when it is legal and without cost.

You become the ideal person that you would want to have at your side when you have a problem, who doesn't judge, doesn't question, who provides you with anything you need. I think an *acompañante* creates an invisible connection with the accompanied woman, you sort of become the woman that she wishes you to be, as if you were her best friend, even though you are a stranger. After women abort with us, they say 'I would never recommend another woman to go to a clinic, I would tell her to go to an *acompañante*' (Cloe – Chiapas)

iii. Disadvantages and challenges

When probed, participants described disadvantages of the accompaniment model. However, they focused on characteristics of medication abortion and social, legal or health system constraints, not the accompaniment model per se. Olivia from Mexico City mentions that "if the woman has privacy issues ... if she lives alone, in her own apartment, it is great, but that is not always the case, there are different settings in which the family is never out, don't leave her [alone], even when she's menstruating, they might ask: 'why are you bleeding so much,' that would be terrible"

⁴ Participants referred using the WHO protocol for safe medication abortion [13], but also guidelines from IPAS [37], FIGO [38], or well-known feminist collectives [39–40].

Participants noted that some women may prefer a surgical abortion. They considered the lack of information about the accompaniment model to be a challenge. Although misoprostol is widely available, they were worried about future access and the limited access to mifepristone. Finally, as all participants were unpaid volunteers, they considered their reach to be limited.

4. Discussion

An important finding of this qualitative study is the lack of difference in accompaniment models between the 3 regions, which have very different social, political, and legal settings. A possible explanation is that although the participants operate in specific settings, they accompany women from other states (and even countries) as well as local women. Thus, the model does not change according to the region where the *acompañante* is based. The practices are adapted to the personal context, needs and preferences of the accompanied women. This flexibility, combined with the other characteristics of holistic accompaniment (trusting the accompanied women, not asking for reasons for abortion, respecting autonomy, emotional accompaniment, economic support, and preventing criminalization) sets the model described in this study apart from other types of self-managed medication abortion. It also adds to the existing knowledge of accompaniment models mainly limited to data on telephone hotlines and some other models managed by well-known feminist collectives [17,19–22,30].

The horizontality and person-centeredness of the holistic accompaniment likely allows a quality of care and interaction between the accompanied women and the *acompañante* from which clinical models could learn [16,31]. The accompaniment model derives from a feminist and sororal⁵ practice and points to a new concept of “abortion services” where the provider-patient hierarchy is replaced by a horizontal relationship between 2 women who support and empower each other [16,18,31,41]. The participants explicitly linked accompaniment to reducing internalized and other abortion stigma. They considered that it can even result in a profound change and resignification of the abortion experience for the accompanied women through the re-appropriation of their bodies, as has been suggested by some authors [16,18,31]. Other benefits of and challenges to autonomous abortion with *acompañantes* identified by the participants coincide with those of medication abortion or self-management in general, as previously described by other authors [9,32,33].

The participants considered the holistic accompaniment-model as safe: their practices are based on the subtasks of the WHO framework for medication abortion [12]. In addition, they go beyond clinical safety or technical quality to encompass interpersonal safety, taking practical, legal, emotional, and social aspects into account [34,35]. An evaluation of the safety of care provided by participating *acompañantes* is beyond the scope of this study; however, we present evidence of knowledge and use of the WHO recommendations on self-managed medication abortion. These include having a source of accurate information and access to a health-care provider if wanted or needed at any stage of the process [6]. Evidence is growing about the safety and efficacy of accompanied abortions during the first and second trimesters [17,19,36], although more studies are urgent.

This study has limitations. The holistic accompaniment model may not be generalizable to other *acompañantes* or in other settings. However, we sampled diverse participants from different networks in 3 regions, with varying legal, social, and cultural settings. We also do not have data from women; *acompañantes*' per-

ceptions may not fully describe what users of the holistic accompaniment model experience and whether it represents improved quality of care compared to in-clinic or provider-led abortion models.

We define a holistic accompaniment model as one that is horizontal and trusting, does not ask for reasons for abortion, respects autonomy, provides emotional accompaniment and economic support if needed, prevents criminalization, aims to reduce stigma, and is flexible and adapted to the needs and preferences of each woman. All women should be able to choose how, where, when, and with whom to abort in completely safe conditions. Our findings suggest that one of the options can be autonomous and within a holistic accompaniment model.

Implications

We describe specific characteristics of a holistic accompaniment model in Mexico; this description facilitates learning across models and could be used to better understand the similarities and differences among accompaniment models, other self-managed medication abortion models, and provider-led abortion services.

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⁵ *sororal* is a term used in contemporary Latin-American feminism that speaks to women's mutually empowering relationships

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