

Original research article

Experience of clandestine use of medical abortion among university students in Chile: a qualitative study^{☆,☆☆}

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Abstract

Objectives: To explore the ways in which medical abortion pills are obtained and used by university students in Chile in a clandestine context.

Study design: Using a qualitative approach, we conducted in-depth interviews with 30 young women who had had a medical abortion between 2006 and 2016 while attending university. We recorded the details of their pathways to abortion and their experience of abortion, and how they used networks in the university to find the pills and learn how to use them. The interviews were analyzed using narrative content analysis.

Results: The findings show that medical abortion did not take place completely outside the healthcare system for these students, who accessed ultrasound scans pre- and post-abortion and post-abortion care. However, even with help and support from contacts, partners and friends, the clandestine situation created uncertainty and fear, which dominated the whole process, from finding and purchasing the pills, to uncertainty about correct doses and whether the abortion was going as it should and was complete or not. There was a high perception that failure and complications might be occurring, which led many of them to seek post-abortion care. The process was very demanding, requiring information, time, privacy to have the abortion, support and resources, and the ability to deal with risk.

Conclusions: Medical abortion allowed these young women to have safe abortions in terms of reduced risks to health and autonomy through self-management. However, clandestinity made them physically, socially and emotionally vulnerable and exposed them to the risk of normative, violent judgments during post-abortion care.

Implications: Access to medical abortion has transformed the experience of abortion in Chile, where abortion is illegal, because it is possible to use it safely and effectively outside healthcare settings. However, uncertainty, fear and risk will continue to dominate the experience, which can only be transformed by making abortion legal and available.

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Keywords: Medical abortion; Misoprostol; Abortion self-management; Clandestine use

1. Introduction

Until 21 August 2017, abortion in Chile was legally prohibited in all circumstances¹ [1], yet indirect estimates show that there are 109,200 induced abortions a year [2].

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¹ After 27 years of a complete legal ban, on 8 August 2017 the Chilean Congress passed a law decriminalizing abortion on three grounds: risk to the life of the woman, fatal fetal anomaly, and rape. On 21 August, the Supreme Court of Chile confirmed its constitutionality. At this writing, it is too early to know the extent to which women will have access to services on these grounds or how clandestine abortion will be affected.

Although clandestine abortions cannot by definition be considered safe, precisely because they are clandestine, the use of medical abortion pills is not causing abortion deaths in Chile. Data from 2010 show that there were only an estimated 3.2 deaths due to unsafe abortion per 100,000 live births [3].

While many countries with restrictive abortion laws have high rates of both illegal and unsafe abortion and a high risk of maternal mortality [3], substantive improvements in overall health conditions in Chile may help to explain the improved safety of abortion in recent years, despite its clandestine status [3]. Equally important, however, is that use of medical abortion is increasing [4], which has been happening across Latin America [5–8], although there is no research as yet on the extent to which this is taking place.

Illegal abortion creates a confrontation between social norms and legitimacy and unofficial practices, between the public and the private, and between religion and politics. The ability to obtain an illegal abortion safely depends on the social conditions pertaining in a society; and, for the individual, it depends on access to the means and material resources available to transgress the law, and the extent of help and support that are available, which in turn are affected by age and social class [9].

The aim of this research was to document the experience of clandestine use of medical abortion among university students in Chile. We focused on university students because we wanted to know whether being in the university and having access to its social networks would affect how they managed the experience. The group was not representative, and as relatively privileged young women their experiences were probably “better” than those coming from less privileged backgrounds. But this study will open a window on the experience in Chile and be helpful in designing more representative studies.

2. Methods and materials

We conducted in-depth, face-to-face interviews with university students who had had at least one medical abortion using mifepristone + misoprostol or misoprostol alone in clandestine conditions while in university. We carried out a theoretical sampling [10] using the snowball technique [10] to find women who met these criteria [11,12]. We obtained a sample of 30 students from 10 universities in the Santiago Metropolitan Region who were born between 1981 and 1996 and had had a medical abortion between 2006 and 2016, aged 17–26 years. They were all single at the time of abortion, and all but five became pregnant with their partner at the time of study, two with ex-partners and three who had occasional partners.

The interviews were digitally recorded for later transcription.² In the interviews, we aimed to explore their strategies to induce an abortion – from the moment they knew they had an unplanned pregnancy until the experience was completed post-abortion. We also sought to understand their feelings and perceptions about what took place in the context of their personal lives [10,13]. We used the concept of pathways, to develop a thematic mapping of what happened at each stage, how they managed, and who else was involved, [6] which we describe in this paper.³

The research was approved by the Ethics Committee for Research in the Social Sciences, University of Chile. We ensured confidentiality and maintained anonymity in the

women’s identities, including not naming their universities and using pseudonyms.

3. Results

3.1. Choice of medical abortion

Medical abortion with mifepristone + misoprostol or with misoprostol alone was common knowledge among these young women, who directly or indirectly knew of other young women who had used it. This knowledge circulates within young women’s circles, despite being “forbidden”. They said they did not discuss the practices of their mothers and grandmothers in these conversations, perhaps because practice had changed so much and also due to the silence and stigma attached. Because the conversations excluded older women, no other inter-generational transfer of information was shared, nor did they discuss surgical methods or any other abortion method.

They saw medical abortion as the opposite of the unsafe, out-of-date practices of the past, symbolized by blood and death, repression and terror:

“I have always had an image [regarding abortion] of illegal, dirty clinics. You didn’t know whether you would get out dead or alive. Like in a Mexican movie, you’re doing it and the police break in. But I am able to do it [now] with a safe method.”

[(Florence, E6)]

The women saw use of medical abortion as a rational option for two reasons. First, their knowledge – accurate or not – of its clinical attributes made it seem a safe method. Second, its use would be self-managed, in their own hands.

3.2. Abortion ultrasonography

Once they had confirmed their pregnancy with a self-administered test, the majority of the young women made an appointment at a clinic. A pre-abortion consultation, by definition in Chile, does not exist. But just as with women who will continue their pregnancies, women intending abortion may also want information about their pregnancy. This was a common part of the management strategy of these young women, who considered ultrasound a critical resource, both before and after the abortion. Knowing the number of weeks they were pregnant and that it was intrauterine could make the difference between a successful and failed abortion. Afterwards, a scan would confirm (or not) the success of the medication.

“I got a doctor’s appointment because I knew what the process was: pregnancy testing, spending an hour with the gynecologist, having an ultrasound — then having the abortion. But first, go to the doctor and say, ‘I’m pregnant, I need an ultrasound!’”

[(Helga, E8)]

They learned this from peers who had had abortions, or found brochures or instructions that recommended ultrasound. Knowing the number of weeks of pregnancy told

² Claudia Moreno, Andrea Álvarez, Irma Palma and Alondra Richards, conducted the interviews.

³ Irma Palma, Andrea Álvarez and Claudia Moreno, developed the analysis of the interviews.

them how much time they had to get the pills and do the abortion. Women on Web (WoW) [14] and the Chile Safe Abortion Hotline (*Linea Aborto Chile*) [15] both advised this. WoW, which was one of the main sources of information used by the women we interviewed, requires women to have an ultrasound before giving them advice.

The women went to a doctor for this, not another cadre of health professional. They did not want help to decide on abortion nor any involvement in the abortion itself. They wanted an unknown doctor whom they would not consult again at the end. Only exceptionally did they go to their own doctor. They did not perceive their own doctor as a resource, nor want them to know about the pregnancy or their plans to terminate it, as most did not know their doctor's views on abortion.

"I took the decision not to go to... anybody I knew; I wanted there to be no trace of my passing through."

[(Wilma, E23)]

When they needed expert information on the medical method, instructions for its use or advice on the process, they asked a friend for a referral to a doctor who either provided an illegal abortion service or would provide good information.

3.3. Obtaining the pills

Although the Chilean Institute of Public Health approved misoprostol, it has not been available in pharmacies since 2009, unlike in some countries in the region [16]. Until 2009 it was possible to get it with a prescription or through an illegal purchase from pharmacy market intermediaries, which at least ensured the authenticity of the pills. We do not know whether the sale of misoprostol is linked to trafficking in other medicines, as is found in Brazil [17], or whether some health professionals provide them privately, as this has not been investigated. In our group, only one young woman received the pills from her doctor, who was providing them in his practice.

The rest used three main sources [18], which had been used by people from their universities. A third of the women found a pill seller indirectly through their friendship network and personal relationships and connections with members of certain university groups.

"My best friend had an abortion, and she was the first person I went to. I knew she would help; she had the information, which she had from a feminist group in my Faculty. She gave me the telephone number and put me in contact with a person who I phoned and bought the pills from."

[(Karina, E11)]

Getting the information from university contacts allowed the interaction between the buyer and the seller of the pills to feel safe. They learned to recognize whether an interaction was reliable, both with respect to the authenticity of the medication and the risk to both parties of denunciation to the police.

The second route — followed by seven of the interviewees — was direct purchase on the Internet, in two stages. A typical website may appear to be accredited by a pharmaceutical company, and will include two elements: instructions on dosage, effectiveness and use, and how to recognize the abortion is complete. Such websites provide contact details of an anonymous seller and state the type of medication, quantity and price. Next, there is a face-to-face encounter in a public place where large numbers of people circulate, in which the pills are exchanged for money. These sites may also contain a forum where individual communications are posted anonymously, and where actual experiences may be described, including testimonies about the failure of the pills or requests for help, and warnings about false drugs.

"I was worried that the misoprostol would not work. Distracted, I posted this message: 'Please help, I do not know if it worked'. They answered: 'Please, come to the church.' I was scared to death."

[(Isabel, E9)]

The intermediaries handing over the pills from these sources are from the same generation, both men and women. The main buyer is the young woman who is going to have the abortion. If there is police involvement in the drug transaction, it is she who is most exposed, especially when receiving the pills in a public place. The initial expectation is that the seller is a clandestine exploiter, a plant by the police, yet also a resource in a moment of adversity. When face-to-face with the seller, the picture changes; these are peers, apparently university students too. The fear is mutual; in this situation, both young people are at risk. This was the extent of the information about the pill sellers provided by the interviewees, they did not know anything more.

"The seller was super cool, she was far more scared than I was. I avoided looking at the surveillance cameras..."

[(Barbara, E2)]

The pill sellers offered a phone number should problems arise during the process, but none of the young women used it. Yet without this kind of help, they had to rely on their own ability to know whether the process was safe and effective or not.

The third type of source was an internet-based telemedicine service that asks questions, instructs, monitors what happens and provides the pills and advice, such as WoW [14]. WoW restricts counseling and sending medications for pregnancies less than nine (and more recently) 10 weeks at the time of abortion. Getting the medication from them meant allowing about 4 weeks for shipment, only possible for those starting the process very early. It also required being able to tolerate the waiting. Only four women followed this route, but many others used it initially as their main source of information.

In fact, half the women asked for instructions or advice either from Women on Web [14], Women on Waves [19] or *Linea Aborto Chile* [15], who explained how to use the pills,

described the two main side effects — bleeding and cramps — how much and how strong these effects might be and the accompanying pain. They explained how to recognize an incomplete abortion and indications for seeking emergency care — if the bleeding became more intense and more extended over time, hemorrhage and/or prolonged and unbearable pain. One in three also asked a medical professional about use of the medication, the process and how to know it had succeeded.

We presumed that only misoprostol was readily available in Chile, not mifepristone, and had the impression that supplies of misoprostol came from nearby countries with fewer marketing restrictions. Mifepristone is approved in the region only in Uruguay, but is not available there in pharmacies [20,21]. Many of the young women we interviewed, though, knew of mifepristone (mainly through WoW [22]), and those who bought pills from WoW received mifepristone. In a few cases local vendors offered them, but an examination of the pills showed they were fake.

Of those who did not get accurate advice on misoprostol dosage, there were major differences in how many pills they used, both too few and too many (e.g. seven students used four pills or less, and six used 12 or more). In some cases, the number of pills they should use was not among their main concerns. They considered it the seller's role to give them the right pills in the right quantity. But the sellers offered different types and numbers of pills, according to price.

"He said: 'I have 2 types of pills. One that costs \$70,000 for 4 misotrol, and one that costs \$ 90,000 which includes 6 mifepristone, which I think is the best dose to use. It's up to you'."

[(Wilma, E23)]

3.4. Starting the abortion

After using the medication, the process involved monitoring the bleeding and recognizing when the abortion was over — and if necessary, seeking emergency care. Most of the women still lived with their families; none was living alone. Two out of three had the abortion in their family home, going back and forth between their own room and the bathroom. The rest did it at their partner's family home or the place they shared with their partner.

All of them kept it secret, hidden from everyone except those who were helping them. One young woman who did not inform anyone said:

"I calculated the number of hours, I went to my bedroom at 10pm. I told my mom I was getting my period and was feeling bad. I also told a friend. I closed my door and went to bed with a little teacup. I had toilet paper with me, plenty of water and hidden lemons. I had taken a paracetamol against the pain. I put the pills into my vagina and went to bed. I [also] put a washcloth inside me wrapped around a candle. But when I went to wash the candle, I suddenly thought: 'I [need] to stay still so the pills don't fall out,' because we had spent 50 thousand pesos for only 4 misotrol. I waited...waited... I was

scared to death, shivering. Then, I thought: 'What the hell am I doing!' My parents in the next room, and... there I was, how awful! I imagined they would find me bleeding the next day. I didn't know what would happen."

[(Carla, E3)]

3.5. Self-monitoring

"It's hard. It's that uncertainty of not knowing if what's happening is part of the process, or if something is going wrong. You have no idea if this is how your body should react — or not."

[(Oriana, E15)]

Careful observation for fetal tissue is needed to check the abortion is complete. Sometimes, it happens almost unobserved, in other cases, not.

"At one moment, I lost a "mass" that must have been the embryo. I couldn't tell whether it was an embryo; it didn't have a human form."

[(Úrsula, E21)]

"The whole night I had terrible pain. I thought I was going to die of bleeding. It's not possible to imagine the suffering, it was a horrible physical pain."

[(Natalia, E14)]

Pain is an important element of the process, as research shows [23]; seven out of 10 women require analgesics [24]. Severe pain, prolonged bleeding, possible ineffectiveness, and fear of going to a hospital for treatment to complete the abortion are the main negative aspects of the experience described by women in other legally restricted contexts in Latin American [5].

Some of the women thought their abortion had "failed" because they did not begin bleeding "soon enough" or with enough blood loss. They interpreted this as drug ineffectiveness. Others believed they were having prolonged and excessive bleeding, i.e. complications, and yet the abortion had not ended. These were their perceptions, not clinical evaluations, but they acted based on these perceptions.

3.6. What self-management meant

In the context of clandestinity, from the beginning to the end, the abortion required management of knowledge, time, relationships and resources, as well as risks and emergencies.

Consciousness of time became acute at three points: the "delay" in menstruation, the decision to abort, and the upper limit of nine or 10 weeks for safe home use of the pills as indicated by their sources. With the passage of time, to do nothing is to let the pregnancy continue. The further it advances, the more difficult everything becomes in clandestine conditions: time represents risk. Missing the deadline removes the option of using the pills, and they believed that after the 12th week an abortion cannot happen at all, which is not true in legal settings.

Delays getting hold of the pills may result from not having ready money, getting fake pills, or waiting for a shipment from abroad. Money is also needed for medical consultations, ultrasounds and potentially hospitalization. Some women had to borrow money or accept cheap pills.

“Being delayed made the abortion a very heavy experience, because I saw the fetus. I’m sure that wouldn’t have happened earlier, but the money was just not there.”

[(Elisa, E5)]

“We got the pills, but they were fake. That was the hardest thing because it happened twice. So I used three doses. I couldn’t lose another minute.”

[(Karina, E11)]

Once the pills were administered, contractions, bleeding and evacuation did not happen in a simple orderly fashion. How long it would take and when it would end was uncertain, subject to multiple interpretations. And while it was happening, it felt endless for almost every woman.

3.7. The involvement of others

Abortion is an intensely personal experience, but it is often not thought through or carried out alone. The women involved two other people from their intimate circle most often: their partner (whether or not they were cohabiting) and a female friend [25,26]. One in three of our interviewees involved both her partner and a female friend.

With the fact of menstrual delay, the young women started by telling their partner they might be pregnant and later about abortion. With ex-partners or unknown progenitors, two of the women told them about the situation.

The partners played a part before the purchase of the pills and assumed a caring function during the abortion, helping to arrange where it happened, being present for administering the pills and during the abortion itself. In the women’s accounts, this was a difficult and complex time for these young men too. They tried to understand symptoms they knew nothing about and also deal with the blood and the pain. They too suffered from fear and uncertainty and felt exposed to the risks.

“He also thought I was going to die. He imagined taking me to the public health emergency service in a serious condition. He imagined the two of us arrested by the police. Those were our biggest fears.”

[(Sandra, E19)]

Friends were asked for information about how it should go, especially if they had had an abortion themselves, or they asked other friends to help to prepare their friend for the event.

“My friend had rather vague information – that she bought some pills, how many she bought, where. No, no, no, I wanted to know exactly how it’s done – the right way.’ I wanted effectiveness and safety for myself.”

[(Gabriela, E7)]

Mothers and/or a sister were involved by five of the women who were not in a couple or did not want their partner to participate, or their partner did not want to. There were also cases where family members were involved without realizing what was happening. In two cases, family members accompanied the young woman to the hospital, without being told the reason why. In a third case, the young woman went to her aunt’s house without telling her she would be having an abortion; her aunt was a health professional, who could help in an emergency.

Almost a third of the women also described support from certain university collectives, contacted through an extended circle of acquaintances [25,26], which allowed wider access to support and resources [27]. These groups gave help mainly as mediators to buy the pills, but they did not support women during the process the way the Socorristas en Red of Argentina do [28], for example.

3.8. Emergency, risk management and final evaluation

Clandestinity introduces three major sources of fear and risk with abortion: failure, death and prison. The first is the continuation of the pregnancy and having a baby, which is life-changing. The second is fear of hemorrhaging and death. The third is fear of being discovered by the police when buying the pills illegally or being reported if hospitalized.

“I was afraid of everything. At one point I thought I might die. Afraid of being taken to the police station, afraid of having a D&C, afraid of infertility, afraid of anybody knowing because I was still bleeding, afraid of people and loneliness. It’s you and your decision, and even though there is someone next to you, you are always alone.”

[(Florence, E6)]

It also creates a form of radicalism:

“I was scared of what would happen to me, but I was so determined, my goal was not to have the baby. If something happened to me, I would behave like the victim, totally evading responsibility. If I died, I died, but I would not have the baby.”

[(Carla, E3)]

At some point during the abortion process, 27 of the 30 women consulted a doctor or went to the emergency room of a hospital. Half did so because they believed the situation was an emergency. Among those who went to a hospital, five had a curettage and one received additional medical abortion pills. Six others had no intervention but the abortion ended in the hospital. Three others consulted private doctors, and with a further dose of the pills, their abortions ended satisfactorily. Three women felt they did not need medical attention but sought it anyway.

None of these women mentioned they had induced an abortion. They had all decided not to tell in advance. To ensure they succeeded in this they kept silent, denied it, lied, accepted rough treatment, did not express any pain, and did not ask for information.

“This was a clandestine situation... I would have to act surprised, put on a performance. I was not going to say I had had an abortion or expose myself to abuse or be denounced.”
 [(Renata, E18)]

Still, they were all afraid they would either admit to the abortion or be “discovered”. None of them was reported to the police, however, either because the abortion was not detected or the staff maintained confidentiality.

“I was admitted and taken to a room and asked: ‘Have you drunk something?’ ‘No, I have not.’ In the room, a doctor examined me manually, roughly and without showing care. Then they did an ultrasound. I could see my uterus, and I was scared they would see remnants of the pills and take me to prison. Instead they took me to the operating theatre. I asked if they used anesthesia and they said, ‘No, just like this.’ So I said: ‘No, please use anesthesia. I do not want any more pain.’ In an ironic tone, someone asked: ‘You know what a lot of pain is, do you?’ But they gave me the anesthesia.”
 [(Josefa, E10)]

Information handbooks advised acting this way – getting treatment while reducing the risk of rejection and denunciation. This was empowering.

“Those instructions were very important. The handbook said that abortion is a right and that medical services must be willing to treat someone who has aborted, whether natural or induced... And that although abortion is prohibited, they had to provide medical attention.”
 [(Josefa, E10)]

These young women did see abortion as a right, but without feeling entirely confident about it. Although they expected the health professionals not to report them, they knew this was not assured a priori. So, in order not to be reported, they expected the health professional not to ask. And in order to avoid being denounced, they did not admit to it. Not all of them were asked if they had induced the abortion, but those who were asked, denied it.

The three women who did not seek medical help during the abortion went for an ultrasound afterwards to check the abortion was complete. This meant an appointment with a health professional who might surmise what had been going on, which even at this stage led to fear of being discovered and denounced.

4. Discussion and conclusions

The use of medical abortion seems to be extensive in Chile. We do not know how extensive, but these young women saw it as the main method in current practice, and as both safe and self-manageable in spite of the concerns that led most of them to seek medical help. Based on their views and experience, we argue that medical abortion has become a social necessity in Chile because it is possible to self-use it safely and effectively, even though abortion is illegal, and to receive help from health professionals without them being responsible for doing the abortion.

The perceptions of the young women in this study were that they managed the abortion themselves, and it happened in their bodies, whereas with surgical abortion, a health professional manages everything and carries out the abortion on their bodies. This indicates a substantive transformation in the meaning of clandestine abortion, de-medicalizing it with or without the participation of health professionals. The woman can obtain the knowledge and drive the process herself, although with a lot of help. Thus, it is associated with women’s autonomy over their own reproductive processes.

This study shows that managing one’s own abortion in a clandestine situation requires a high level of self-motivation, self-confidence and action. It requires planning and rational thinking, but it also creates strong feelings of uncertainty, desperation, fear and pain, and perhaps most of all, precariousness.

The young woman as protagonist is conscious that she must face the consequences alone if she wants to end a pregnancy in clandestine conditions. She needs a strategy but also to make decisions as the situation unravels, strongly restricted by illegality.

Self-management is also accompanied by the risk of failure. Thus, a practice that starts with autonomy can end with a clinical intervention, without there necessarily being an actual medical failure or complication. Moreover, the health professional who sees them may have no knowledge of the induction.

In 2009 a Ministerial brief established that a forced declaration during the provision of health care is a form of torture, thus protecting women from self-incrimination in the case of abortion and reminding doctors of the importance of confidentiality.⁴ However, although medical confidentiality is interpreted as not being forced to give information, providing information voluntarily in a post-abortion consultation is still considered to be self-incrimination that can lead to denunciation to the police.

With more information on how the abortion should progress and when it is complete, and with the assurance of confidential medical care if required, we believe more of the women would have completed their abortions without incident on their own. In the absence of either of these conditions, feelings of vulnerability and fear motivated them to seek help that they may not have needed.

Confidentiality in a situation of illegality is paradoxical, but it enables safe abortion care while keeping abortion illegal. Despite the high prevalence of abortion and post-abortion care-seeking, few women are being prosecuted for abortion in Chile [4], and health personnel are not reporting women who present with incomplete abortions —

⁴ Circular N° ORD A15/1675, Ministry of Health-Chile, signed by the former Minister and sent to all Health Services Directors [24.04.2009]. The Circular was grounded in the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment, ratified by Chile in 1988 [33].

though with exceptions.⁵ In this sense, confidentiality is also political.

In the context of illegal abortion, women's position vis-à-vis health professionals is extremely unequal. Health professionals may know full well what the woman has done, which puts them in a difficult position too, but it also gives them an unspoken power. The health system has its own mechanisms for punishment — stigma and fear. Post-abortion care can involve well-documented forms of punishment and normative violence against pregnant women — verbal abuse, rough handling, and refusal of pain relief [29–32].

This research has shown that access to medical abortion is a necessity in a country where abortion is illegal but continues to take place. While young women do succeed in having abortions, uncertainty, fear and risk dominate the experience. This situation can be transformed by making abortion legal, available and accessible.

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⁵ In 2015–2016 the Research Program on Abortion in Chile (University of Chile) recorded 13 cases of women denounced in public health services, that is to say, 13 cases that got media attention [34].

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