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“Cada paso es un obstáculo." -- Women’s Experiences Accessing Publicly Funded Abortion in the Wake of Policy Changes in Catalunya

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Access to safe abortion is critical to women’s and public health. Women around the world encounter obstacles when they seek abortion care, which contribute to health care inequalities that disproportionately affect poor and marginalized women. The most marginalized women tend to encounter the most obstacles to abortion. In 2010, the Spanish government enacted policy changes affecting abortion availability in both Spain and Catalunya, an autonomous region with a contested relationship to Spain. These reforms expanded legal access to abortion and included it in the public health system for the first time. Using a mixed-methods approach combining quantitative surveys and demographic data with qualitative interviews and intensive participant-observation, this research explored women’s, providers’, and advocates’ perceptions of women’s experiences with the process of navigating the public health system to obtain legal, publicly funded abortion in Catalunya, in the wake of policy changes enacted between 2010 and the second half of 2013. Participants described the often-difficult course they had to follow to receive vouchers for care in the Catalan health system, as well as other logistical, social, and economic obstacles. Participants also reported that women mobilized social support and resisted structural inequalities inherent in the health care system, in order to successfully overcome obstacles, in the context of a widespread economic crisis in Catalunya and Spain that provoked austerity-related cuts to health care. Growing support for full Catalan independence also informed participants’ experiences.

1 “Each step is an obstacle.” – A phrase uttered by multiple participants.
2 Out of respect for the emic view passionately expressed by locals, I use the preferred Catalan terminology and spelling, “Catalunya,” rather than, “Catalunya, Spain” or “Catalonia” throughout this dissertation.
“Cada paso es un obstáculo.”\(^3\) -- Women’s Experiences Accessing Publicly Funded Abortion in the Wake of Policy Changes in Catalunya\(^4\)

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\(^4\) Out of respect for the emic view passionately expressed by locals, I use the preferred Catalan terminology and spelling, “Catalunya,” rather than, “Catalunya, Spain” or “Catalonia” throughout this dissertation.
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“I will choose what enters me, what becomes flesh of my flesh. Without choice, no politics, no ethics lives.

I am not your cornfield, not your uranium mine, not your calf for fattening, not your cow for milking.

You may not use me as your factory. Priests and legislators do not hold shares in my womb or my mind.

This is my body. If I give it to you I want it back. My life is a non-negotiable demand.”

Excerpt from The Moon is Always Female, Marge Piercy (1980)

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7 These words appear on an illustrated poster that I gave (with a translation into Catalan), to the directors of the Today Clinic and Family Planning Organization and to several clinic workers and other individuals in Barcelona who supported my research.
Introduction, Policy & Practice

“Duran8” sits at her kitchen table in a small town in northeastern Catalunya, an hour’s ride on commuter rail from Barcelona. Her toddler son crashes around at our feet, as the teenage babysitter plays on a cell phone nearby. Duran is reticent at first, her manner muted. She seems uninterested in her own story, even though she was more than willing to re-schedule our interview when a migraine forced me to cancel the first time. In her early 30s, Duran sits below pictures of her two sons (one now at school now) on display on a narrow shelf, along with a box of birth control pills she hastens to tell me she just got from the midwife at her follow-up appointment. When she does begin to open up, Duran describes the turmoil over her most recent pregnancy. She tells me she wanted another child, but her husband’s job is uncertain, and they realized they could not afford it. Like many participants, she did not know CatSalut [the Catalan public health system] would cover the procedure. Duran was initially referred by health system staff to a town only a short train trip away, for an early pharmacologic [medication-induced] abortion, but was too far along for that option when she got there. After borrowing money from her in-laws to pay cash for a surgical procedure only available in Barcelona or another town even further away, Duran arranged childcare for a day when her husband could miss work and accompany her on the longer train journey. By the time staff at her local health center eventually completed paperwork for Duran to have an abortion paid for by the health system, she had taken time to raise money from her husband’s family, and was near the end of the first trimester. Duran tells me softly, not making eye contact, “one week further,” and she would not have gone through with it.

*Field notes, January 2013*

During the time I was in the field, and from mid-2010 until at least the time of this writing9, women in Catalunya and Spain have had legal access to publicly funded abortion care for any reason in the first trimester, and under a set of qualifying circumstances in later trimesters, within existing public health systems. This has briefly made Catalunya, and Spain as a whole, a rare departure from the overwhelming example of countries throughout the world where abortion is illegal, heavily restricted, or otherwise difficult to obtain (e.g., Barot 2011, Amado et al. 2010, Lara et al. 2006). Even in the many other European countries (e.g., Helstrom et al. 2003, Jones et al. 1985, Johnson et al. 2004) and some parts of North America.

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8 A pseudonym chosen by the participant, as were all pseudonyms used in this writing.
9 On December 20th, 2013 the Justice Minister of Spain announced a new law to go into effect pending expected Congressional approval at any moment, that will make abortion illegal (again) under virtually all circumstances.
America (including Canada and in sixteen states in the United States, where abortion is available and publicly funded for eligible women) gestational limits, waiting periods, mandatory counseling and ultrasound requirements, and burdensome travel needed to reach a provider often apply (CARAL 2003, Alan Guttmacher Institute 2012, Jones & Weitz 2009, Jones et al. 2005). Nevertheless, many women in Catalunya, who arguably lived in a setting of ideal abortion access, experienced delays, bureaucratic obstacles, and logistical hassles when they navigated the public health system to obtain care, and faced some of the same social and stigma-related difficulties that women seeking abortion elsewhere report (Ostrach & Cheyney n.d., Kumar et al. 2009, Jones et al. 2005). If women who ostensibly had the best possible access to abortion still encountered obstacles to care, what does this say about the efficacy of abortion law reforms? What can we learn about the implementation and enforcement of reformist policies in health systems? What is the extent to which even legal abortion may be offered only grudgingly or with substantial bureaucratic delays, and not treated as an equal part of a full spectrum of reproductive health care?

Grassroots feminist organizing and popular support led to the 2010 abortion law reforms that expanded access to legal abortion in Spain, and in Catalunya (Hughes 2011). Catalunya is a historically and officially autonomous region, recognized as such by the 1978 Spanish constitution, that culturally and politically identifies as independent of Spain, but which wrestles with ongoing economic and political ties to Madrid (Bel 2013, Barambio 2012, Crow 1985). The 2010 abortion law reforms enacted by a then-Socialist national government in Spain resulted in the full inclusion of legal abortion care in Spanish public health systems through at least 2013, and were also applied to the intersecting Catalan legal and health systems. In Catalunya the reforms gave women the option of requesting a public health system referral to a contracted abortion clinic in Barcelona, where they could obtain publicly funded services (Barambio 2012).
At the same time, *La Crisis*, the local name for a widespread recession and associated economic crash that struck Spain and Catalunya beginning in 2007, plunged many people into poverty or worsened already-difficult economic realities, and continues to reverberate through the economies and governments of the region (Murcia López 2013). While I was in the field in 2012 and 2013, *La Crisis* prompted European Union officials to repeatedly impose Euro-zone austerity measures on Spain via the national government in Madrid, which in turn sought to extend these to the autonomous nation of Catalunya (Raventos & Wark 2012, El Periódico 2012). Although the ultra-conservative Spanish government elected in 2011 now claims that the recession is over, and that their proposed 2014 budget will be free of austerity cuts, people I interviewed were skeptical that the situation in Catalunya would improve quickly, and tended to see full independence from Spain as Catalunya’s best chance for a recovery (Minder 2013). With Spanish Prime Minister Mariano Rajoy making contradictory statements such as, “*Spain is out of the recession but not out of the crisis*” (Russia Times 2013), the Spanish government’s claim that things are improving even as unemployment rates and evictions grow (Homs 2013), did not seem to convince most Catalans with whom I spoke.

The Catalan government’s decisions about how to implement the forced austerity cuts in the public health system, and the health system’s internal structuring of abortion provision protocols, had immediate implications for the actual availability and accessibility of abortion. This combination of factors created the precise (and apparently short-lived) situation which my research explored: in the wake of multiple policy changes at national and local levels, women in Catalunya ostensibly had access to legal, publicly funded abortion care. However, to obtain these services, women and providers had to navigate the public health system. Women also confronted logistical and social factors. What obstacles women perceived, which they found to be most challenging, and how they overcame them within the larger
political-economic and cultural contexts as women experienced them, are the specific questions addressed in this writing.

More broadly, this writing documents the impact of an economic crisis and resulting shifts in cultural and political identities on women’s and providers’ perceptions of access to public health services -- in this example, abortion care. In this historical period when threats to legal abortion are apparent in a myriad of state-level campaigns (in the Unites States and elsewhere), when the links between legality and safety are the focus of political and public health efforts to expand abortion legality in several Latin American and European countries, and when health care reform debates in the U.S. and elsewhere focus on what reproductive health services should be covered or excluded, the Catalunya case exemplifies the many layers of economic, political, social, cultural, and interpersonal dynamics that can and do affect access to health care, particularly abortion. Moreover, the research presented and discussed here has been and will be of use to reproductive health and justice advocates who work to maintain and expand abortion access and legality, including where it is covered by public health systems, and to providers who hope to understand what women experience before they arrive in the exam room.

This writing offers opportunities:

1) To consider how an economic crisis may shape a woman’s thinking about continuing a pregnancy or not;

2) To provide a glimpse of how cuts to public health care affect access to care and inform residents’ reactions to political movements that resist such cuts, and, most importantly;

3) To recognize how marginalized women mobilize social support, or tap into a culturally shaped sense of self-determination, to successfully obtain abortion care despite delays and difficulties: navigating and resisting structural barriers in the form of bureaucratic, logistical,
and social obstacles by engaging in efforts to challenge, and/or get their needs met within, institutionalized power structures.

In this last sense, the research I conducted reveals the persistent commitment of many women to do ‘whatever they have to do,’ in the face of structural violence, social inequality, poverty, stigma, and institutionalized delays and barriers, to obtain a contested but legal medical procedure. This fierce determination to demand and receive health care even in the context of a devastating recession and constantly changing policies, constitutes a powerful example of the long-recognized truth that women will access abortion care at approximately the same rate the world over, regardless of legality – the main variation will be in the safety of the care they receive. With clear negative public health implications from reducing or eliminating access to legal, safe abortion, understanding how women overcame barriers to care in an ‘optimal’ setting, and what helped them succeed in doing so, reveals important insights into how to protect women’s health, safety, and rights internationally.

I developed and carried out this research in Catalunya for several reasons:

1) Catalunya experienced a higher abortion rate per capita among residents for many years, compared to other autonomous regions considered part of Spain (Spanish Ministry of Health data, 2010). Catalunya, moreover, is home to a greater percentage of immigrants, who experience more unintended pregnancies, generally seek abortion at a higher rate (Faundes 2012), and encounter more barriers to abortion care (Ministry 2010, Roca i Girona 2009, Magarolas et al. 2008). Catalunya was an ideal setting for studying marginalized populations’ access to abortion. Overall, immigrant women’s access to, and experiences with, abortion care are particularly important to understand, as this population is more likely to live in poverty, more likely to experience higher rates of unintended pregnancy, and more likely to seek abortion care in most settings, while typically having reduced or no access to public
health systems. Paying attention to immigrant women’s experiences with abortion access in a region where they did have at least some right to public health care can therefore reveal clues of where to focus larger efforts to improve immigrant women’s health internationally.

2) Until a few weeks after I arrived in the field in mid-2012, all immigrants in Catalunya were eligible for coverage in the public health system, without a waiting period, simply by registering at their local town hall (no documentation of immigration status was required). The Euro-zone austerity measures imposed on Spain and passed along to Catalunya resulted in immediate health cuts that particularly targeted immigrants. Changes in abortion access for immigrants are thus a window into the changing nature of immigrant status in European societies, and an example of how Euro-zone austerity cuts can directly affect immigrant health, important in light of the significant populations of migrants in many European countries including Spain and Catalunya.

3) The women’s health NGO that advised the Spanish Ministry of Health on the content and implementation of the 2010 abortion law reforms is based in Barcelona, and offered to host and facilitate my research. The coordinator of the NGO proposed that I collect the first (and thus far, only) known data on women’s experiences with abortion access following the expansion of legal abortion in the region, and its inclusion in the public health system. To our knowledge, no literature has yet been published on the topic. I thus was able to conduct groundbreaking research on a set of issues—changing abortion laws and public health policies, and women’s access to abortion—that have international implications, in what was essentially a natural experiment.

To date, the only other known qualitative or mixed-methods study on women’s abortion care experiences in Catalunya since 2010 is written in Catalan, and unpublished. Various studies reporting on quantitative data collected by clinics have been published in Castilian and Catalan, indicating abortion utilization patterns. When relevant, I cite all of these sources.
4) The director of a Barcelona abortion clinic, who is also the president of both the Catalan and national Spanish associations of accredited clinics, and a member of the above-mentioned NGO’s Board, agreed to allow me to collect quantitative data, recruit interview participants, and engage in participant-observation at his facility, one of only two contracted abortion clinics offering surgical abortion services to public health system recipients in Catalunya at the time. This allowed me significant access to potential datasets, women seeking abortion, providers, and to clinical and other sites that comprised the abortion landscape in Catalunya.

Women’s personal perceptions of the impact of structural forces and inequality on their lived experiences of accessing publicly funded abortion care in Catalunya emerged against backdrops of political, economic, and social shifts in Catalan society, and the larger context of Spain’s response to La Crisis. Based on participants’ reports of the actual process of navigating the public health system to obtain abortion care in Catalunya following policy changes that resulted from the 2010 abortion law reforms and the post-Crisis austerity measures, I use the data from this study to illuminate structural factors that produced obstacles and delays for women seeking abortion.

I evaluate perceived obstacles to care in light of the political-economy of the Catalan health system in the context of economic crisis, and frame delays and difficulties that unnecessarily impede women’s efforts to assert and enact their legal and human rights (e.g. Margolin 2007) to safe, publicly funded abortion care as a form of structural violence (Galtung 1969). This concept, that institutionalized forms of inequality enacted upon vulnerable populations constitutes a form of violence, is particularly applicable in a region where a sudden downward economic turn plunged many communities into greater relative poverty than they had experienced before, and likely disproportionably affected already-
marginalized populations such as immigrant women. Structural violence is evident, for example, in the negative health outcomes and reduced economic survival options resulting from racism, feminized poverty, and other forms of oppression that take shape in political and economic policies (Farmer 2004). Women, particularly women in poverty, immigrants, and other groups of women dramatically affected by social inequality, are exposed to structural violence in many aspects of their lives, not least of which are access to health care and the ability to make decisions about motherhood and family size and spacing. This concept thus framed my approach to understanding women’s experiences with accessing publicly funded abortion care in the context of economic crisis, in Catalunya.

In addition, power relationships evident in interactions between health system case workers and women requesting vouchers that were required to obtain public abortion care can be seen as a form of civilized oppression (Harvey 1999), described as the “burdening of another person physically, mentally, or spiritually by abuse of power or authority.” (Rogge et al. 2004: 306). The elements of Harvey’s civilized oppression, as outlined by Rogge et al. (2004: 306), that I see as functioning in situations where health system policies and case workers deliberately or unconsciously interfere with women’s speedy access to coverage or needed paperwork for abortion care include:

a) The presence of non-peer, power-laden relationships

b) Interactions that diminish and control the [health care] recipient

c) Cumulative acts of omission [that are] obscured in routine or daily encounters (Rogge et al. 2004: 306).

In Catalunya, civilized oppression took the form of some women who sought abortion care being minimized and diminished by case workers and other institutional representatives because of stigma associated with abortion, and, frequently, as a result of the relative power imbalance between bureaucratic representatives and health care recipients.
Finally, the frequency with which women who had sought abortion care, and the providers who offer it, mentioned then-loomining, now-pending threats to the abortion laws in Spain (CFRR 2012), poised to take effect any day now, for me signifies that political discourses related to the precarious state of abortion legality functioned as a form of symbolic violence (Bourdieu 1991): something invisible or intangible, based in ideology and shared or dominant thought rather than occurring through overt action or physical violence, but nonetheless producing very real anxiety and stress.

In contrast to the structural violence against women that stems from institutions, policies, and social inequalities that make women more vulnerable to poverty and more in need of economic and social assistance to obtain care, which is enacted on people through the civilized oppression of case workers who withhold or delay health system coverage for abortion, my use of symbolic violence in this example describes the felt and lived experiences of women seeking abortion who confront the specter of anti-abortion rhetoric, and with an awareness of the frequent pervasive media coverage of powerful elected and appointed government officials’ serious threats against abortion rights. Being told that the procedure they are frantically trying to obtain may become illegal at a moment’s notice perhaps did not directly affect women’s practical ability to get an abortion while I was collecting data, but for the women and providers in this study, the constant threat of imminent changes to abortion laws was stressful, frustrating, and confusing. I revisit and expand on these theoretical explanations of women’s experiences, in the following chapters.
Abortion access, safety, and legality

To situate this research on the impact of social inequalities and structural constraints on marginalized populations’ access to reproductive health care, I begin from the accepted premise that women around the world are forced to navigate legal, socioeconomic, bureaucratic, logistical, and social support-related obstacles when seeking abortion care, and often encounter delays when accessing abortion (Ostrach & Cheyney n.d., Barot 2011, Boonstra 2007, Ellison 2003). Such obstacles push women to seek unsafe, clandestine care where abortion is illegal or heavily restricted, measurably increasing female morbidity and mortality internationally (Barot 2011, Kumar et al. 2009, Grimes et al. 2006). Women in poverty, immigrants, and other marginalized populations are more affected by barriers to abortion care than mainstream populations -- this has immediate implications for their health (Ostrach & Cheyney n.d., Dehlendorf & Weitz 2011, Kiley et al. 2010, Weitz & Yanow 2008).

Even in settings where abortion is legal and ostensibly available, delay factors known to push women into a later gestation of pregnancy while seeking care, such as mandatory waiting periods or counseling, time spent waiting for public health system coverage or finding a provider, and arranging and paying for transportation, time off work, or childcare, have a greater impact on women in socially and economically marginalized populations, including immigrants, rural women, teens, and women in poverty (Ostrach & Cheyney n.d., Jones & Weitz 2009, Jones et al. 2005, CARAL 2003). Research on delay factors in the United States (Ostrach & Cheyney n.d., Kiley et al. 2010, Jones & Weitz 2009) finds that coverage delays in public and national health systems (such as Medicaid) are clear predictors of the likelihood that women will ultimately obtain second-trimester abortion care, even in cases where they began seeking care early in the first trimester of a pregnancy.
Improving access to safe abortion is an issue of great concern for public health. Multiple studies suggest at least 20% of pregnancies worldwide end in abortion, complications from unsafe and illegal abortion are responsible for 13% of maternal deaths, and at least 215 million women in the developing world wish to prevent pregnancy but lack access to modern contraceptives (Barot 2011, AGI 2012). Unsafe and illegal abortion is a leading cause of maternal mortality and morbidity, particularly in countries and regions where abortion is stigmatized, heavily restricted, or banned (Barot 2011, Culwell et al. 2010). The current estimate is that for every 1,000 women of childbearing age, 29 will have an abortion in a given year -- this number is similar whether a woman has access to legal, safe abortion, or not (Bartlett 2004, AGI 2012). In fact, the abortion rate is slightly higher in countries where the procedure is illegal (Bartlett 2004, AGI 2012). Ironically, one way to lower the frequency of abortion is actually to ensure it is safe, unstigmatized, and legal (Ostrach 2012, Barot 2011, Kumar et al. 2009).

We know that legal abortion care is safer abortion care (Barot 2011, Grimes et al. 2006). Almost all women who suffer reproductive morbidity or die as a result of complications from unsafe abortion do so where abortion is illegal and/or highly stigmatized (AGI 2012, Kumar et al. 2009, Grimes et al. 2006, Bartlett 2004, Henshaw et al. 1999). Women who encounter delays in the process of seeking either legal or illegal abortion may be more likely to access abortion services after the first trimester, when rates of complications also go up with each week of gestation (Weitz & Yanow 2008, Kumar et al. 2009). For these and many other reasons, obstacles that result in delays accessing safe, legal abortion care seriously increase risks to women’s health and increase the burden of injury and illness for the global population.
In terms of the social and cultural contexts of abortion, for women who perceive abortion-related stigma, the emotional and psychological effects of such stigma have significant impacts on women’s perceptions of the availability of abortion care, and on women’s actual physical and mental health. Abortion stigma, like stigma related to HIV and other STIs or obesity, can also produce deleterious physical effects by serving as a deterrent to complying with follow-up instructions or seeking needed care for, in the case of legal abortion, rare but serious complications (Kumar et al. 2009, Castro & Farmer 2005, Liburd et al. 2004, Cozzarelli et al. 2000, Inhorn 1986). While Spain and Catalunya have traditionally been Catholic countries where religious attitudes against abortion are sometimes apparent (and increasingly so under the PP regime), and where anti-abortion protesters occasionally targeted clinics, including the Today Clinic, in past decades, research suggests that the majority of people in Spain supported the expanded legalization of abortion in 2011 (Bruni 2011, Hughes 2011). Current polls conducted since the announcement that legal abortion will be overturned at any moment find 80% of Spaniards surveyed support legal abortion (Reuters 2014). Culturally, the potential for abortion-related stigma stemming from the religious history of the region appears to be mediated by a strong post-Franco era commitment to secular values guiding social policy in Spain (Bruni 2011, Crow 1985), and even more so in Catalunya (Raventos & Wark 2012, Tremlett 2008, Crow 1985).

This secularism can be traced back to the Spanish Republic of the 1930s, and the Spanish Civil War (1936-1939), and is widely seen as a reaction to Franquism (Roca i Girona 2009, Tremlett 2008, Crow 1985). In the wake of many decades of Fascist rule following the Spanish Civil War, and with a history of frequently electing socialist leaders beginning again in the 1980s and lasting until 2011 when the PP and affiliated conservative parties swept both national and Catalan elections, the majority of Spaniards and Catalans support secularism (Barambio 2012, Associació de Planificació Familiar de Catalunya i Balears 2010, Roca i
Girona 2009, Crow 1985). Despite the current conservative government’s attempts to distract voters from *La Crisis* by repeatedly threatening and then announcing a roll-back of abortion rights, Catalans and Spaniards generally do not want religious beliefs to determine social policy (Barambio 2012, Crow 1985). As several members of the Family Planning Organization explained to me, “*religion is something you do at home with your family, not something that should inform public policy.*” This is also evident in the most recent poll finding that 86% of Spaniards feel the decision about an abortion should be left to a woman and her doctor (Reuters 2014).

In this writing, I examine factors that affected, constrained, and delayed women’s access to safe, legal abortion care in a then-optimal setting, to reveal what obstacles and delay factors may be most persistent and difficult to overcome, in any setting. A goal of this research is that my findings be used to determine arenas in which applied work to increase abortion accessibility, and thus reduce morbidity and mortality for pregnant women, is most needed. In fact, the Family Planning Organization and its larger coalition of advocates and activists for abortion rights and reproductive justice in Catalunya and Spain planned and plan to use my findings to push Catalan and Spanish legislators to defend the existing abortion rights at the time, and maintain health system coverage of it, while the national association of accredited abortion clinics in Spain already made my summary of findings available on their website, for all providers and policy-makers in the region.
The Catalan push for full independence

To truly understand the Catalan cultural and political contexts of my research and of participants’ lives, it is necessary to acknowledge that while the Spanish government still views Catalunya as part of Spain, the majority of Catalans wish to fully separate from Spain (BBC 2013). Significantly, one in six people in ‘Spain’ are Catalans, living in Catalunya (Tremlett 2008). Many participants in this study expressed a commonly held local view that the Spain-Catalunya relationship is an exploitative, colonialist interaction. In this view, Spain is criticized for extracting financial value from Catalunya, while returning only a small portion of the considerable Catalan wealth they extract in the form of funding for public services (Bel 2013, Desquens 2003). As coverage of the growing unrest in Catalunya has accurately described, Catalans are frustrated that up to 20% of “Spain’s” GDP is directly from revenue generated in Catalunya (representing 8-10% of Catalunya’s own GDP being extracted), while estimates are that only 10% of Spain’s budget for supporting infrastructure in the autonomous states goes back to Catalunya, one of the biggest and most populous ‘states’ in Spain (Catalonia Direct 2012). Catalans strategizing for a planned November 2014 referendum on full independence from Spain, point out that this very wealth, once successfully withheld from Spain, will ensure Catalunya’s economic viability as a fully independent nation.

11 Residents and sympathizers who support Catalunya’s continued and expanded independence from Spain, prefer the term “independentist” and “independence” over “independence” or, worse, “secession.” As explained to me by a member of the Catalan National Assembly (the independence movement’s governing body) supporters of independent Catalunya (Catalanists) believe that Catalunya has historically been independent, and, under the 1978 Spanish Constitution, is recognized as an independent nation (Castro 2013). Thus it is not independence that is sought, but rather, an expanded respect for, and acknowledgement of, the current and growing independence that already exists. Out of respect for many research participants’ fierce insistence on their Catalan identity, and the prevalence of Catalanist sentiment while I was in the field, I use the terminology preferred by these participants.
The popular and widespread Catalan commitment to the historically accurate view that Catalunya was once a fully independent nation beginning in the 1100s or earlier, and taken over by Spain only in the early 1700s (Tremlett 2008), and the associated belief that the current effort to more fully separate from Spain is thus a movement to regain full independence (rather than to secede or become independent for the first time), is part of why activists and leaders in the movement use the term, “independentista,” independentist (Castro 2013). Most Catalans reject references to themselves as separatists, or references to theirs as simply an independence movement (Castro 2013). This slight semantic difference symbolizes the vast difference in how Catalans understand their own push to create a separate European Union nation (Castro 2013), as compared to how it is viewed by Spain, or in international media coverage (Raventos & Wark 2012).

During the time I was in the field, Catalans, including immigrants who are both strategically and genuinely warmly welcomed into the independentist movement (Nous Catalans 2013, Time World 2013, Shepard 2013), actively engaged in a passionate and highly visible struggle for full independence from Spain. This is a movement that continues to grow as of the time of this writing. Culturally, most Catalans do not consider their country part of Spain (Bel 2013, Time World 2013, Crow 1985), and an overwhelming percentage of surveyed voters in Catalunya supported the independentist movement’s call for a national referendum vote on fully separating (Bel 2013, BBC 2013).

As one key informant, the doctor who owns and runs the clinic where I collected data, took pains to say in English (so as to preserve the rhyme) in our first meeting, “Barcelona is my city, Catalunya is my country. Spain is a pain!” He was not alone in this sentiment -- on September 11, 2012 (the Catalan holiday Diada, which commemorates Catalunya’s fall to the Bourbons in 1714), more than 1.5 million people from all over Catalunya (itself a country of 7.5 million), flooded the streets of Barcelona in support of renewed independentist efforts
Forcadell Lluis 2013). I was in the streets of Barcelona with the crowds that day, myself a newly arrived immigrant, and the passion for a distinct Catalan identity was exciting and palpable. Hundreds of banners read, “Catalunya, new state in Europe,” “Spain is Pain,” and “Independence, already!” in a mix of Catalan, Castilian, and English. This popular emotional and political investment in Catalan independence unavoidably informed my research, emerging as both the subtext and the overt language of many conversations and formal interviews about the state of the health system, the economic crisis, and public healthcare funding cuts.

Abortion law reforms and abortion in Spanish health systems

In mid-2010 the Spanish government, under the Socialists then in power, lifted earlier restrictive legal limits on abortion for women in Spain and within the autonomous states covered by the nationally funded but locally organized health systems, including Catalunya (Finer & Fine 2013, Barambio 2012, APFCiB 2010). From 1985 to 2010, abortion in Spain, Catalunya, and other autonomous nations was officially legal only in cases of rape, incest, fetal malformation, and/or threat to the woman’s physical or mental health (including if a fetal malformation diagnosis was deemed to cause a woman undue stress). In practice, many women who could afford to pay privately for abortion were able to find clinics where a staff psychiatrist would document a “mental health necessity,” after a consultation. Within Europe, abortion is legal at least in the first trimester and widely available at least for citizens, in many countries, though not all. 

12 Notable exceptions include Ireland, Malta, and Andorra.

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12 For example, Sweden (Helstrom et al. 2003), France (Jones et al. 1985), the Netherlands (Jones et al. 1985), England (Jones et al. 1985, Porter 1996), Romania (Johnson et al. 2004), and France (Jones et al. 1985) all offer legal abortion in the first twelve weeks of a pregnancy, and in later weeks in some countries. Abortion is legal up to ten weeks gestation.
In Italy and France, abortion is legal in the first twelve weeks after a woman’s missed menstrual period. In 2010, Spain belatedly joined many of its European Union neighbors when it liberalized abortion laws to allow the procedure to be offered on demand for any reason in the first trimester, and under qualifying circumstances (fetal malformation, risk to woman’s physical or mental health, rape, incest) in later weeks (Finer & Fine 2013, AGI 2010).

The long-sought liberalization of a procedure that had been restricted at all gestations except in cases of rape, incest, fetal deformity, and for maternal physical and mental health reasons (de Ramales et al. 2009) came about as the result of popular pressure and grassroots organizing (Hughes 2011), through mobilizations that I view as a form of systems-challenging praxis as it is described in critical medical anthropology (Singer 1986). This organizing began with the efforts of reproductive healthcare providers and feminist community organizations (Hughes 2011) in Spain and Catalunya that had long assisted women seeking abortion care to raise funds to pay for private abortion services, and/or to navigate the health system to procure a waiver on one of the grounds listed above (APFCiB 2010).

The expanded legal access to abortion in Spain and Catalunya that began in mid-2010 and lasted at least until the time of this writing, is now in limbo. The Spanish ruling party’s Justice Minister, Gallardon, announced on December 20\(^{th}\), 2013 that he will move to overturn the 2010 reforms and restrict abortion to only cases of rape where a formal police report was filed before the pregnancy was confirmed, or in cases of fetal deformities incompatible with life, and only in the first twelve weeks of a pregnancy in either case (El Pais 2013). The proposed new law goes before the Spanish Congress at any moment, and is thought likely to in Turkey (Akin et al. 2005). Abortion is entirely or practically illegal in Andorra, Malta, Ireland, and Vatican City (Barambio 2012).
be confirmed, as the PP (Gallardon’s party) has a super-majority and a recent secret ballot sought by the opposition did confirm the almost-certain passage of “the Gallardon law.”

According to personal correspondence from the Family Planning Organization coordinator and other participants in my research, the popular response from women’s movements and health advocates following the Spanish Justice Minister’s recent announcement of plans to overturn legal abortion was immediate, and continues to be widespread and vocal. Thousands of protesters have filled the streets in hundreds of cities around Catalunya and Spain. Many more joined in solidarity protests all over Europe and the world, demanding that no steps backward ("¡Ni un pas enrere!") be taken in women’s rights and health. Catalan feminists were quick to look to the Catalan Parliament, which in September 2013 had preemptively adopted a resolution committing to maintain legal and accessible abortion in Catalunya, even if Spain were to subsequently overturn the 2010 reforms (see Appendix III for the full, translated text of the Catalan abortion rights movement’s statement in response to Gallardon’s announcement). Within a few weeks after the announcement, the Family Planning Organization and broader coalitions of feminist and women’s health organizations from across Catalunya and Spain organized a “train to liberty” action that saw tens of thousands of people from all over the region and from other parts of Europe travel together on high-speed rail and converge in Madrid for huge protests on February 1st. Hundreds of women who had sought abortions and health professionals who provided them have publicly sought “health asylum” at French consulates. French, Italian, Scottish, Irish, Puerto Rican, Salvadoran, and other feminists have organized solidarity mobilizations targeting Spanish consulates in their own countries. Most recently, women in Spain and Catalunya have staged protest actions wherein they report to local government ‘property registration’ offices, to register their own bodies as private property, walking out triumphantly holding slips of paper that enshrine their ‘ownership’ of their own reproductive
organs. While such actions could be dismissed as publicity stunts, they nonetheless send a clear message to the PP, and to the European Union, that a sizable number of Spanish and other EU residents oppose the proposed new abortion restrictions sought by the PP.

Health professionals throughout Spain publicly reject the idea of overturning legal abortion, with the head of the national transplant organization, leading psychiatric experts, and high-risk perinatologists renouncing any interest in being professionally called on to decide which women are at enough mental or physical health risk to justify an abortion on very limited grounds, or to be expected to determine which fetuses can definitively be said to be non-viable, in order to meet anticipated new criteria under which abortions would be permitted (Nosotras Decidimos 2014a; 2013, Mujeres.net 2014). The press in France referred to the likely reversal in abortion law in Spain as a “catastrophic regression” (Nosotras Decidimos 2014b:1), and global headlines have marked ‘the Gallardon law’ as a return to the Franco era. As I will explore later, in the wake of this pending shift in Spanish abortion policy, Catalan abortion rights advocates continue to view Catalunya’s independent identity as a possible avenue to preserve abortion access even in the face of Spain’s seemingly inexorable move toward draconian measures reducing abortion legality, and thus, women’s safety.

Under the reformed abortion laws that took effect in 2010 and continued through the time of this writing, women gained the right to seek a legal abortion through public health systems in Spain and the autonomous nations for any reason up to fourteen weeks gestation (APFCiB 2010). Following that gestational cut-off, abortion care could be sought and approved under certain conditions (rape, incest, fetal deformity, threats to the pregnant woman’s mental or physical health), in later stages of gestation (APFCiB 2010). While the process on paper to seek such legal, free abortion care through public health systems was regarded by providers, advocates, and feminist activists as a victory and a vast improvement
for women’s health, those familiar with the health systems predicted from the beginning that delays and bureaucratic challenges would continue to affect women seeking abortion in Catalunya and in Spain (APFCiB 2010), particularly so for immigrant women, who already encountered more barriers to both using the health system, and to obtaining abortion care (Magarolas et al. 2008, Carrasco-Garrido et al. 2007).

Even prior to the 2010 reforms that increased abortion legality (for now), women who qualified for one of the health-related waivers and sought care through the public health systems were required to make an average of six different visits to government and health system offices before being approved (Magarolas et al. 2008, de Ramales et al. 2009). Despite the devastating changes that could be wrought at any moment, the data for this study were collected while the liberalized abortion laws were still in effect. This writing largely describes the experiences of, and implications for, women’s access to legal, publicly funded abortion – though this is unlikely to last in the current economic and political climate. My study constitutes, to our knowledge, the only anthropological research yet conducted about the lived realities of legal, publicly funded abortion care in Catalunya or Spain. If legal abortion is indeed overturned in Spain and Catalunya, my research will have been the only investigation conducted during that brief historical moment.

Immigrant women, abortion, and health system cuts

A publicly funded study, conducted in part by the Spanish Public Health Institute prior to abortion liberalization, reported that the specific problem of access to abortion care directly and disproportionately impacts immigrant women, causing such women to arrive at clinics at later gestations, on average, than their locally born counterparts (de Ramales et al. 2009). Immigrant women in Catalunya and Spain have long expressed concerns about
seeking care through the public health system, due to scheduling difficulties, fears about their legal status, or other issues. At the outset of this study, I anticipated that immigrant women might not benefit from increased access to abortion care under the new laws, to the same extent that citizens and longer-term residents would. My research investigated, and confirmed, this expected disparity.

Increasing the likelihood that immigrant women would encounter more obstacles, the Catalan government, under pressure from Madrid to bow to austerity measures, announced changes to the health system shortly after my study began (El Periódico 2012). These changes required immigrants to be registered with their respective town hall for at least three months before applying for a health card, and restricted registered immigrants’ coverage to only primary care services for the first year covered (El Periódico 2012). Although pregnant women were supposedly exempt from the three-month wait for a new health card, I began collecting data with questions looming: Under the new rules, would abortion care be considered primary care, or specialist care? Would immigrant women know that they can apply for a health card right away if they are pregnant, or will they hear that immigrants have to wait, and not even try to apply until three months have passed, potentially delaying them into a later gestation and reducing their options for providers? What proof of pregnancy or other eligibility would immigrant women have to show, to be allowed to apply for a health card without waiting? If immigrant women in fact proved unable to access abortion care in the first year of coverage, would a two-tiered system develop in which Catalan citizens and long-term residents could get free abortion care, but newly arrived immigrants would have to pay a cash rate?

Early during my time in the field, a rumor also spread in feminist and pro-choice social networks that any Catalan resident who had not paid into social security for more than two years, or youths whose parents had not paid in to social security (i.e., those unemployed
for two years or more, or college students with unemployed parents), would soon lose health coverage in the public system as well. This was a serious matter, considering that an estimated 57% of young people in the region are currently unemployed (Homs 2013). If not only immigrants, but also young and/or unemployed women would lose public health coverage, the implications for reduced abortion access among economically vulnerable populations were dramatic. I address these questions, and the larger research questions about women’s perceptions of obstacles encountered while navigating the public health system in Catalunya to seek abortion care, in subsequent chapters.

Doing Research

I conducted research in the field from late August 2012 through June 2013 in various parts of Catalunya, and continue to stay in regular communication with several participants since my departure. Anonymous surveys were collected for me by clinic staff at a contracted abortion clinic in Barcelona (“Today Clinic”) that provides care to women in Catalunya on behalf of the public health system, and where the medical director is the president of a regional association of accredited abortion clinics, of a national association of all accredited clinics in Spain, and a member of a regional women’s health NGO (“Family Planning Organization”). I engaged in intensive participant-observation at the Today Clinic at least two full days per week for more than nine months, and recruited participants for qualitative interviews at the Today Clinic and with the above-mentioned Family Planning Organization at their administrative offices and in the Youth Center they run. In collaboration with clinic staff, I collected quantitative and qualitative data from women arriving for abortion services, from clinic staff, and from NGO staff and volunteers. The intensive time I spent in the Today Clinic was particularly useful in building rapport with
clinic staff, as they appreciated the many ways that I was able to be helpful within the confines of my role. With nearly thirteen years spent working in abortion care prior to my arrival in Barcelona, including often as the only Spanish-speaking counselor, I was able to find multiple ways to help with clinic flow, as a volunteer, while maintaining my IRB-defined observer role.

In a typical clinic day, I assisted clinic staff by preparing and printing follow-up instruction sheets for social workers to go over with patients in the discharge room, updating partners and family members when their loved one was out of surgery and in the recovery room, translating for English-speaking patients, assisting ultrasound technicians, and preparing blank charts and other standard paperwork for appointment schedulers. While my interactions with patients in the clinic were generally limited to calling women back for intake (by first name only, to preserve their privacy under the terms of my approved IRB protocol), escorting them from the recovery room to the social workers’ office to be discharged, and occasionally giving discharge and follow-up instructions once I had been trained in the clinic’s protocols, these small ways of helping created many opportunities for developing trust and familiarity with clinic staff members. In particular, I developed strong friendships with the social workers and technicians who did most of the problem-solving with women having difficulty getting the health system paperwork needed to obtain publicly funded procedure.

I gained this considerable access to the Today Clinic, and to the Family Planning Organization, and was able to develop a collaborative relationship with both entities, over several months of initial outreach in Barcelona in late 2009 and early 2010, and when I returned to Barcelona in 2012. I maintained contact in-between with consistent electronic and Skype communication. Originally, I traveled to Catalunya twice, to explore the feasibility of a study on abortion access under conditions of (then) illegality. In the first trip, I met with
anthropologists and sociologists at various regional universities, to learn about the current state of access at that time, and to ask what aspects warranted further study. At that time, I was interested in studying the phenomenon that, although abortion was illegal in Spain and Catalunya except in cases of rape, incest, and threats to the woman’s health, women who could afford to go to a private clinic and pay cash could speak with a staff psychiatrist who would document a qualifying “mental health reason” that could be used to justify a government-approved abortion under a set of qualifying waivers to the law banning abortion – and many women did so (de Ramales 2006). I planned to study how women found out where to go, and what to say, to attain the ‘justification’ for a permitted abortion.

A graduate student at one of the universities, who also worked at the Family Planning Organization, put me in touch with the NGO coordinator, who later chose the pseudonym “Greta-Maria” when I returned to the field and interviewed her. During my second trip to Barcelona, in early 2010, I met with Greta-Maria and learned that abortion laws were about to change, legalizing abortion in the first trimester (up to fourteen weeks gestation) for any reason, and under specific ‘waiver’ categories in later trimesters. At that time, she encouraged me to come back after the legal reforms would be implemented, to investigate the outcomes and state of access once abortion was integrated into the public health system, as she predicted it would be. In the ensuing time between my second visit, in 2010, and the beginning of my fieldwork in 2012, Greta-Maria facilitated my introduction to the director of the Today Clinic, who chose the pseudonym “Dr. Barcelona.” He and I established the parameters of my research at his clinic through a series of emails and Skype conversations prior to my 2012 arrival in Barcelona. The Institutional Review Board (IRB) at the University of Connecticut approved the study, including my participant-observation in both the clinic and with the NGO, in June of 2012.
Once in the field, I used survey and demographic data collected in cooperation with clinic staff members, recruited qualitative interview participants, and engaged in participant-observation (Bernard 2006) as a volunteer in the clinic, and as an observer at the Family Planning Organization and Youth Center. In addition to observing counseling and other interactions with patients in the Today Clinic, I observed conversations and meetings among staff at the clinic and NGO, spent time in neighborhoods and communities where women seeking care lived, visited public areas of health system centers in various neighborhoods to observe the physical settings and clinic lay-outs, and also spent time with several community-based grassroots organizations that advocate for women’s and abortion rights. I engaged in auto-ethnography (Bernard 2006) based on my own experiences of navigating the public health system on behalf of my young child, and the associated bureaucratic processes I had to confront as an immigrant mother newly arrived in the region. I did all my research, from pilot interviews and meetings to establish research sites, to participant-observation, and all interviews, in Castilian (Spanish), which I have spoken fluently since childhood. To the extent that conversations in the clinic were carried out in Catalan, clinic staff translated for me until I rapidly reached the point of comprehension. I had anticipated that conducting interviews or doing participant-observation in a language other than English might produce some awkward moments or communication difficulties, but happily, it did not ever seem to. Many of the women I interviewed were also immigrants from Central or South America and spoke Castilian with accents that were familiar to me, and most of us were in the same position of learning as much Catalan as we needed to in order to navigate and understand the health system. I do not believe that my language abilities impeded my research at any point. In fact, my efforts to learn Catalan facilitated rapport-building with clinic and NGO staff, not only because they spoke it, but because they were

13 Convenience, opportunistic, and convenience sampling (Bernard 2006).
continually delighted that I tried to. The director of the Today Clinic on several occasions introduced me to colleagues and associates as ‘his’ anthropologist, and bragged about my growing comprehension of Catalan.

I began this study hoping to interview up to fifty women and clinic or NGO staff, or as many as needed to reach concept saturation – the point when no new concepts are brought up (Bernard 2006). Ultimately, during the IRB-approved data collection period I was able to interview eleven women who had obtained abortion care at the Today Clinic, and eleven members of the Today Clinic and Family Planning Organization or Youth Center staff, for a total of 22 in-depth interviews. Initially, 108 women and clinic or NGO staff members filled out forms expressing willingness to be contacted to schedule an interview. Of these, I was unable to reach 16, due to numbers being disconnected or wrong. Twenty-eight women, once I reached them, said they were no longer interested or did not have time for an interview. Sixteen women initially agreed to schedule an interview, but then cancelled or could not be reached to confirm a time and place. Two women scheduled and confirmed interviews, but then were not home when I arrived, and did not respond to my efforts to reschedule. Twelve women who filled out interview interest forms turned out to live in other countries or in parts of Catalunya or Spain that were inaccessible with the transportation means available to me.

One woman who wanted to be interviewed was too young, according to IRB restrictions placed on my study. All eleven members of the clinic and NGO staffs who agreed to be interviewed followed through and participated in an interview. Half of the women seeking care who I interviewed were immigrants to Catalunya. It is unclear the extent to which immigrants may have been more or less likely to volunteer to be interviewed, or to follow through to schedule and participate in an interview. I stopped interviewing when I reached concept saturation (clinic and NGO staff), and when no further women volunteered to be interviewed. I contacted all women who filled out interest forms, and interviewed all
who were willing to schedule a time to meet. Further information about my sampling techniques, data analysis techniques, and other research methods is detailed in Appendix II.

I interviewed women in their homes, in cafes, or in parks, as they preferred. Most interviews lasted about two hours, though some were considerably longer. After going through the fairly stilted but required step of explaining the IRB consent procedures (a wholly foreign concept in European social research) to each participant, and obtaining a signature on the consent form, I began each interview by asking a few demographic questions (age, where from, how long in Catalunya if not Catalan, number of children, occupation, gestation at time of confirming pregnancy, etc.) and asked women to choose their own pseudonym. I do this latter as a way of involving participants in the process of defining their own narrative and presence in the data, and to hopefully break the ice after the awkwardness induced through the IRB consent process.

From there, I always started with the same open-ended question, using modified Grounded Theory (Charmaz 2006) interviewing techniques:

*Please tell me about everything you had to figure out, and everything you thought about and went through, from when you found out you were pregnant until you got to the clinic for your [abortion] appointment.*

Some women began their stories by talking about the decision, or the romantic relationship that resulted in the pregnancy, while others began immediately describing their experiences with the health system and clinic. In general, women seemed to view the clinic as part of the health system, and I view many of their comments about the clinic as an evaluation of the health system, by proxy. Similarly, women often conflated assistance with logistical obstacles (transportation, childcare, etc.) with social support, talking about who in their lives did or did not help them overcome obstacles by listing off who helped them resolve logistical challenges, or who failed to, as much as they talked directly about emotional accompaniment.
Among women I interviewed, six of the eleven were Catalan, one was born elsewhere in Spain, three were originally from South America, and one was Rumanian. Non-Catalans had been in Catalunya an average of 6 years, with the most recent arrival being in the prior year, and the longest residence period being 12 years. Ages ranged from 24 to 41 years old, and all but three had children or had previously given birth (one participant’s only child died as a young girl). Seven women were married or cohabitating. Occupations included doctoral studies, manual labor, sex work, nursing school, stay-at-home mother, janitor, college student (several), lab tech, on disability/medical leave (two), and unemployed/laid off (three.)

Clinic and NGO staff who participated in interviews included receptionists, social workers, physicians (Ob/Gyns), administrators, a translator, director, coordinator, and psychiatrist. They ranged in age from mid-20s to 60s. Their extent of experience in the field of sexual and reproductive health, including abortion care, ranged from four to more than forty years. Several had begun to work in sexual and reproductive health, facilitating clandestine abortion care under Franco’s regime, well before it was first (partially) legalized in 1985.

Some interviews with women who had obtained abortion care at the Today Clinic were easier than others – the two women who chose the pseudonyms “Frida” and “Sofia” were both fellow immigrant graduate students, and sympathetic to the difficulty of recruiting research participants. Others were more challenging – a woman who decided to be known as “Montse” lived in a very small town in rural Catalunya inaccessible by public transportation - I was only able to interview her because my father happened to have rented a car for an out of town trip and drove me there. She spent at least two hours of her interview spinning a very convoluted tale of multiple messy break-ups and betrayals by various men with similar names, involving groups of ‘gypsies’ (Rumanian immigrants, who are often viewed negatively by Catalans and Spaniards) in her town who she felt were out to ruin her
reputation, as well as various digressions about ongoing health problems unrelated to the abortion.

Some of the hardest interviews for me emotionally were with women who stated they had wanted to carry their pregnancies to term, but could not due to economic reasons or because of a concern over potential fetal anomalies. Interviewing women who professed they did not really want to have an abortion, about what was then difficult about obtaining that abortion, sometimes provoked in me a sense that I was focusing on arbitrarily concrete aspects of what had been, for them, a much more complex process. In those moments, talking with, for example, Duran, or a young Catalan woman who called herself “Superwoman,” or the older woman who chose as her pseudonym the name she ‘would have given her daughter (sic),’ “Leyre,” I tried to remember that women often volunteer to be interviewed about abortion experiences because they just want to talk to someone who is non-judgmental and who will listen to and validate their experience. That is what I always tried to do, within appropriate boundaries.

Sometimes formal interviews naturally turned into much more relaxed, social interactions. After everything on my checklist of prompts/topics had been exhausted in a given interview, and women stated they had nothing else they wanted to talk about related to obtaining abortion care, we sometimes shifted into casual conversations about parenting (I lived in the field with my daughter, who celebrated her seventh birthday in Barcelona), the frustrations of navigating government procedures as immigrants, local politics, the state of abortion access in the U.S., or simply what we liked about Catalunya. But by far the most heartbreaking interview, for me, was with a self-identified immigrant prostitute, “Alina,” who reported such a drop in demand for her work, attributed to La Crisis, that she faced immediate eviction from the tiny, plywood-walled make-shift bedroom she rented weekly. Alina had not had enough money to buy food for several days when I interviewed her.
Alina’s difficulties getting a publicly funded abortion seemed to be the least of her concerns when we met, as she repeatedly burst into tears during our interview, describing her despair and sense of aloneness at having no resources and nobody to help her. Feeling helpless to do anything to reassure her, I simply offered her the phone numbers for hotlines, shelters, and the local equivalent of a sex-workers’ union, and offered to be present with her during her procedure, if she wanted me to be. At the time of our interview I gave her the last €10 I had on me, hoping she could eat that day. Alina was the only woman I interviewed prior to her actual abortion, as she had to reschedule her surgery for later dates at least three or four times, due to a variety of logistical problems and health coverage delays. That I write about her in such detail here underlines the extent to which her plight was etched in my memory and how, along with the stories of other women I talked to, the memory of her struggle helped motivate the completion of this writing.

Interviews with clinic and NGO staff were simple by comparison. We spoke a common language of abortion care, reproductive justice, and frustration with Madrid’s (our short-hand for the conservative government) threats to the abortion reforms. The biggest challenge in doing these interviews was scheduling them around workers’ clinic and Youth Center hours, so that we could talk at length without taking them away from patients and clients, or keeping them late after a long day. Clinic and NGO staff were particularly interested in hearing, at the beginning of each interview, what women had told me about what was most challenging about accessing care. Understandably, given the extent that women conflated the clinic’s own requirements or scheduling issues with problems with the larger health system, staff members were sometimes defensive when I tried to tactfully share women’s complaints about anything that fell under the purview of clinic protocols. Even so, some of the staff who agreed to be interviewed were quick to mention ways that the clinic or NGO could make things easier, if given the leeway to change their internal protocols.
Women who sought abortion care at Today Clinic

To capture a broad demographic picture to contextualize my qualitative data, I collected data from 350 women who sought abortion care at the Today Clinic, using surveys collected by clinic staff that requested demographic data and measured women’s perceptions of various obstacles. I reached my goal of collecting 350 surveys in February 2013, after slightly more than four months of formal data collection in the clinic. The average age of survey respondents was 28, with a range from 13 years old to 49 years (though both younger and older women were seen in the clinic during the course of the study). The average age found in this sample is identical to that found in earlier studies of women seeking abortion throughout Catalunya and Spain (ACAI 2010). Forty-six percent of respondents were single, 22% married, 7% divorced, and 24% were living with a partner. The latter percentage was almost twice as high among women throughout Catalunya and Spain in earlier studies (ACAI 2010), although that statistic collapsed married women and unmarried but cohabitating couples, bringing the demographic profiles back to similar levels.

Fifty-three percent of women completing surveys for this study had completed secondary school only, while 15% of respondents had each completed only primary school, or some university (without university completion, a licenciatura that is equivalent to a bachelor’s degree in the United States). Five percent had completed their licenciatura, 6% had completed some postgraduate studies, and 4% had earned a master’s degree or PhD. According to Dr. Barcelona, whose association of accredited clinics routinely compiles statistical information on women seeking abortion care in Spain, these levels of educational attainment are representative of women having abortions in general, and are also typical for the overall population. In his words, “you would get the same results taking surveys at any entrance to the metro.”
Seventy-five percent of survey respondents were citizens, 23% were registered immigrants, and 2% were *sinpapeles* (unregistered immigrants). These percentages represent a higher proportion of citizens versus immigrants seeking abortion care, as compared to earlier studies conducted in Spain (de Ramales *et al.* 2006). Clinic staff suggested that immigrants may have been less likely to independently complete my surveys, potentially skewing the results towards the responses of citizens, whereas earlier studies relied on data collected directly by providers using patient records. The clinic director also pointed out that under immigration pacts with former Spanish colonies, many South American immigrants can eventually trade in their original passports for Spanish citizenship, and that such immigrants then identify as Catalan or Spanish, and are citizens, and may therefore have self-identified on the survey as citizens, while earlier studies may not have captured this nuance in identity.

In fact, 35% of survey respondents reported Spanish nationality, 21% reported Catalan nationality, 12% checked off boxes indicating both Spanish and Catalan nationality, and 20% of respondents reported South American nationality. Much smaller numbers were reported for other immigrant groups commonly seen in the clinic during participant-observation: 4% “other European,” 2% each Central American and African (possibly including Moroccan immigrants), and 1% Asian (possibly including Pakistanis and Indians). The latter categories may have been under-reported, as participant-observation and interviews with clinic staff suggest that many Pakistani, Indian, Moroccan, and other African women are seen for abortion care, but that in the frequent cases where the woman’s accompanier is the one who speaks Castilian and the woman does not, the survey may not have been completed for or with her. By comparison, data collected by abortion clinics throughout Catalunya and Spain in earlier years found that nearly 60% of respondents were Spanish, 21% Latin...
American, almost 4% African, less than 1% Asian, and 2.5% from elsewhere in Europe, with Catalan identity not being measured (ACAI 2010).

The vast majority of respondents arrived at the clinic for the first day of what is typically a two-day appointment with pregnancies averaging eight weeks gestation, a point slightly earlier in the first trimester than the average gestation of interview participants. This is consistent with national Spanish data collected in the year prior to the inclusion of abortion in the public health system when, if anything, it could be expected it might have taken women longer to access care (ACAI 2010).

Table 1, Gestation in the survey sample

<table>
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<tr>
<th>Gestation at time of abortion</th>
<th>Average gestation</th>
<th>First trimester</th>
<th>Second trimester</th>
<th>Referred to hospital or turned away (&gt;22 weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surveys</td>
<td>8-9 weeks</td>
<td>90%</td>
<td>8.6%</td>
<td>1.4%</td>
</tr>
</tbody>
</table>

Sixty-seven percent of women who completed surveys for this study indicated that the pregnancy resulted from a contraceptive failure, compared to about 70% of women throughout Catalunya and Spain who had abortions in the most recent other year for which data were available (ACAI 2010). While the numbers of reported contraceptive failures found in my study are higher than in the United States, where slightly more than half of women

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14 Under the current law, as enforced by health system and clinic protocols, the typical time from pre-operative testing and counseling to the abortion procedure varies from a few days to a week or more, depending on scheduling and demand. In accordance with the clinic’s preference, women completed surveys on their pre-operative appointment day -- I assume most women were perhaps a week further along in a pregnancy by the time of the actual procedure, meaning that the apparent discrepancy between gestations in the survey sample and the interview sample may be an artifact of how data was collected, not an actual difference.
seeking abortion care report having used contraceptives during the time period they became pregnant (AGI 2013a), it is worth noting that birth control is more widely available and cheaper (or free) in Catalunya and Spain, where birth control pills can be purchased at low prices over the counter without a prescription in any pharmacy, and other methods are available for free through the health system. One possible explanation is that more women in Catalunya were using birth control, that then failed, than in a comparable U.S. sample.

Table 2, Contraceptive usage and failure rates, survey sample (n=350)

<table>
<thead>
<tr>
<th>Using contraceptives when got pregnant</th>
<th>Condoms</th>
<th>Pills</th>
<th>Vaginal ring, Withdrawal</th>
<th>Patch, Condoms + Withdrawal</th>
<th>Rhythm method, emergency contraception, condoms + pills</th>
<th>IUD, injectable hormones, vasectomy, condoms + pills + ring (sic), condoms + IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>67%</td>
<td>55% of failures</td>
<td>27% of failures</td>
<td>3% each of failures</td>
<td>2% each of failures</td>
<td>1% each of failures</td>
<td>0.4% each of failures</td>
</tr>
</tbody>
</table>

The demographic profile of women seeking abortion at the Today Clinic during the study period highlights the relative poverty of many women who seek abortion, especially considering average family size. The average annual income among survey respondents was equivalent to about $13,000.00 USD -- only slightly above the Catalan poverty threshold (Generalitat 2011). Most women had at least one child to support on these meager incomes.
Table 3, Income levels and Family size

<table>
<thead>
<tr>
<th>Average income (not adjusted for family size)</th>
<th>No income</th>
<th>Max. income reported</th>
<th>No children</th>
<th>One child</th>
<th>Two children</th>
<th>Three or more children</th>
<th>Avg. family size</th>
<th>Max. family size</th>
</tr>
</thead>
<tbody>
<tr>
<td>€9699/year</td>
<td>25-66% 15</td>
<td>€30000</td>
<td>42%</td>
<td>28%</td>
<td>21%</td>
<td>8%</td>
<td>2</td>
<td>12</td>
</tr>
</tbody>
</table>

The techniques I used to analyze all of these data are presented in detail in Appendix II. Overall, the mixed-methods nature of the study provided a wealth of data on women's demographic and socioeconomic circumstances, and on women's and providers’ perceptions. Open-ended interviews produced narratives of women and providers describing, in their own words, how obstacles to abortion access affect the experience of seeking care, and revealed larger political-economic contexts of abortion access in Catalunya.

Structural factors and critical medical anthropology

This study was rooted in a political-economic and critical perspective, using critical medical anthropology (Baer et al. 2013) as a theoretical framework to focus on marginalized populations’ lived experiences with a public health system in light of structural forces and deliberate unequal distribution of resources. Of particular concern to me were structural constraints affecting women’s access to abortion in the health system, in the context of policy

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15 Twenty-five percent of respondents wrote in a zero on the line provided for reporting annual income, but another 41% did not fill in anything at all; a response that could also be interpreted as zero income, or as a reluctance to report income levels, meaning that the percentage of women seeking abortion care who have no income could be as high as 66%. The latter interpretation appears quite likely based on participant-observation in the clinic and interviews with clinic staff.
changes and political and economic shifts in the surrounding society, particularly insofar as these constraints produced a form of structural violence that disproportionately affected women in poverty, immigrants, and other marginalized populations. In this writing, as mentioned earlier, I also explore the extent to which civilized oppression (Harvey 1963) and symbolic violence (Bourdieu 1991) add nuance to the larger lens of structural violence, in explaining women’s experiences with delays and obstacles in the health system, and perceived threats to legal abortion access. The prediction that women would perceive and experience delays and obstacles in the process of seeking now-legal and publicly funded abortion care in Catalunya proved to be true for many in the context of economic crisis and cuts to social services, while threats to the legal status of abortion and funding cuts in the health system also colored the discourse of abortion providers, advocates, and seekers.

As the following chapters describe, while a woman in Catalunya had the legal right to seek an abortion through the public health system during my time in the field, the actual process to do so was time-consuming and frustrating, and, particularly for some women in the interview sample (immigrants, from rural areas, and women who perceived little social support), extremely difficult. In the field, women seeking care and those who worked to serve them displayed notable concerns about the shifting landscape of health system funding and abortion legality, and implications for abortion access. In Chapter One, I delve deeper into the political-economic contexts of La Crisis, resulting cuts to services and how they particularly impact immigrants, the 2010 abortion law reforms and the current threats to these, growing support for Catalan independentism, and the extent to which all of these impacted women and providers. In Chapter Two, I present the situation of abortion care as offered in the Catalan health system during the study, how it was supposed to work, how it actually worked, how it changed during that time, and women’s and providers’ experiences with it, including from the perspective of the clinic’s and NGO’s evolving interactions with
the health system. Chapter Three zeroes in on the women themselves – who they are, their various subcategories (immigrants, Catalan women, etc.), and their experiences with social support obstacles to care, with emphasis on the interplay between these various factors.

Chapter Four moves into a discussion of the implications of my findings as they relate to critical medical anthropology and the broader landscape of international abortion access, and wraps up with conclusions and recommendations – including how the landscape of abortion access in Catalunya’s contemporary political-economic context offers insights into reproductive rights internationally, and the important role of public health systems in ensuring or limiting abortion access. In Chapter Four I also discuss current popular responses to the announcement of the Spanish government’s plans to overturn legal abortion.

Fundamentally, women’s and providers’ perceptions of obstacles encountered while seeking care, the ways that women overcame delays and difficulties to obtain care, and what they thought and felt about the political and economic settings in which they did so, are at the heart of the narratives, statistics, and analyses presented here. As Spanish and Catalan feminists insisted throughout struggles for abortion legalization in the 1970s and 1980s, for the reforms of the 1990s and 2000s, and as hundreds or thousands of people chant loudly and insistently in the streets of Barcelona each time conservative politicians in Madrid threaten the right to legal abortion, including as I write this, women in Catalunya demanded and still seek to protect, “¡Avortament, lliure i gratuit!” (Abortion, legal and free!).

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In Catalan, two distinct words indicate “free” as in no cost, and “free” as in, freedom to do something. “Lliure” is the word that means legal, permissible, or something you can freely do. “Gratuit” means free in the sense of not having to pay.
Chapter One: Catalunya, Crisis, and cuts

I arrive at Prat de Llobregat airport outside Barcelona for the third time on a muggy, hot, sticky-slow day unlike the comparatively cooler days when I’d landed for pilot research visits in December 2009 and March 2010. The whole city is practically shut down for August vacation, a month when anyone who can flees to the countryside or beach, and everyone else waits through the daylight hours inside with shades drawn, only venturing out at night. Nevertheless, I have little trouble finding a taxi to take me, my two suitcases, and my long-suffering sixty-pound dog on the fifteen minute drive to a tiny flat I’ve rented, sight unseen, in the historically working-class, immigrant neighborhood that sits in the shadow of Montjuic, a small mountain overlooking one side of Barcelona. I haven’t been in the taxi two minutes when the affable driver asks me why I’ve come, “For vacation?” No, I tell him, I’m a researcher, here to do the investigation for my PhD. He asks what I’m studying, and I hesitate, not yet aware of how entirely comfortable everyone here will be with me talking about abortion. I settle on saying, “I’m studying the health care system ... what people have to do in order to use it.” That easily, the ride into town becomes my first opportunity to informally learn about perceptions of health care access, as my first conversation in my new home becomes a one-sided lecture, with the taxi driver regaling me with all of his opinions on the problems La Crisis is causing for the health system. He’s the first to tell me about the prospect of cuts to coverage for immigrants, something he emphatically decries. He is Catalan, he says proudly, and is equally proud that the Catalan health system covers everyone, regardless of immigration status. He waxes eloquent about how vital the tourism industry is to Barcelona’s success, and insists that Catalan tourism depends largely on immigrant workers, who thus need, and deserve, education and health care. He asks what I think of “Obamacare,” and when I tell him about my healthy skepticism that it will accomplish what is really needed, he replies, “If this [Obamacare] were proposed to Catalans, there would be a revolution!” The taxi driver is adamant that single-payer health care is not only a right for residents, but also a necessity for economic and public health stability, and that the current threats to Catalunya’s version of it could be disastrous. I smile through my jet-lag, and know I’ve come to the right place.

- Field notes August 24th, 2012

Institutional, political, and social barriers to abortion and other health care function as a form of structural violence that not only directly affects women currently in need of abortion, but also looms as a threat to any woman’s ability to access abortion if needed in the future. When marginalized populations are prevented or delayed from accessing needed health services, the institutionalized nature of social inequality and income disparities become inscribed on people’s bodies and lives. Spanish and Catalan scholars directly describe the
current threats to the abortion law reforms as an example of structural violence (Rodríguez-Armas n.d.), and identify various ways that marginalized women in Catalunya are delayed from obtaining needed reproductive and abortion care (Martínez Morant n.d.). Participants in this study were keenly and explicitly aware of how the political, legal, and economic climate in which they sought care affected their ability to successfully obtain an abortion, and many of them referred explicitly to *La Crisis*, the cuts to health services it was used as the excuse for, and/or to the conservative government in Madrid’s repeated threats to undo abortion law reforms as factors they considered while attempting to obtain a publicly funded abortion.

Building on Critical Medical Anthropology (Singer 1986) and the anthropology of [health] policy (Singer & Castro 2004), this writing focuses on how women and providers perceived the experiences of navigating a health system governed by health policy, in the larger political-economic contexts of precarious abortion laws, economic crisis, austerity measures, health care cuts, and a growing demand for full independence. While the particulars in this case are uniquely Catalan in context, similar threads likely weave through many other tapestries of health care access or in-access.

We know that illegal and unsafe abortion is a leading cause of morbidity and mortality for pregnant women worldwide, especially where abortion is heavily restricted or prohibited by law (Henshaw *et al.* 1999, Bartlett 2004). This means that policies which reduce or interfere with access to legal abortion directly threaten women’s health. Social and cultural factors that predispose women in certain countries, regions, or communities to reduced access to safe abortion care combine and intersect with political-economic contexts, exposing some women to more delays and obstacles. Such factors also increase women’s risk of experiencing complications related to unsafe or delayed abortion care and abortion-related stigma, or even to being forced to carry unwanted pregnancies to term with all the associated

Delaying or reducing access to abortion, potentially forcing a woman to continue an unwanted pregnancy and raise a child she does not feel prepared to care is no less a form of structural violence than denying treatment for tuberculosis, cancer, or HIV, in that women are more likely than men to live in poverty internationally, and the experience of single motherhood or parenting in the absence of adequate social support can keep or push women and their children into socially marginalized categories where they are more affected by various forms of institutional oppression and deprivation, than are their male counterparts (Farmer 2004, Ellison 2003). These limitations and negative outcomes are even more of a risk for additionally marginalized women, including immigrants (Ostrach 2012), and in some areas, teens and rural women (AGI 2013a).

Forty-five percent of women I interviewed in Catalunya who sought abortion care explicitly mentioned *La Crisis* and threats to the abortion laws. Sixty-three percent of clinic and NGO staff mentioned *La Crisis* as a threat to abortion accessibility, and 72% mentioned looming political threats to the abortion laws. In contrast to frequent concerns about economic motives to seek abortion, threats to health care services, and the precarious state of abortion legality, some interview participants, and many women and providers I interacted with referred hopefully to the promise of Catalan independentism, the potential for the current, growing movement towards Catalunya’s full separation from Spain, to succeed. A typical analysis heard from abortion providers, including Dr. Barcelona and Greta-Maria (who both work on political advocacy and legislative efforts to protect access to legal abortion) proposed that maintaining and expanding Catalunya’s political autonomy might in fact be a way to protect the level of comprehensive Catalan health care offered to all in the region, while also defending the legal status of abortion. All of the providers I interviewed
vocally supported full Catalan independence\textsuperscript{17}, though this appeared to be less of an overt concern for Catalan women who sought abortion care.

In the view of those who support full independence, the history of Catalunya’s greater health system accessibility for immigrants, even now vigorously defended by successive Catalan governments (both conservative and socialist) in the face of various rounds of austerity cuts, presents a model for how to maintain health equality in a future Catalan nation within the European Union. Along with Catalunya’s surprisingly public commitment to finding ways to offer abortion services even when it was ostensibly illegal in Spain (Barambio 2012, APFCiB 2010), this hints at the likelihood that a fully independent Catalunya would protect and maintain public health care, including abortion. In this idealistically hopeful view, fervently held up as an explicit strategy by Dr. Barcelona and others of his political leanings, a fully independent Catalunya will guarantee legal and publicly funded abortion, for all residents, even if Spain slashes both. This chapter further outlines the background of \textit{La Crisis} and resulting health care cuts, the 2010 abortion law reforms and ensuing threats to them, support for Catalunya’s full independence among reproductive justice advocates, and the role of each of these in women’s experiences accessing publicly funded, legal abortion in the Catalan health system.

\textit{The specter of La Crisis, threats to abortion legality, and popular responses}

Participants’ political views and reactions to current events bubbled up in multiple interviews, and in many informal conversations that took place during my work at the Today

\textsuperscript{17} In fact, my own support of the independentist movement is partially what helped me earn Dr. Barcelona’s trust, and my efforts to learn Catalan and acknowledge Catalan identity were a continual source of pride for the providers who introduced me to others as ‘their’ anthropologist.
Clinic, and with the Family Planning Organization and Youth Center. Particularly whenever the conservative government in Madrid issued new statements threatening the survival of the abortion reforms, or when austerity cuts imposed by Madrid on Catalunya appeared likely to result in cuts to public health coverage, women who had sought abortion care in the health system, and those who worked to ensure access to such care, displayed strong reactions. The outburst below, from a 26 year old married Catalan woman with one child, who chose the pseudonym “Afrodita,” was in response to my question about what she thought would make it easier for other women to get abortion care, after she had an abortion paid for by the health system:

[Abortion] must always be free! Always! CatSalut cannot play around with that. What does Rajoy [Spanish Prime Minister] say, that aborting a malformed fetus is not a motivation for abortion, what is that, why does he say that? That’s something, if a fetus isn’t well, and that’s not a motivation for abortion, what is a motivation, because, my God, it’s not him that will have to be with those children?! He won’t, it’s the women that have to stay with them, how nice for him to say that a malformation isn’t a problem. For them no, for the mothers, yes. Because I, you know, I have three friends who have had children with malformations or something, and they are, they were working, but they’ve had to stop working to [care for] their kids, there’s no help, there’s nothing. So, those people [Rajoy’s government], they see that, and they tell me, that it’s something fun? Man, please! And who will pay for that, will someone come to help, who will pay for it? [I jokingly say to her daughter, “your mom is becoming a feminist!”] A little, a little, but it’s that, he [Rajoy] is making me one, they [his government] make me [a feminist]! I will not be in favor of a man who is telling me I have to be a mother because he says so! Please! That is unbelievable...

Like many participants, Afrodita discussed the precarious economic situation in Catalunya as a factor in her need for abortion care. Afrodita said she would have preferred to have another child “if things were better [financially]” but that she and her husband did not have the “economic ability” to continue another pregnancy after the birth of her young daughter. Her husband works out of town and is only home on the weekends, for the rest of the week.

Afrodita is a single mother studying to finish a college degree and caring for an active toddler.

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18 Block quotes from participants are reproduced in the original Castilian in Appendix 1, in the order they appear in the text.
alone. As Afrodita said, “I prefer to have one child and care for her well than have two that go hungry, you know?!” – a sentiment echoed almost verbatim by 36% of women I interviewed.

Another young college student who, like 18% of women I interviewed, reported struggling with the decision about whether or not to terminate her pregnancy, discussed how, while she liked the idea of having a child, and felt she could manage it alone emotionally, she did not want to face an inevitable struggle to feed and care for a child while going to school and working part time. Referring to herself by the pseudonym “Superwoman,” this articulate and thoughtful 24-year old Catalan who works two jobs while going to school for a degree in Biology, framed the life she knew she could give a child as “torture,” with financial insecurity and family strife a certainty:

*It’s that I’m very young, I’m not in an appropriate situation at all, I’m at the university, I work in the mornings, it’s not the moment, and I don’t have the money to do it... it was an economic problem for me, I don’t have money for this. Both my parents are doctors. If I had to cry to someone for money, I would cry to them, it’s not for that. But influenced by the theme of my parents, if I fight with my parents, the money ends. And that I would fight with my parents is obvious, very obvious. So, those two factors were very important for me. The fact of having a child alone was not a problem for me, speaking plainly, I consider myself a very strong woman, I’ve been through worse... but also the problem on top of it all, if I have the child, what will it cost me to eat, how to take him to school, feed him, the diapers? From what I see, if I’m going to have something beautiful in my life, I would do it. But I, entering the situation I’m in now, with no time and running around all the time, everything, it was not something I hoped for, and it wouldn’t have been well-received. If it would have been, I wouldn’t have been crying all week, what to do?*

This last idea, that a pregnancy that should be continued would not evoke stress and upset, was also offered by the Today Clinic’s staff psychiatrist as an argument for why the government’s requirement of documented physical and mental health justifications for abortions to be performed after 14 weeks gestation is flawed and unfair to women. “Jorge,” who had worked at the clinic since it opened in 1989, told me early on during my research that he saw the psychiatric justification requirements as a tactic used by the conservative
government to punish women who attempt to make decisions about what is best for them and their families.

Jorge framed the legal need for a woman at certain gestational limits to convince a psychiatrist that continuing an unwanted pregnancy, or a pregnancy with severe malformations, will cause her undue suffering or negatively impact the family members who already depend on her, as a misogynistic, draconian effort to control women and deter them from obtaining abortion care. He described it in terms echoed by “Superwoman,” stating that, in his professional opinion, psychological suffering or depression caused by an unwanted pregnancy, that can be used to justify later abortions under current Spanish law, is easily ended by ending the pregnancy itself. Jorge pointed out that he routinely tells women, “If this were a pregnancy you could continue, you wouldn’t be here crying, right?” He argued that the conservative Spanish Justice Minister Gallardon’s current pledge to overturn legal rights to any abortion performed because of fetal deformities, and to ban all abortions after either 12 or 14 weeks (CFRR 2012), would produce exactly the kind of psychological suffering for affected women that it is now his job to document to justify the need for abortion.

That both a woman who had obtained a legal abortion, and the psychiatrist who reviews mental health justification requests from women seeking abortion care, view an unwanted pregnancy as an obvious source of distress underscores the strong popular rejection of attempts to seriously limit access to legal abortion (CFRR 2012). For example, in one poll conducted while I was in the field, fully 81% of people surveyed in Spain and the autonomous states opposed Gallardon’s proposal to reinstate parental permission laws for sixteen and seventeen-year olds, and to end all abortion care in cases of fetal malformation (CFRR 2012).
On September 28th, 2012, observed as the international day for abortion rights, hundreds of people marching in Barcelona gleefully shouted one of the most popular chants of the day, “¡Gallardon al paredón!” (“Gallardon to the wall [firing squad]!”). Several Catalanist activists I met during my participant-observation, including Dr. Barcelona, expressed their strong belief that fully separating from Spain would be one way to protect abortion rights in Catalunya, by removing the Catalan health system and legal system from the influence of Gallardon, Spanish Prime Minister Rajoy, and their extremely conservative, some say neo-Fascist, Partido Popular (PP) party, originally founded by Franco’s cronies (Tremlett 2008). Moreover, one year later, on September 28th, 2013, the Catalan Parliament upheld a resolution introduced by a leftist party on behalf of an abortion rights coalition that the Family Planning Organization co-founded, proclaiming a commitment to maintaining and protecting legal, publicly funded abortion in Catalunya, regardless of votes or rulings to the contrary in Madrid (Parlament 2013).

Abortion-related stigma in Spain and Catalunya, to the extent that it is evident at all, appears to be highest among immigrants, who typically come from countries in South America, North Africa, and the Middle East, where religious and cultural traditions more often prohibit abortion (Magarolas et al. 2008). Because immigrant women in Spain and Catalunya experience a higher rate of unplanned pregnancies, and seek abortion at a higher rate than do Spanish-born women, abortion-related stigma in immigrant communities may have a more significant effect on perceptions of abortion accessibility (Magarolas et al. 2008, de Ramales et al. 2006), though abortion stigma does not appear to have a large impact on non-immigrant women in the country.

Interestingly, religion was not mentioned as a factor in the decision to seek an abortion, or in the ability to identify social support while seeking care, by any women I interviewed. Clinic and NGO staff downplayed the role of religion in affecting women’s
experiences with abortion in Catalunya, reminding me frequently that Catalunya is historically and currently more secular and even more anti-religious, compared to Spain (Bruni 2011). If Catholic sentiment is likely to affect abortion access anywhere in and around Spain, Catalunya is the least likely place to see it (Roca i Girona 2009, Tremlett 2008, Crow 1985). The only hint of religiosity as a factor that I encountered in the entirety of my time in the field was once or twice when clinic staff mentioned to me that a woman had gotten as far as the preoperative room with a rosary in her hand, that she was then asked to leave with her personal belongings until she came out of surgery. Clinic staff commented on this rare phenomenon only in relation to their concerns it might upset other patients if they noticed a fellow patient in a waiting area holding a rosary, rather than relating it to the woman’s own decision-making.

Austerity and the health system

Regardless of legality, women’s access to abortion care is frequently affected by various economic, logistical, and social obstacles to access that result in delays or difficulty obtaining care (Ostrach & Cheyney n.d., Jones et al. 2005, Henshaw et al. 1999). Although which obstacles or delay factors have the greatest impact on women varies depending on the particular geographic, legal, cultural, economic, and political contexts in which women seek care, access to abortion is more restricted than access to other types of reproductive health care worldwide.

Most geographic regions and countries worldwide provide some level of basic prenatal and maternal healthcare (Ostrach 2012), either through national health programs designed to improve maternal-child health, or through the efforts of non-governmental health organizations. Of course, a lack of access to contraception or prenatal care can interact with
limited access to abortion in a particular setting, particularly for immigrant women (Martinez Morant n.d.), or increase women’s risks for having to carry unwanted pregnancies to term (Barot 2011), but abortion care generally tends to be less accessible than other reproductive health services even in places where abortion is legal.

This holds true in Catalunya, where my fieldwork revealed that women who can access CatSalut, the public health system, are able to obtain basic gynecologic, prenatal, contraceptive, and prenatal care at neighborhood clinics, including through. Until late August 2012, all residents, regardless of immigration status, could use CatSalut without a waiting period for eligibility. This is still true for people who have resided in Catalunya for at least three months, and supposedly, for pregnant women, children, and those with disabilities. Surgical abortion care, and all abortion care between about 7-22 weeks gestation, is the only form of sexual and reproductive health care aside from, reportedly, sometimes mammography, for which women in Catalunya must seek a referral voucher to be seen at a separate facility. Even women who can obtain a wide range of reproductive health care for free, near their homes, face additional levels of bureaucratic requirements, and additional visits, to obtain abortion care in Catalunya. Other researchers have found that immigrant women encounter more problems accessing the health system than do Catalans, and that all women are likely experience some delays in obtaining publicly funded abortion care, as compared to other types of care (Martinez Morant n.d.).

Illustrating some of the challenges with the health system that will be explored in subsequent chapters, a woman who chose the pseudonym “Frida,” a 27 year old Colombian graduate student who had been in Catalunya about a year when I interviewed her, had to make repeated visits to her CatSalut center, and deal with a frustrating degree of misinformation:
What they did ask of me [at the CatSalut reproductive health center, or ASSIR] was that I had to take time to think to decide if I wanted to have the abortion... and [that] is where I begin to see failures of information because that was in the morning. In the morning they told me, “you have to take 72 hours after you find out [you are pregnant], to decide what is the step you want to take.” But when they confirmed for me the diagnosis [the pregnancy], in some way there was already a decision made, no? And I wanted effectively to do this as soon as possible, because also from there came the next failure of information, and it was that the person who did the evaluation calculated that at that time, at that time I was six weeks pregnant. Another failure of information, because obviously [I myself] had done a calculation, but she told me, “you [are] six weeks and that is just exactly about the time, because it’s ideal [to do it] the seventh week [sic],” so they told me, “process this if you want to do it, soon.” So then that same day I talked to my boyfriend, I told him that, “look, we have to wait 72 hours,” I did not feel good, we said that [same] afternoon, “we’re going to try to see if they’ll let us request the appointment for the abortion.” And it turns out they told me one thing in the morning and another thing in the afternoon, [in the afternoon] they told me, “okay, we’ll attend to you now,” and they made out the voucher in the same place, just in the afternoon they told me something else! You know, so if I had not tried in the afternoon, I would have waited three more days to go another morning! In addition we also waited about three hours at the CatSalut center, and later, the doctor gave us [the voucher], he gave us the information about the clinic, how to contact them, that it was in charge of doing the abortion.

Where to even begin with the mistakes that were made in Frida’s treatment by CatSalut? She ultimately went to the center three times to get all her paperwork filled out correctly, and then made two trips to the clinic – one for preoperative tests and counseling, and one for the abortion itself. CatSalut representatives incorrectly told her that she needed to wait 72 hours after the pregnancy test to request the voucher for an abortion, an assertion that does not appear in the abortion laws or CatSalut policies. In fact, the health center employee who told her this may have deliberately or inadvertently misinterpreted the tenet of the abortion law that stipulates 72 hours must pass from the date on the voucher to the date of the abortion itself. This built-in delay in the law is characterized as a “reflection period” (Barambio 2012), but, in actuality, seems to have very little impact on the time it takes for women to obtain care, as no clinic offers same-day appointments, and most providers routinely schedule the preoperative day and the surgery day at least a few days apart, anyway. The Today Clinic deals with the 72 hour delay rule by scheduling women for the preoperative appointment as
soon as they call, and then automatically offers women surgery appointments that fall on the third day after the date on the voucher. Not one woman I interviewed, nor any women in the clinic, ever mentioned or complained about the 72 hour wait.

Nevertheless, in Frida’s case and who knows how many other women’s, the 72 hours might have become 144 hours, or 6 days, of delay. If Frida had not felt empowered by her partner’s support to go back to the health center the same day and try again to get her voucher for care, she would have waited three days to go back and request it, and from that point would have waited still another three days to obtain care. It is hard to say how many women are encountering civilized oppression in the form of such “creative” interpretations of the abortion laws by CatSalut staff, but, based on the number of problems with vouchers seen in the Today Clinic, and the experiences of women I interviewed, many and varied permutations of misinterpreted health system protocols, and simple paperwork errors, forced some women to make more visits than should have been necessary, to succeed in getting the necessary vouchers for care.

Moreover, CatSalut employees’ periodic mistakes in accurately calculating gestations, in the apparent absence of routine use of ultrasound scans in the neighborhood health centers, also produced frequent problems with vouchers that listed the wrong gestation or trimester (sometimes requiring women to get a new voucher). This also meant that women sometimes came to the clinic much further along than they expected, and thus closer to gestational cut-offs for care. Frida had calculated that her pregnancy was at an earlier stage than CatSalut staff estimated, and thus when she reached the clinic and found she was in fact earlier than the staff at her neighborhood health center had said, she was asked to reschedule for a later date. The Today Clinic protocol, like some centers in the United States, is to not offer suction
abortion until a gestational sac can be easily visualized on ultrasound, around 6-7 weeks gestation.¹⁹

For Frida, who was confirmed at the clinic to only be 4-5 weeks pregnant as she had originally thought, the additional delay resulting from clinic protocols was an inconvenience that exposed her to two additional weeks of nausea and fatigue while going to school and working. While not explicitly a health system-related delay, Frida conflated the time she spent waiting to be eligible for a surgical procedure at the clinic with the other delays she was subjected to by CatSalut. For women closer to a legal cut-off to obtain an abortion at all though, a CatSalut error in estimating gestation could mean the difference between being able to obtain an abortion, or not. As I will discuss in Chapter Two, the Today Clinic administrators tracked all cases of such referral errors made by CatSalut in the first year of the publicly financed abortion collaboration, and found many more examples of this kind.

To make matters worse, shortly after I arrived in the field in August 2012, the Catalan government announced that, under pressure from Madrid, Eurozone-induced austerity cuts would be incorporated into CatSalut, in the form of cuts to eligibility for immigrants. According to local news accounts, the PP in Madrid originally demanded that Catalunya cut all health care for all immigrants. The Catalan government and health department, fiercely defending the high standard of public health that Catalunya has long been known for, refused to do so (Raventos & Wark 2012), and counter-proposed a compromise in which immigrants would have to show they had resided in Catalunya for at least three months to obtain a new CatSalut health card, which could then only be used for primary, non-specialist care in the first year (El Periódico 2012).

¹⁹ In fourteen years of working in abortion care in the United States, I have witnessed many providers who are skillful, experienced, or open-minded enough to routinely offer earlier care, with suction procedures offered as early at two weeks after a missed period, with no associated increase in complications or missed pregnancies.
Children, people with disabilities, and pregnant women were said to be exceptions to the residency waiting period, but the abortion providers I worked with expressed doubt about whether most pregnant immigrant women would know or hear that they could get health coverage right away. Moreover, as will become apparent from interviews described below, pregnant women could not even use newly acquired coverage for abortion care, during the first month of such coverage. At the same time, rumors began circulating that CatSalut would also cut coverage to anyone who had not paid into the Social Security system for at least two years. This would constitute an unprecedented step that would, for the first time, link access to public health care to employment status. Catalans I spoke with mentioned the devastating impact such a cut would have on long-term unemployed residents, children of those unemployed, and college students – all groups who had previously been guaranteed health care, but who would now face losing their coverage. While I was never able to confirm cuts to health coverage for Catalans not paying into social security, fears about such a step came up in many interviews.

Particularly in light of the high level of unemployment in Catalunya, now at more than 50% among college-age residents (Homs 2013), cutting health services to recently arrived immigrants and those without jobs was seen by those I interviewed and spoke with informally as a form of looming structural violence that would inevitably produce a precarious public health environment. As evident in Afrodita’s quote earlier, according to participants, such an environment would mean one tier of society would have access to preventive and acute care, while those most vulnerable in society would be left without a health safety net. To the extent that health care cuts stemmed from La Crisis (as the government argued), the perceived impacts underscored the common perception that “The Crisis” is a crisis of capitalism and neoliberalism (Raventos & Wark 2012), as seen in the popular chant at the frequent general strikes, anti-austerity, and anti-globalization rallies that
occurred while I was in the field, “¡No és La Crisis, és una estafa!” (It’s not the crisis, it’s a scam!).

To my knowledge, no scholarly research has yet been done to document the actual cuts made to the Catalan health system, or the impact of the crisis on the accessibility of the health system for those eligible. Some research, however, has explored the impact of the crisis on the frequency and duration of Spanish workers’ use of medical leave, and the perceptions of women in Catalunya about obtaining abortion care with the assistance of a government-funded office (Murcia Lopez 2012, Martinez Morant n.d.). Other sources for this aspect of the discussion primarily pre-date the abortion reforms, or come from popular news articles, and comments from health system and other health workers, but even my preliminary qualitative data suggested that immigrant women waited longer on average for their CatSalut voucher for abortion care, which could indicate delays in getting health coverage at the outset.

Today Clinic staff mentioned that many immigrant women, or any women, who apply for health coverage for the first time due to a pregnancy receive a temporary, initial CatSalut card that covers all services offered at their neighborhood health centers immediately, but that comes with a built-in waiting period for all outside care requiring referrals. The temporary card is issued on the spot, but a permanent card is mailed to new applicants within 4-6 weeks. I learned in interviews with Today Clinic receptionists (presented in more detail in Chapter Two) that the temporary, initial CatSalut card cannot be used for care outside of the neighborhood health centers, meaning that newly covered women are automatically blocked from obtaining a surgical abortion for at least a month. This one month of waiting for care may not seem like a burden to someone seeking a consultation for non-acute specialist care, but for a woman dealing with an unwanted pregnancy and facing gestational time limits for a legal abortion, it could mean the difference between obtaining care, or not.
I also dealt with the vagaries and confusion of applying for *CatSalut* coverage first-hand. From my own auto-ethnographic experience, I cannot imagine how a pregnant immigrant woman who does not speak Catalan, and may not even speak Castilian, manages to traverse the process of signing up for *CatSalut*. Upon arriving in Barcelona, and while waiting for Dr. Barcelona to confirm my participant-observation schedule at the clinic, I began the process of registering my then 6-year-old daughter for school, which necessitated having her see a local physician for a required pre-enrollment physical exam. As a graduate student and single mom doing my fieldwork on a small research grant, I did not have the luxury of paying for private health care, but knowing that my daughter, as an immigrant child in Barcelona, would be eligible for *CatSalut*, I set out to get her signed up for *CatSalut*, reflexively knowing that I was embarking on the same process that many of my research participants would also have faced.

The process that ensued was nothing short of maddening. The first step to get health coverage in Catalunya is to complete the *empadronamiento* process, registering at the town hall corresponding to your neighborhood. This can be done regardless of immigration or legal status, as the town hall only requires proof of residence in the form of a lease, rental contract, or utility bill, and a “*libro de familia*” (birth certificate) for minors. Nonetheless, the simple act of taking my daughter to our town hall to show our papers and get a form stating we were duly *empadronados*, took at least three separate visits, and a lengthy process of obtaining a ‘certified’ copy of my daughter’s birth certificate from the U.S. state where she was born (her passport proved inadequate). With the proper paperwork in hand, and allowing for the reduced government hours that limit bureaucratic business to only a few hours on a few days per week for the entire the month of August, we finally got ourselves *empadronados*.

At that point, I contacted the health center I knew corresponded to my neighborhood, but was told they did not enroll children on-site. I would have to go to another clinic for that,
even though my daughter’s medical care would be provided at the center closer to our flat. We made our way to the clinic we were told to go to, to sign my daughter up for *CatSalut*, but upon arrival, were told:

1) They “don’t sign up children,” and,

2) United States citizens are “never eligible for European health care” (patently false), or at least, not without a waiting period (which is not supposed to apply to children) and proof of the parent’s employment with a local company (which, as a researcher on a student visa, I did not have).

Instead of arguing, I calmly restated my understanding that *all* children were eligible for health care without a waiting period, and asked where I could sign her up. I was sent to yet another health system office, requiring another metro ride and a long walk, and at the next location, was told we actually needed to go back and sign up at the neighborhood health clinic I had contacted initially. By then it was the end of the local business day, and we had been on our quest for about eight hours.

So we started fresh the next day, going directly to our neighborhood clinic, where I presented the birth certificate and *empadronamiento* form, and received my daughter’s temporary health card, and an appointment for her school physical, on the spot, within about ten minutes of walking through the door. The permanent *CatSalut* card that could be used to obtain care outside the neighborhood center, arrived in the mail more than a month later. All in all, with paperwork delays and everything else, and even with my own flexible schedule and bilingual abilities, it took about two weeks to get my child signed up for *CatSalut*, and it would be another month at least before she could receive care outside the local clinic. This whole experience felt like a form of hazing, and proved to me the truth of a local saying,
“siempre en tres visitas,” (“always in three visits”) meaning that any government-related or bureaucratic task takes at least three attempts.

If I, a highly educated, bilingual, experienced medical professional who studies health systems and worked with public health care eligibility requirements in the U.S. for many years, had this much trouble and experienced this many redirects, bureaucratic headaches, and discouraging responses while simply attempting to get health coverage for my child, imagine how a recently arrived pregnant woman in need of abortion care might experience the process! Throughout the hassles and irritations I faced personally, I was constantly aware of the likely impacts of such bureaucracy on women I had come to do research with.

Women’s and provider’s perceptions of how *La Crisis* affected the health system, and abortion accessibility, will be presented in more detail in the next chapter.

*Abortion law reforms*

In mid-2010, under pressure from feminist movements (Hughes 2011, Barambio 2012, APFCiB 2010) and with popular support from the majority of Spaniards (Bruni 2011, Hughes 2011), the Spanish government liberalized existing abortion laws, making the procedure legal on demand for any reason in the first trimester, and under certain circumstances in later semesters (Finer & Fine 2013, AGI 2010) within Spain and in autonomous regions, including Catalunya. Prior to the 2010 reforms, there were established criteria for certain health and mental health-related exceptions to laws prohibiting abortion. Practically speaking, abortion services were actually available in both public and private clinical settings not only for women who met the exception criteria, but also for women who could pay cash to go to a private clinic with a doctor or psychologist on staff who could

Unlike the many parts of the world where legality would dramatically improve abortion safety, the procedure was already extremely safe in Spain and Catalunya, as in other parts of Europe, because it was mostly performed in clinical settings. The greater impact of the 2010 abortion reforms for women in Spain and Catalunya was more likely to be seen in the equalizing step of offering free care. All women would ostensibly become able to seek care in the public health systems, and only those who did not meet the criteria for procedures after 14 weeks would be denied public coverage – even they could appeal to a review committee at a public hospital, under some circumstances (APFCiB 2010). But even as they celebrated this impending improvement in abortion access in early 2010, reproductive justice advocates and women’s health activists in Spain and Catalunya, including everyone at the Family Planning Organization (which was asked to advise the national Spanish Ministry of Health on both the writing and implementation of the new abortion laws), predicted that women would continue to encounter obstacles and delays in the process of seeking care as they navigated the public health systems (AFPCiB 2010).

Their concern was that, prior to the 2010 reforms, even women in Spain and Catalunya who met the criteria for exceptions to the laws against abortion had to make, on average, up to six visits to different government offices and health clinics to obtain the necessary paperwork and vouchers. Like women who sought care at private clinics who had to raise necessary funds, women obtaining publicly funded abortion would still confront the possibility of abortion stigma, and need to arrange for time off work, travel funding, and/or child care (Magarolas et al. 2008, de Ramales et al. 2006, Font-Libera 2009). Even in the new context of legal, publicly funded abortion, providers and advocates suspected that women seeking care would continue to have to jump through a variety of bureaucratic hoops
to, for example, first see a primary care doctor in order to verify a pregnancy, then obtain the necessary paperwork, and then take it to clinics that would be contracted to offer abortion services for the health system. Their predictions proved largely to be correct.

*Immigrant women and abortion in Catalunya*

Immigrant women overall are more likely to be affected by obstacles to reproductive care (Ostrach 2012), and immigrant women in Spain and Catalunya are vulnerable to widespread fears of utilizing the public health system, language barriers (particularly in Catalunya, where the local official language is Catalan and many government forms are not translated even into Castilian), employment situations that are less compatible with the business hours of government offices and clinics, or a lack of social support with their extended families likely back home in their native countries (Magarolas *et al.* 2008, de Ramales *et al.* 2006, Font-Libera 2009). The potentially greater relative impact of abortion stigma on immigrant women also may contribute to the continuum of delay factors. This array of possible obstacles likely reduced immigrant women’s access to abortion care prior to the 2010 reforms, and undoubtedly continued to function as underlying obstacles within the context of broader abortion legality.

Immigrant women that agreed to be interviewed for this study did not seem to perceive that they had experienced more delays or obstacles because of being immigrants, but they did have to wait longer, on average, and make more visits, on average, to health system offices, to get the voucher required to obtain publicly funded abortion care. Interview participants all had to make more visits than they should have had to (an average of four visits; for Catalans the average was 3 visits, and for immigrant women the average was 4.6
visits). Under *CatSalut* policy, the voucher should have been given in the same visit it was requested.

Immigrant women who participated in interviews were also two weeks later in gestation, on average, by the time they were able to obtain care with a health system voucher, often because of delays or misinformation within *CatSalut*. Several immigrant women were delayed, or almost delayed, beyond the 14 week cut-off to get an abortion for any reason, while trying to get a *CatSalut* voucher. In the clinic, immigrant women often arrived with *CatSalut* vouchers that were filled out with the wrong date, with the wrong diagnosis code, or the wrong procedure listed, or made out for the up-to-fourteen-weeks procedure when the accompanying doctor’s notes clearly showed the woman was further along, or vice versa. Each time this occurred, clinic staff had to send the woman back to her *CatSalut* center to request new paperwork, further delaying care.

Even so, 80% of immigrant women I interviewed, who had been in Catalunya for nearly ten years on average (though several had only arrived in the past year or so), reported that institutional support from *CatSalut* or clinic and NGO staff was what most helped them overcome obstacles, and obtain care. Few immigrant women complained about *CatSalut* delays, compared to the many Catalan women who did. Clinic and NGO staff interpreted this, as I did, as representative of the fact that most immigrant women come to Catalunya from countries without public health care. Catalans who are accustomed to using *CatSalut* for everything, without major delays, may find the experience of needing to wait to get a voucher to go outside the system more frustrating, than do immigrant women who are merely grateful to have access to public health care, at all, even though immigrant women appear to experience more actual delays. Immigrant and other women’s specific perceptions of abortion accessibility in the health system will be presented in more detail in the next chapter.
Shifting politics and political identities – threats to the abortion reforms, cuts, and Independentism

The conservative PP government’s public threats to the 2010 abortion reforms, which began as soon as Prime Minister Rajoy was elected in November 2011 (Canaleta 2013, Barambio 2012) and now stand to imminently make abortion, are heard by reproductive justice advocates and abortion providers, and the leftist movements in Catalunya, not only as typical conservative grandstanding and a cynical effort to retract newly won rights, but also as an attempt to regress the role of women, and women’s autonomy, in Spanish society (Raventos & Wark 2012). Seemingly, part of leftist-feminist Catalan resistance to Rajoy and Gallardon’s menacing of abortion rights in Spain stems from a desire to distinguish and protect abortion access in Catalunya from the likely fall-out of any changes in the national abortion laws, as part of a larger effort to resist the PP government’s suite of austerity reforms (Raventos & Wark 2012). As Morgan and Roberts (2012: 251) argue, about Latin America,

Reproductive governance. . . has always reproduced social distinctions, identities, alliances and produced subjects and citizens. . . At this historical juncture an analytics of reproductive governance can elucidate how the national and transnational configuration[s]. . . [fit] within larger social movements and the geopolitical and economic calculus of. . . nation-states.

Their insightful assessment of the interplay between political strategy and the rhetoric of reproductive rights applies not only to Latin America, but also to the Spanish/Catalan example. A 36 year old under-employed Catalan woman, Carla, tied together the issues of anti-abortion rhetoric, the role of La Crisis in her decision to have an abortion, and current threats to the abortion laws in a few brief comments in our interview:

*I say that to ‘kill’ is to have a child and give them a bad life, I say that’s worse. Bringing a human being to the world, to suffer? I see that as bad. I prefer to have one child and care for it well, than to have another and they suffer. In the era occurring now, it has to be [that abortion continue to be legal], you can’t have another child during The Crisis. I think that way, yes. A child comes, another child comes, and then*
you can’t care for them? They suffer penury. In that aspect, [abortion] must always be [legal and publicly] funded!

The evolution of the debate over abortion rights and legality in Spain and Catalunya reflects four decades of political shifts in the post-Franco era: the movement demanding abortion legalization accelerated in the 1970s (Cambronero-Saiz et al. 2007), even before Franco’s death, and continued throughout the 1980s and 90s, and in the 2000s, with each new administration (AFPCiB 2010, Roca i Girona 2009). For example, an iconic image from the 1970s (Ca la Dona 2008) shows hundreds of women marching behind the now-classic, “Avortament lliure i gratuit” (“Abortion, legal and free”) banner, with a large sign held aloft just behind it, “Ni PSOE ni Jutges – les dones decidim” (“Neither the PSOE nor Judges – women will decide”), demonstrating that even under the then-newly elected Socialist government (the PSOE party), activists felt the need to take to the streets to demand the rights they sought.

Activists with the Family Planning Organization, and Dr. Barcelona, told me throughout my fieldwork how the recent history of shifting abortion rights under various governments in the 1970s, 80s, and 90s shaped the formation of women’s health organizations, and directly influenced the development of the public health systems, in Spain and Catalunya. Each interview with several longtime staff members of the Family Planning Organization, and with Dr. Barcelona, began with stories about the work s/he and the organization did to push for abortion rights over multiple decades, and how abortion needs were met prior to the 2010 reforms. For example, when I asked Dr. Barcelona, a Catalan in his 60s, how long he has been working in abortion care, this was his response:

*I have worked in reproductive health and the right to abortion since before I finished my training, like forty-and-some years this issue already preoccupied me. [My] specialty of gynecology, I did it because this issue preoccupied me. Evidently, when I started, it did not preoccupy me the same way it does now. I worried about it because when I started my studies there was a high rate of female mortality here [related to*}
the burden of repeat pregnancies and having many children]. So when, let’s say, from my twenties I was trying to change the world (laughs at himself). And helping with what I can. Well, before I provided abortion services, what we did was to look for a solution, that is, to start sending people outside of Spain, when it was prohibited. I was one of the discoverers [of other providers in Europe], if you want to say, we did not even know where to go. No, it’s clear that in Spain there was a social-Catholic dictatorship, one that was Fascist-Catholic, well, we did not have any information. We started to look for solutions for the process. It was a complicated situation, and difficult, and also, it had to be hidden, because you were playing with going to jail. We were four, the four of us [who started to do abortions], I did not tell anyone else, I helped a lot to set up, or, in the setting up of the first family planning centers [in Catalunya in the 1970s and 80s], there were about ten in Barcelona. I became responsible, not just for the women that were my own patients. They called me for [abortion] services. I have come to know people who dedicated themselves here to contraception, from the family planning association. I’m a historic person (said wryly) in this, because I was there. It’s that I form part of this.

In this way, Dr. Barcelona calmly detailed for me decades of struggle to provide abortion care in the context of legal prohibition, risking jail, and his dedication to the movement to expand women’s access to contraception and abortion care in Catalunya and Spain. Within the same breath that he identified himself as one of few abortion providers during the Franco era, he also spoke admiringly of the people who established the earliest family planning centers, long a site for resistance to cuts to both abortion rights and of health care access for marginalized women.

As evident in the above quote, the institutional memory of reproductive governance in Catalunya within the reproductive justice and health movement is long, and kept in view at all times. People I interviewed even sometimes reached back to the Second Spanish Republic of the 1930s, referring to its establishment of rare legal abortion from 1932 until the Civil War (Roca i Girona 2009, Crow 1985), and framing Catalunya’s current need to protect and maintain abortion rights as part of the legacy of that anti-Capitalist, pro-women era. Many elements of the strong and visible anti-austerity, anti-neoliberal movement in Catalunya, Spain, and Europe characterize conservative governments’ austerity measures as part of a cynical strategy of capitalizing (pun intended) on vast disparities in income, in order to
manipulate a time of economic crisis and push forward a draconian agenda aimed at cutting many social services, and curtailing many democratic rights (Raventos & Wark 2012, Posner 2010). This analysis was not seen by my participants as a paranoid fantasy, but rather as an accurate and timely assessment, and part of the justification for supporting Catalan independence from Spain. A conservative push to use the crisis as an excuse for counter-revolutionary social reforms was part of the popular discourse about austerity throughout my time in the field (Carnicero 2013).

Supporters of abortion rights who also support Catalan independentism (most of the providers and advocates I interviewed fall in that category), saw the potential for a fully separate, independent Catalunya as one possible model for preserving legal abortion and public health care even in the context of La Crisis, at least for Catalans and residents. Several people mentioned that, in an imagined, future that has given rise to a fully separate Catalan state, they expect women would travel from Spain to seek abortion care, once it (inevitably) becomes illegal or less-legal there again. Part of Dr. Barcelona’s support for an independent Catalan state in the European Union, for example, is directly related to his firm belief that an independent Catalunya will defend legal abortion.

Some independence supporters I spoke with suggested that this could be one way to partially fund a continuing independent Catalan health system with full and free coverage for residents of Catalunya, by charging fees for care provided to ‘medical tourists’ from outside (many women currently travel from all over Europe to obtain abortion services in Barcelona, most paying cash). Whether this model of care is one that an independent Catalan government would adopt following the planned 2014 referendum on independence, if that vote will results in a formal announcement of separation, and if that would in turn provoke military resistance or an invasion by Spain (perhaps supported by the United States), all remains to be seen.
Either way, an awareness of *La Crísis*, austerity, cuts to health care, threats to the abortion reforms, the question of Catalan independence, and the intersections between these issues, all informed and overlaid many of my conversations with women and providers. In Catalunya and beyond, abortion is never just a medical or even a moral issue, it is an explosive nexus of intense social conflict over power and the equity of distribution of resources in society.
Chapter Two – An uneasy collaboration between public and private care

*I went to the doctor, did a test, and it came out positive... in the gynecology center [at CatSalut]. And nothing, and there they gave me the voucher. Two weeks passed between when I went for the test, and my appointments.*

- Afrodita

As Afrodita described, the process to successfully obtain a publicly funded abortion in Catalunya involved navigating the public health system, interacting with at least one representative of that system to receive a voucher for care, and then coordinating with a contracted clinic to ultimately get the health services she sought. Such multi-step processes for obtaining care in a national or other public health system are common, and particularly so for reproductive and abortion care (Ostrach 2012, Magarolas *et al.* 2008, de Ramales *et al.* 2006). In studies of abortion accessibility in other public health systems, restrictions on public funding for abortion care, and delays and difficulties associated with such funding programs, have been shown to affect women’s ability to access care in a timely manner, and to likely prevent some women from obtaining an abortion altogether (Medoff 2008, Weitz & Yanow 2008). Medoff (2008) found that restrictions on public funding increased the cost of providing abortions for providers, which may deter some providers from participating in publicly funded care provision. Nonetheless, worldwide, women (particularly immigrant women), appear to have more access to abortion in countries where the procedure is indeed covered in a public health system (Ostrach 2012).

Based on such research, we could assume that the reform of abortion laws in Spain and Catalunya in 2010 and the subsequent inclusion of abortion in the public health system, could have led to any or all of the following: a higher abortion rate, improved access, and more or more stable business for providers. In fact, the abortion rate in Spain grew by only 1.3% in the first year after legal reforms took effect (APFCiB 2011). Moreover, this increase was popularly attributed to the growing effects of *La Crisis*, rather than to expanded legal
The abortion rate in Catalunya (without including data from the Balearic Islands) actually fell following the 2010 legal reforms (APFCiB 2011). Providers and researchers attribute the apparent slower pace of growth in abortion utilization, or even an apparent drop in abortion demand, largely to La Crisis, the growing rate of unemployment in Spain, and the resulting net decrease in the number of immigrant women (a group that seeks abortion at a higher rate than others) arriving or staying in the country (Barambio 2012, APFCiB 2011). Of particular interest to this study, the abortion rate in Catalunya slowed considerably following legal reforms (Punt Avui 2013, APFCiB 2011). The Catalan Health Department reported in a news article in early 2013 that the abortion rate for 2011 in Catalunya (not including the Balearic Islands), one year into the post-legal reform era, and even with the (under-utilized) public reimbursement program, was actually 7% lower than the year before (Punt Avui 2013). Providers and women’s health advocates in the region maintained that abortion rates in Spain and Catalunya were not affected by the 2010 abortion reforms alone. More likely, they argued, any possible increases in abortion rates resulting from better access to legal abortion were effectively mediated by

Prior to the reform of abortion laws, immigrant women in Catalunya and Spain accessed abortion services at rates three times higher than did resident Spanish women, and possibly as much as four times more frequently (Orjuela & Regidor 2009, Magarolas et al. 2008, de Ramales et al. 2006), and immigrant women were more likely to need financial assistance in order to obtain abortion care (Magarolas et al. 2008, de Ramales et al. 2006). There were many potential socioeconomic factors implicated in immigrant women’s higher abortion rates in Spain, including increased difficulty obtaining contraceptives through the public health system (Zurriaga et al. 2009, de Ramales et al. 2006), language barriers, and family planning clinic hours incompatible with many immigrant women’s work schedules (de Ramales et al. 2000, Magarolas et al. 2008). Immigrants can access the public health system, now subject to waiting periods in some area, but many are not aware of this, and likely assume that seeking care could result in legal ramifications (de Ramales et al. 2006).

The exception was an increase in the abortion rate in the Balearic Islands (considered part of Catalunya, but with a separate health system), where the abortion rate grew from 2010 to 2011 after abortion costs began to be reimbursed for women accessing care with local Balearic government approval (APFCiB 2011).
the co-occurrence of decreasing in-migration to these countries (Barambio 2012, APFCiB 2011).

For women in Catalunya who knew the health system would cover an abortion, being able to obtain a voucher for publicly funded care represented a significant cost-savings over paying out of pocket for private services. But the question of the extent to which women actually knew they had this option for public funding of their abortion need, and were able to benefit from it, is an important and complicated one. The Catalan Health Department admitted that 47% of women who obtained abortion care in Catalunya in 2011 paid out of pocket without government funding, despite the option of being reimbursed – likely due to a lack of awareness of this option (Punt Avui 2013). This figure is similar to the number of surveyed women in my study who arrived at the clinic unaware the public health system would cover their abortion.

Whether the inclusion of abortion in the Catalan health system stabilized the flow of patients (and revenues), for providers, is a very different story. As I will discuss later in this chapter, the ways in which CatSalut chose to establish the referral system for women who wanted a CatSalut-sponsored abortion at an outside clinic in fact created many problems for providers. CatSalut’s restructuring of public funding quotas may have even reduced access to second-trimester abortion in Catalunya following the 2010 reforms, by effectively endangering the ability of the only contracted clinic offering full-spectrum second trimester services to stay in business.

*From CatSalut to the clinic – the uneasy relationship between a public system and providers*

The actual process for a woman in Catalunya to request and obtain a publicly funded abortion went through various permutations following the 2010 legal reforms, and the ever-changing policy of how to actually go about getting an abortion under CatSalut was
highlighted by several women I interviewed as a specific source of confusion, and thus difficulty, obtaining care. Members of the Today Clinic and Family Planning Organization staffs, including workers at the clinic and at the organization’s Youth Center who routinely process the required paperwork for an abortion to be publicly funded, described to me the initial, varying processes for women to obtain public funding or reimbursement. Apparently, in 2011, women who qualified for a *CatSalut* abortion had to pay cash up-front at a private abortion clinic, obtain a receipt, and then submit it to the social security office to receive reimbursement, a process that could take up to six months to complete. This shifted in late 2011, and continued in 2012, to a process where women obtain the voucher from *CatSalut* and present it directly at the clinic, to receive care without paying anything directly. Nonetheless, women also reported widespread rumors, and outright misleading information, that they heard from by *CatSalut* staff, about supposed limits on how many abortions per woman would be reimbursed,\(^2\) how many weeks gestation a woman could be at and still be reimbursed for care, and so on. This sort of creative interpretation of laws and policies constituted yet another form of civilized oppression.

In late 2011, according to clinic staff, *CatSalut* announced a new process for women seeking publicly funded care, which was in effect throughout the period of my research. Under the new protocol, a woman interested in obtaining an abortion would first go to her neighborhood *CatSalut* facility (all of which are supposed to encompass a dedicated sexual and reproductive health unit, known as an ASSIR), or to another contracted sexual and reproductive health provider (such as the Youth Center or locations specifically set up by *CatSalut* to meet the health needs of adolescents, immigrants, etc.) for a walk-in pregnancy test. With a verified pregnancy estimated at less than or close to 22 weeks gestation, under *CatSalut* protocols, a woman can choose between a pharmacologic (medication) abortion (but

\(^2\) An issue of concern, as the circumstances that lead to one unwanted pregnancy do not magically resolve after one abortion (Weitz 2012).
only for pregnancies of less than seven weeks gestation), a course that can be initiated
directly at the SRH center. Alternatively, a woman could request a voucher (referral) for an
instrumental (surgical) abortion.

For all pregnancies between seven and 22 weeks gestation, and for any pregnancy of
less than seven weeks when a woman prefers the surgical option, she should receive the
referral and voucher that day, in the same walk-in appointment. Women with pregnancies
estimated to be between fourteen and a half and twenty-two and a half weeks by the time they
would have the abortion are also required to be able to justify the need for an abortion under
various criteria, including that the pregnancy is the result of rape or incest; that there is a
diagnosed fetal anomaly; or that continuing the pregnancy would endanger the woman’s
physical or mental health, or her ability to care for existing dependents. Under the 2010 laws,
two different vouchers were thus required, depending on whether the pregnancy was
estimated to be at or less than 14 weeks gestation (requires an “Article 14” voucher), or if it
would be between fourteen and a half through 22 and a half weeks by the time the woman
would have the abortion (requires an “Article 15” voucher). With the correct voucher, the
woman can schedule an appointment at any CatSalut-contracted clinic. With a voucher for a
second-trimester procedure, a staff psychiatrist at the contracted clinic must have a specific
counseling session with the woman to assess and document her eligibility for the Article 15
criteria.

In the beginning of the referral era, there were only two contracted clinics, both
located in Barcelona: the Today Clinic, which was contracted to provide care through 22
weeks gestation, and another clinic nearby, which offered care reportedly through 14 weeks,
and ‘maybe up to 16 or 17 weeks,’ depending on which staff worked on which days. This
meant that, for the first several years that a referral to a contracted clinic was required to
obtain a publicly funded abortion, most women in need of second trimester (Article 15) care,
and all women needing an abortion between about 16 or 17 and 22 weeks of pregnancy, had only had one option. All women seeking publicly funded care had to travel to Barcelona, regardless of where in Catalunya they lived. Even taking into account private abortion clinics, some of which were rolled into CatSalut contracts in early 2013, the Today Clinic was the only non-hospital provider23 of abortion care between 19-22 weeks in all of Catalunya, a reality that produced very serious implications for access.

During the course of my research, CatSalut announced it would expand its contracts to include more clinics, and redistributed the clinics’ quotas, thus changing (reducing) the number of public procedures for which each clinic could be reimbursed. This development, both in advance and in effect, produced a great deal of uncertainty and anxiety for the staff of the Today Clinic. From the moment of the first such announcement, it was clear that just how many procedures CatSalut took away from ‘our’ clinic, to redistribute to other clinics (most of which offered care only in the earliest phases of a pregnancy), would determine whether the Today Clinic would continue to have enough steady business to stay open. In fact, while I was still in the field, when CatSalut did open up contracts to more clinics, and re-organized the quotas in March 2013, the Today Clinic quickly exhausted their remaining approved quota of publicly funded procedures for the year, in less than two months. This abrupt change in CatSalut reimbursement arrangements resulted in an abrupt and dramatic schedule reduction at the Today Clinic (cutting down from three days per week of surgeries to only two), reductions in staffing hours and benefits, multiple rounds of staff lay-offs, and continuing doubts about whether the practice will survive. One of the two social workers/technicians I worked most closely with during my participant-observation up to that point was suddenly laid off, a move I was uncomfortably aware the clinic management had

23 While public hospitals in Catalunya ostensibly offer hospital-based abortion services under circumstances of severe fetal anomalies or for maternal health, the actual availability of such care, and what seeking it entails, is unclear and not well documented.
perhaps felt they could make with the knowledge that my presence as a volunteer meant I would pick up some of the slack.

While the Today Clinic had relied on business from private patients for several decades prior to the 2010 legal reforms, when it became the first contracted CatSalut clinic in 2011, the bulk of their business and focus, shifted to public patients, to the detriment of the private practice side. As the public patient pool dwindled in early to mid-2013 as a result of changing CatSalut policies, it was apparently too late for the Today Clinic to regain the private business level that would have been required to maintain staff hours. While in December 2012 and January 2013 the clinic saw up to 30 or 40 abortion patients and at least as many preoperative patients, on a normal day, and sometimes twice as many on Thursdays (when the schedule was extended and workers stayed from 8am. until 9 or 10pm.), by March 2013 the patient load dropped dramatically. By the time lay-offs and reduced hours were announced in the spring of 2013, we were down to 15 or 20 patients on a normal clinic day (of which there were then also fewer per week), and scarcely more than that on the ‘doubled’ days. By late June 2013, when I reluctantly left the field, there were quite a few Thursdays during which we saw fewer than 10 patients, and some regular clinic days consisted of five or fewer procedures performed.

As of now, a year after the drastic redistribution of quotas, the Today Clinic faces being forced to close down altogether, even without the recent announcement that abortion might become illegal again in all but a very few circumstances. Before the threat of losing access to legal abortion became that much more vivid, the potential closure of the main provider of most Article 15 procedures for all of Catalunya, despite policy reforms that expanded legal access to abortion and initiated public funding for abortion for several years, loomed as something that would have been a clear consequence of the way that CatSalut chose to restructure its referral system in 2013. Such a closure of the only contracted clinic
that offered later procedures in Catalunya would force many women in need of second-trimester abortions to go abroad and pay cash, or appear before a hospital review committee to make their case for a publicly funded procedure to be performed in the hospital.\textsuperscript{24}

Even as of this writing, with the \textit{CatSalut} quotas already used up, the Today Clinic currently cannot accept vouchers for health system care, meaning that women in need of publicly funded care after 18 weeks between May 2013 and now have had no option but to pay cash (which can total thousands of Euros), or go before a hospital review board that is said to consist of a psychiatrist, two Ob/Gyns (neither of whom can be the woman’s own physician), and sometimes a social worker or administrator from the hospital. If the hospital review committees deem that the woman’s ‘reason’ for seeking a later second-trimester procedure is unconvincing (as reportedly often happens), she may be denied care altogether, increasing her risk of finding herself and her child(ren) in poverty, or in an abusive relationship, in the future (Newitz 2012). In this way, \textit{CatSalut}’s deliberate or simply thoughtless decision to reduce the number of public patients the Today Clinic could see contributed to a form of structural violence in which women already at risk for poverty and other forms of marginalization may have been forced to bear unwanted children, and end up deeper in poverty. How the specific experience of appearing before such a review committee affected or may affect women, while beyond the scope of this project, is certainly an area deserving of further study in this setting or elsewhere.

\textsuperscript{24} Interestingly, this same dynamic of expanding care to more clinics that only offer first trimester care, and decreasing Medicaid reimbursement rates, is also dramatically affecting the viability of independent abortion providers and small clinics that offer second-trimester care in the United States. For example, the U.S. clinic where I did my master’s research examining abortion access and Medicaid from 2009-2010, which was the only provider of second-trimester care for most of the surrounding region, has since been forced to close because of increased competition from multiple clinics in the area offering only early abortion care, which were opened by a large corporation, in the absence of demonstrated need.
Further burdening clinic finances, *CatSalut* often referred women to the Today Clinic, who, during the preoperative appointment, turned out to not be pregnant, to be already more than 22 weeks pregnant, to be pregnant with non-viable or ectopic pregnancies, or to have an underlying, known health condition that contraindicated an out-patient procedure (e.g., uncontrolled glucose levels, cardiac irregularities, clotting disorders, or other health problems that precluded the use of anesthesia outside of a hospital). All of these characteristics meant that the clinic could not ultimately offer a surgical abortion to these would-be patients, which also meant the clinic was not allowed to bill *CatSalut* for the many expensive steps of the preoperative appointment: an ultrasound, blood testing, health history review, informed consent counseling, and so on. Under *CatSalut* policies, only appointments that resulted in a complete surgical abortion could be billed for reimbursement (this is also the case for Medicaid providers in the U.S.). These mistaken or careless referrals cost the clinic money, and further delayed affected women from achieving the accurate diagnosis, or resolution of their situation, they deserved and desired.

Moreover, according to Dr. Barcelona, all of these “bad referrals” could have been avoided by *CatSalut* staff doing careful medical history reviews with patients before filling out referral paperwork, performing blood tests for pregnancy rather than just urine tests, or performing routine ultrasound scans before referring a woman for abortion care. My understanding from *CatSalut* and clinic staff was that all ASSIRs (the sexual and reproductive health units located in all major *CatSalut* primary care centers) have access to ultrasound machines, but that midwives and others who fill out referral forms are not directed or trained to routinely use them. What could be simply a training issue, easily corrected, results in many inappropriate referrals that, at the very least inconvenience women and cost providers money, and that in a worst case scenario, could mean an ectopic pregnancy is missed at the early stage when it can be easily resolved, ultimately resulting in a burst
Fallopian tube and lasting reproductive harm. This failure of the health system to follow best practices was cited by clinic staff, rather than women themselves, as an obstacle or delay factor, but it is true that bad referrals could also result in delays for women seeking care.

In a report prepared for presentation to the Catalan Department of Health in May 2013, entitled “L’atenció a La Interrupció de l’embaràs, Un Any de Col·Laboració Públic – Privat” (Attention for pregnancy interruption [abortion], One Year of Public-Private Collaboration), the administrators of the Today Clinic outlined the numbers of cases for which, and reasons why, they were not able to provide billable abortions to some women referred by CatSalut during the first year of the voucher/reimbursement protocol. The report reveals that nearly 4% of women referred to the clinic by CatSalut during that time, all of whom arrived with vouchers having already seen a CatSalut midwife or Ob/Gyn to verify a pregnancy and evaluate the best option for meeting the woman’s needs, were in fact not even pregnant, had undiagnosed current ectopic pregnancies, other pregnancy complications or health conditions that precluded outpatient care, or were too far along to be seen outside of a hospital, or at all (Muñoz 2012).

Four percent may not seem like a large number, but it represented nearly 300 women just in that one year, each of whom cost the clinic for unreimbursed staff time, equipment and supplies, and used an appointment time that could have otherwise gone to a woman who could be served at the clinic. For a woman with an undiagnosed ectopic pregnancy, the days that pass between receiving a voucher for care within a CatSalut center that could arguably have detected the ectopic pregnancy, and being seen for preoperative screening at the clinic where it is actually diagnosed, could result in a ruptured Fallopian tube or other adverse sequelae. Even before CatSalut redistributed the quotas for clinics in early 2013, working in collaboration with the public health system cost the Today Clinic unnecessary wasted money, and wasted time, and may have posed health risks for some women. Moreover, 63% of clinic
and NGO staff I interviewed, who talked with hundreds of women seeking publicly funded care each week, perceived that the process of navigating the public health system produced obstacles for women in need of abortion. Specifically, 40% of clinic and NGO staff felt that a lack of information, that they thought should be offered to women by CatSalut, was an important obstacle.

Women’s experiences with health system coverage of abortion

The vast majority of women coming to the Today Clinic for the first day of what is usually a two-day appointment for abortion care arrived with a voucher/referral form (derivación) from the public health system that, if filled out correctly by health system personnel, enabled them to obtain a free. However, 51% of the 350 women who filled out surveys for my study indicated they were not aware CatSalut would pay for the abortion, even though most them of had in-hand the voucher that would cover the cost. This means that many women who had already taken the step of requesting an appointment or walking in to their neighborhood primary care health center, and had already seen a midwife or gynecologist to procure the voucher, were unaware it would fully cover the cost of the abortion care, and anticipated having to pay out of pocket.

A study released by the Catalan Department of Health during the course of my study confirmed that 47% of women obtaining abortions throughout the region following the inclusion of abortion care in the public health system continued to pay out of pocket, even though they could have obtained free care (Punt Avui 2013). The author of the article, and all providers and advocates interviewed for it, felt that the low utilization of the CatSalut-funded abortion care in the first year it was available was due to widespread misinformation and misunderstandings about it. The same news article featured excerpts from an interview with Dr. Barcelona, who made reference to my preliminary findings that echoed a similar
percentage of women unaware that their abortions would be paid for, and criticized the health system for not properly training its staff to explain the process to women seeking care.

It is unclear how many women may not even seek a voucher for care for a subsequent abortion if they have already obtained a publicly funded one, or may otherwise avoid requesting a voucher because of other myths and misinformation they have encountered. One woman I interviewed specifically believed, even after visiting the ASSIR and talking to her midwife, that *CatSalut* had limits on what they would fund. Choosing the pseudonym “Carla,” this unemployed 36 year old Catalan mother of one sat with me on a park bench near her metro stop on an unusually chilly spring evening, relating her experience:

_No, no at first I thought that most likely I would have to pay, but no, it’s financed by social security [sic]. What happened was that not much [time] had passed... [since an earlier abortion], because you see that up until, until a minimum [sic] of three times, from then on after three times you have to pay [sic]._

Carla’s gynecologist had warned her, incorrectly, that *CatSalut* would pay for a maximum of three abortions for any one woman. It is worth pointing out here that of the estimated one in every two or three women who will have an abortion in their lifetimes, 50% will have more than one (AGI 2013a). Factors that increase the risks of an unwanted pregnancy, such as difficulty accessing effective contraception, irregular periods, chaotic life circumstances, or intimate partner violence that increasingly takes the form of a partner sabotaging a woman’s birth control or deliberately attempting to get her pregnant when she does not wish to be (Moore *et al.* 2010), do not magically resolve or disappear after a first abortion (Weitz 2012). All of these reasons, and greater risks for some of them, may be part of why immigrant women in Catalunya and Spain have historically had a higher abortion rate per capita, and per year, as compared to the overall populations, as discussed later in the chapter.
While most of the 350 survey respondents reported being seen at a health center and getting their voucher for care in less than a week (something that should only take one day), more than a quarter of women had to wait longer than they should have under the health system’s own protocols – a stark example of civilized oppression. In theory, any pregnant woman registered (empadronado) with the town hall in her town of residence in Catalunya (including immigrants) should be able to walk into a neighborhood CatSalut center during normal business hours and be seen by a doctor or midwife who can issue the voucher on the spot, without an appointment. In the data I collected, this often took more time, and more visits, than it should. As indicated in Table 4, most women surveyed only needed to visit a health system center once to get the voucher, but nearly a third of women had to make more than one visit.

Table 4, Health system delays/obstacles, as perceived by women seeking care (n=350)

<table>
<thead>
<tr>
<th>Wait time for referral</th>
<th>Number of visits to obtain referral</th>
<th>Knew health system would cover abortion</th>
</tr>
</thead>
<tbody>
<tr>
<td>72% less than a week</td>
<td>73% one visit</td>
<td>49% yes</td>
</tr>
<tr>
<td>20% one to two weeks</td>
<td>22% two visits</td>
<td>51% no</td>
</tr>
<tr>
<td>4% two to three weeks</td>
<td>4% three visits</td>
<td></td>
</tr>
<tr>
<td>2% more than three weeks</td>
<td>0.9% four or more visits</td>
<td></td>
</tr>
</tbody>
</table>

Because the mandatory three-day reflection period begins from the date stamped on the voucher by CatSalut staff, and two visits to the clinic are typically required before the abortion is complete, any hold-up in the process of obtaining the voucher necessarily further

25 Women answered this question after already obtaining the voucher that would cover the abortion.
delays women from obtaining abortion care in a timely manner. Such delays can affect the trimester in which a woman ultimately obtains care, and the Article her voucher must fall under, potentially requiring her to start over to get a different voucher if waiting for an initial voucher takes so long that by the time she receives a voucher it is no longer valid for her actual gestation (which necessarily changes over time). If a woman is delayed beyond the first trimester, the complexity and risks of the procedure increase, as does recovery time. Problems getting a voucher can even delay a woman far enough into a pregnancy that a legal abortion can no longer be obtained.

Twenty-nine percent of surveyed women seeking abortion care during the study period reported that navigating CatSalut produced “very or somewhat challenging” obstacles to abortion access. Sixty-five percent of other obstacles written in by women on an open-ended portion of the survey related to problems with delays in the health system, the lack of accurate information provided by CatSalut, and the lack of sufficient contracted abortion providers in the region.

Overall, in my detailed interviews with eleven women who sought a publicly funded abortion, more than half talked explicitly about problems they had with the health system -- several more mentioned delays or misinformation they did not necessarily see as obstacles, but which likely contributed to delays in getting care. For example, several women described needing to make multiple visits to their main CatSalut centers before they received a voucher, and/or mentioned mistaken information they were given by CatSalut staff, but without knowing they had been inappropriately delayed or misinformed, they did not always characterize such factors as obstacles to care. For “Superwoman,” the fiercely independent Catalan mentioned in an earlier chapter, simply learning that CatSalut would pay for the abortion alleviated one source of worry and allowed her to focus on other aspects:
Of the economic [aspects], when I first looked I did not know it was free, either. I thought there would be some kind of cost. Anyway, I learned it was free, so then that problem disappeared.

However, despite “Superwoman’s” relief that she would not have to come up with money to pay for the abortion, as we sat on a park bench under fragrant orange trees in the back garden of a government building that doubles as an art museum in Barcelona, she recounted multiple delays at the ASSIR (CatSalut center) where she sought her voucher. The first day she went she was told they “did not offer gynecology services that day.” This likely violated CatSalut protocols at the time, as I understood them. Any midwife or other CatSalut staff members were ostensibly authorized to perform urine pregnancy tests in order to provide pregnancy verifications and vouchers required for abortion care, on a walk-in basis. Nevertheless, “Superwoman” reported she had to go to a CatSalut center at least twice to get the voucher, and was told to only come at certain times, such as one day in the morning, another day in the afternoon, and so on (conflicting with her work schedule), rather than being offered the option of walk-in care as she should have been.

Another Catalan mentioned in the introductory chapter, Leyre, anxiously fiddled with her coffee cup and cigarettes as she described her frustrations with CatSalut staff whose failure to coordinate her pre-conception care, in her estimation, set her up to need an abortion she had not really wanted. At age 41, in her second marriage with a blended family of three children at home (including two teenagers), and on medical disability for a neck injury, Leyre and her husband (who participated vociferously in her interviews but whose comments I cannot include because of IRB limitations) had wanted a baby of their own, a fact of which Leyre’s gynecologist was well aware. Leyre stated her gynecologist also knew Leyre was seeing a CatSalut psychiatrist for depression resulting from her extended unemployment and chronic neck pain. The psychiatrist ostensibly also knew, from shared electronic medical records used across CatSalut facilities, that Leyre was trying to conceive. Leyre angrily
drummed her fingers on the sleek, modern table in her dining room in the posh Arc de Triomf neighborhood in Barcelona, compulsively flicking ash from her cigarette as she fired off the sequence of events that caused her frustrations with *CatSalut*. While Leyre’s main anger was directed at the gynecologist and psychiatrist who failed to coordinate her care enough to appropriately counsel her on the dangers of conceiving while on her psychiatric medication, Leyre still laid the blame with *CatSalut*, for, in her words, not training the different physicians to pay attention to what their colleagues are doing with patients.

Leyre’s sadness about the way that poor coordination between her care providers resulted in her having an abortion she did not want to need was not a direct result of misinformation about *CatSalut*’s obligation to fund abortion care. But the knowledge that *CatSalut* staff had already failed her in this way colored how Leyre perceived the subsequent process of obtaining her voucher for care and then scheduling with the Today Clinic, which together caused a two-week delay. Waiting for the *CatSalut* referral, and then for an available appointment, amplified Leyre’s suffering, as she was ever-conscious that she was about to terminate a wanted pregnancy. How obstacles to care, and the overall process of seeking abortion care, affect women terminating wanted pregnancies due to diagnoses or risks of fetal anomalies is yet another area deserving of further study.

Montse, the single mother I interviewed in a small town in rural Catalunyá, also experienced problems getting her voucher, but more due to *CatSalut*’s structural constraints and lack of infrastructure in rural areas, than because of miscommunication or deliberate delays. The town where Montse lives is one of the few in Catalunyá so small it does not have an ASSIR at the *CatSalut* primary care center (as required by *CatSalut* protocols). Instead of assigning a member of the local staff to perform urine pregnancy tests (that any health professional can easily be trained to do), and authorizing someone local to fill out vouchers
for abortions, women in this small town, as in a few others, must travel to a larger town nearby on the certain days of the week that a midwife is scheduled there to see rural women.

Montse sought abortion care while also dealing with the chaotic breakdown of a relationship that involved threats of violence from the local Roma community (of which her ex-partner was a member). She was the target of local stigma and harassment for getting pregnant by a Roma man, a fact that was widely known because she was seen going into the local social security office to see the person who routinely tells women where to go for pregnancy testing. In a town so small that all conversation stopped when my parents (who had rented a car to drive me to Montse’s town) walked into the local bar, Montse’s personal struggles with a break-up, an unwanted pregnancy, and past experiences of abuse and domestic violence all became common knowledge. Meanwhile, her son’s father, an earlier partner, was aggressively trying to get back together with her. Simply walking past jeering neighbors and hovering exes to reach the bus stop to travel to the town where she needed to request a voucher, not to mention finding a way to get to Barcelona to go to the clinic, with no public transportation that would go all the way there, was a struggle for Montse. While she seemed less concerned about the delays and difficulties associated with getting her voucher for care than she was about the threats of violence and general stigma she faced in her tiny town, she mentioned that taking the time to go to the social security office to find out where to get a voucher, then traveling by bus to another town for the pregnancy test, and then arranging for someone to drive her to Barcelona (in the absence of reliable social support), meant she experienced about a two week wait, and had to make a total of four visits to offices and health centers in three different towns.

Other misunderstandings and failures of information propagated by CatSalut included a frequently heard belief that the need for a publicly funded abortion had to be justified to CatSalut staff, or that a CatSalut midwife had the leeway to decide whether or not a woman
deserved a publicly funded abortion. One young, unemployed Catalan I interviewed, who chose the pseudonym “Yolanda,” described how she made her case to her regular midwife (front-line reproductive health care providers within *CatSalut*). Yolanda said she cited both her current unemployment and a birth control failure as reasons for needing a *CatSalut* voucher:

*The next day we went directly to the hospital [sic] to talk with the midwife [at the ASSIR at a particular center], where my gynecologist is, another gynecologist saw me [to confirm the pregnancy], and then she [the midwife] well, so, said, “what do you want to do?” I told her, well, in this situation of life, that my [birth control] patches had also failed, so, having this problem, really, I did not see any possibility to go forward having a kid, also because I haven’t been with my partner long, we don’t live together, I’m on unemployment, all negative things for which we decided, the two of us, that really this was not the moment. So, well, when I explained well the theme of what had happened with the contraceptives, she told me, because of my situation and that I am also unemployed, she told me about a clinic that they only work with [sic], and that it would be best if I did not have to pay all the money for the abortion, which is €450 or something like that.*

Yolanda’s narrative about convincing her health care provider of why her situation merited a voucher for public funding of an abortion illustrates precisely the subtle but real civilized oppression that I argue operates in many interactions between *CatSalut* workers and women seeking an abortion voucher. Yolanda likes her midwife, and stated she felt good about the care she received, that she felt heard and understood. But never once, apparently, did the midwife explain that Yolanda was legally entitled to a publicly funded abortion regardless of her financial, relationship, or employment circumstances. Yolanda also believed that even with the voucher she would still need to pay the clinic upfront, and then apply to be reimbursed (as had been the system in 2010 and part of 2011). Describing the discharge portion of her appointment at the Today Clinic, Yolanda stated, “*she [the social worker] filled out the forms for me to not have to pay the amount of the abortion.*” Yolanda told me she later took the form back to her midwife, suggesting that she thought she had to return her discharge form (which is only meant to provide follow-up information) to *CatSalut* to ensure she would not have to pay for the care she received. Yolanda further opined,
Now I think it is much better [as compared to when people had to pay privately], that when you tell them [CatSalut] your situation, the ‘why’ [they pay for it]. To pay that amount of money on the spot, it depends on the situation, for example, that I’m on unemployment, to not have to pay that money, and I’m staying with my mother, obviously... so, it’s impossible, no? Because, you pay, and then, and well, what would I do all month? [if had to pay for care out of her unemployment benefit]

Instead of alleviating Yolanda’s concerns about paying for the procedure in advance by telling her it would be publicly funded without further documentation or justification, the midwife either purposely or inadvertently maintained an unequal power dynamic between the two of them, and diminished Yolanda’s rights in their interaction, by reinforcing the idea that she was filling out the voucher for Yolanda because the situation merited it, rather than because it was her job to do so.

Other examples of the misinformation frequently given to women seeking care, by CatSalut staff, as shared with me by women themselves, and anecdotally from clinic and NGO staff, included such statements as: “abortion is illegal after 14 weeks” (untrue); that “CatSalut will only pay for one abortion” (untrue); that “CatSalut will only pay for a certain number of abortions within one year [or within two years, five years, etc.]” (untrue); and that “CatSalut will only pay for abortions for women who have been paying into social security for a certain amount of time” (untrue). Perhaps most disturbingly, I heard many stories of women who were seen by CatSalut staff who grudgingly filled out their vouchers, but told them the publicly funded abortion they sought would “make them infertile,” “give them breast cancer,” or cause them to be “so depressed they would be unable to care for their existing children.” Such perpetuation of stigmatizing, unscientific, and thoroughly disproven abortion myths, by government representatives charged with providing health care, demonstrates not only the dangers of civilized oppression, but also the very real risks for the negative mental health impacts of abortion-related stigma as described by Kumar et al. (2009), suggesting that even where abortion is legal and funded, women’s experiences of accessing care can be shaped by stigma and institutionalized forms of oppression.
Staff members at the Today Clinic expressed many concerns about CatSalut’s treatment of women seeking abortion care. One of the two clinic receptionists, a 37 year old Catalan who chose the pseudonym “Alba,” had worked at the clinic for ten years, explained the gamble that women take when they go to their health center to obtain information about getting an abortion:

_There are times when it depends on the [CatSalut] clinic that pertains to you, they [can] solve the problem quickly, and it depends on the person you find there, as they [women seeking care] sometimes tell me, “well it’s that they don’t tell me anything, I’ll go back next week” because the person there [at the health center] gave them misinformation. In some places of CatSalut, the person [worker] that is there in that moment does not know what to tell you, they invent anything to make the person [seeking care] get a little lost._

Alba also reported that some women arrive at the clinic after encountering overtly anti-abortion staff at their CatSalut centers: “on some occasions it depends on your health center, if it’s a little anti-abortion well they... put [the brakes] on you a little bit.” The other Today Clinic receptionist, who had worked there more than twelve years, was a 59 year old Catalan, and chose as her pseudonym “Ariadna,” echoed Alba’s perceptions that some women encounter deliberate misinformation from CatSalut staff, as a particularly insidious form of civilized oppression:

_There are some health centers that have, how would I tell you, a limit for the type [of procedure]. They say that up to the most [they will do vouchers for 15 [weeks], and maybe the patient is at 18 [weeks], so yes that is a problem._

Ariadna’s description of CatSalut centers that creatively interpret the laws pertaining to before-14 weeks gestation (Article 14), and more-than-14 weeks gestation procedures (Article 15), violating both standing CatSalut policies and the abortion reform laws, echo and confirm what many clinic and NGO staff reported. It is difficult to estimate how many women are turned away and never succeed in obtaining a wanted abortion, simply because
the *CatSalut* workers they encounter decide to interpret the new policies as they wish, or have been incorrectly trained on how to interpret and implement them. Ariadna also spoke of women being told by their local health center, primarily in rural areas, that they only have a midwife on site “once a month,” thus delaying any chance of obtaining a voucher for at least that long. Whether there really are centers with such infrequent attention to women’s health needs, or whether women who walk into such centers asking about pregnancy tests are suspected of seeking abortion and thus intentionally delayed as another form of civilized oppression, *CatSalut* clearly has work to do to better meet rural women’s reproductive health needs.

All eleven staff members of the Today Clinic, Youth Center, and Family Planning Organization that I interviewed agreed that *CatSalut* sometimes makes it difficult for women to obtain a voucher for a publicly funded abortion. Initially, Dr. Barcelona insisted that the referral and voucher process (which he helped set up) works “well,” and that the only problems with *CatSalut* are the women who they inappropriately refer who are not good candidates for outpatient abortions. But when I shared with him my findings that 48% of women arriving at the clinic, most already with a voucher provided by the health system, did not know *CatSalut* would pay for their abortion, he was surprised and dismayed.

When I made Dr. Barcelona aware that not only was *CatSalut* sending him patients he could not bill for, and failing to reimburse the clinic for all the procedures they had performed and billed for in the second half of 2012 and the beginning of 2013, but that there were also many women who came to appointments worried about paying for a procedure that was already covered, he became animatedly enraged, gesticulating and thumping the desk in front of him in a way I learned was characteristic any time he felt that he or a woman seeking care had been wronged. It was actually Dr. Barcelona who suggested to the Family Planning Organization that they organize the May 2013 roundtable/press conference where I presented
my findings to the Catalan Health Department, and where he also presented a report outlining the numbers of women who had been improperly referred to the Today Clinic, costing both the clinic and the health system money and producing delays in getting women urgently needed medical care (in some cases). His hopes that our combined data would convince the Health Department that more training was needed within CatSalut may have been dashed, however, when the main responses we received from health system representatives were defensiveness and thinly veiled attacks on our research methods.

Youth Center staff, who typically see young women for the first time after they have already visited their primary CatSalut center, told me that women often arrive with questions that have gone unanswered, or with inaccurate information about their options, and come to the Youth Center hoping for clarification or a better answer. Two gynecologists at the Youth Center who are contracted with CatSalut to do pregnancy verifications and fill out vouchers for abortion care for eligible women under the age of 25 told me they are often asked to provide such vouchers for women who have been turned away by a CatSalut midwife who believed (or at least told them), that abortion is illegal, not allowed for immigrants, or some other excuse. Family Planning Organization staff likewise reported that women still call their offices seeking information on how to obtain an abortion, as thousands did in the years prior to the 2010 reforms. The difference now is the calls are from women who have already been to a CatSalut center, but are still confused about their legal rights and unsure how to get publicly funded care. The policy changes that expanded access to legal abortion for women in Catalunya and Spain, and that expanded CatSalut’s scope of care to include providing vouchers for surgical abortion care at contracted clinics, did not erase the effects of structural inequality and civilized oppression that continue to constrain women’s ability to effectively and fully take advantage of these improved policies.
Immigrants and public health system coverage of abortion

The widespread availability of national and public health systems, many of which cover abortion, does not translate into equal access to care for all women throughout Europe (Ostrach 2012). The list of European countries that offer at least some abortion services through a public health system includes Sweden, France, England, Romania, Spain, Turkey, among others (Linders 2004, Jones et al. 1985, Johnson et al. 2004, Akin et al. 2005). But even where public systems cover abortion, immigrant women have varying degrees of access to this care. For example, in France, where the public health system offers both contraceptive care and abortion (up to 12 weeks gestation), it is nonetheless estimated that immigrant women in France experience more unintended pregnancies than the overall population (Guendelman et al. 1999).

While I was in the field, we heard that France restricted legal abortion to just 12 weeks or less, and the whole world watched in horror as an Indian immigrant woman died of sepsis in Ireland as a result of being denied a needed abortion of a nonviable fetus, sparking renewed calls for a reform of Ireland’s laws (Walsh 2013). The multilingual translator at the Today Clinic, who chose the pseudonym “Greta,” told me that Andorra and Malta both entirely prohibit abortion, while it is allowed up to 12 weeks gestation only under certain qualifying circumstances in Italy. Women coming from other European countries to seek abortion care at the Today Clinic during the study period primarily came from Italy, France, Andorra, and occasionally from some North African countries or Portugal.

I began this research knowing that immigrant women may perceive more obstacles to accessing reproductive health care than do non-immigrant women, as had long been documented in Spain and Catalunya (Ostrach 2012, Magarolas et al. 2008, de Ramales et al. 2006). An earlier study suggests that so-called ‘third world’ immigrants, particularly those from North Africa, have disproportionately limited access to the public health system in
Spain, compared to other immigrants (Calavita 1998), and similar findings exist about the experiences of immigrants from Central and South America in Spain and Catalunya (Magarolas et al. 2008, de Ramales et al. 2006). A study of immigrants from Ecuador, for example, found this population perceived barriers to obtaining care through public health systems in Spain and Catalunya (Terraza-Nuñez et al. 2010). Barriers were primarily related to obtaining health cards necessary for seeking care, the accessibility of the business hours of health clinics, and language barriers: these issues arose particularly in Catalunya and other regions where a local language, such as Catalan or Basque, rather than Castilian, is widely and/or officially used (Terraza-Nuñez et al. 2010).

In a 2006 study, in-depth interviews with clinic workers and social service providers conducted prior to liberalization revealed a shared perception that many immigrant women chose to terminate pregnancies due to a lack of support from partners and families (de Ramales et al. 2006). This finding is echoed in more recent research conducted in Catalunya (Martinez Morant n.d.). Many of the immigrant women that social service workers encountered when they sought referrals or funding for abortion care prior to the 2010 legal reforms had recently arrived in Spain and Catalunya, were in precarious employment situations, had few economic resources, and/or reported having a husband or partner who was not in Spain with them, further complicating their access to social support (de Ramales et al. 2006).

All of these factors likely intersect with, and are compounded by, increasing difficulties for immigrant women to obtain CatSalut coverage, or the need for women who have only recently applied for CatSalut cards to wait for the permanent card to arrive in the mail before seeking care. Greta, the clinic translator, primarily works with women traveling from France, Italy, Andorra, and other European countries who seek abortion care in Barcelona after being denied care in their home countries. She recalled that before the August
2012 austerity cuts, some immigrant women used to be able to move to the area precisely because they needed an abortion, and get *CatSalut* coverage within a few days, “*[They had] a paper confirming they were empadronado... [and went] to social security [sic], but not now.*” Though the number of women who may have, once upon a time, moved to Barcelona briefly and done their *empadronamiento* just to get *CatSalut* coverage for an abortion that would not be permitted in their home country is difficult to estimate (and if it occurred, this phenomenon was admittedly a drain on the health system intended to serve long-term residents), Greta’s description of the disappearance of this option underscores the likelihood that immigrant women already living in Catalunya also encounter delays while applying and waiting for *CatSalut* coverage, if they even know this is an option.

Immigrant women in Spain also frequently report difficulty obtaining or successfully using contraceptive methods (de Ramales *et al.* 2006), potentially increasing their need for abortion services. Social service workers interviewed in other studies attribute this to the likelihood of family planning clinics administered by the public health system not being open during hours that immigrant women can typically visit them, as many immigrants in Catalunya and Spain work in domestic or service work, and cannot attend medical appointments during regular 'business' hours (de Ramales *et al.* 2006). Dr. Barcelona and other providers I interviewed also raised the possibility of cultural expectations and family pressures on women to not use contraception, particularly among certain immigrant groups which are seen by those I interviewed as more isolated, interdependent, and constraining for women.

Several clinic staff insisted that women from Indian, Pakistan, China, and members of various Muslim immigrant communities typically arrived at the clinic with male partners or family members who retain control of the women’s documents, and speak for them when staff direct questions to the women. Clinic staff who told me such things related their
assumptions about strict culturally or even racially informed gender roles affecting women in
these groups to a reduced likelihood of these women being ‘allowed’ to use contraceptives, or
to having any agency over their own reproduction. Such accounts revealed both a fairly
typical Catalan and Spanish unapologetic casual racism that I uncomfortably encountered
throughout my time in the field, but also hinted at a reality apparent in participant-
observation in the clinic, that immigrants do report a lower rate of contraceptive usage.

Other potential barriers to abortion care reported by immigrant women in Spain prior
to legalization included a fear of giving their personal information to authorities, and
misconceptions about the implications for their immigration status if they sought government
or NGO assistance for abortion funding (de Ramales et al. 2006). Bureaucratic hassles
inherent in the process of seeking abortion care allowed under physical and mental health
exceptions to the pre-2010 laws that required, on average, up to six different visits to clinics
or other offices, and misinformation perpetuated by government and social service employees
also presented obstacles to abortion care. Such obstacles were believed to especially increase
anxiety for immigrant women seeking abortion assistance (de Ramales et al. 2006).

Prior to the 2010 reforms, slightly more than thirty-seven percent of abortions in
Spain were obtained by immigrant women, correlating to more than twenty-seven percent of
pregnancies among immigrant women in Spain ending in an abortion, a rate three times
higher than that of Spanish-born women (Magarolas et al. 2008). The abortion rate per capita
among immigrant women in Catalunya was somewhat higher than in other parts of Spain
(Magarolas et al. 2008), a trend that providers I interviewed casually dismissed as
representing migration patterns – southern regions of Spain are more likely to receive African
Muslim immigrants who may be less inclined to terminate pregnancies, while Catalunya,
according to them, has often been a destination for women from South America who have
completed all their desired childbearing before arriving. In contrast, recent doctoral research
conducted at one public health center in a heavily immigrant neighborhood documented an abortion rate of more than 30% among Filipina immigrant teens (Marxen 2012).

Some researchers argue that part of the explanation for the higher abortion rate among immigrants in Catalonia may be that immigrant women are statistically more likely to already have children, or to have more children, than Spanish-born women in their same age-range, and that many immigrant women are also working in order to send money back home to support children they left behind (Magarolas et al. 2008). In Marxen’s study (2012), the young immigrants who sought abortion appeared to do so largely because they lacked information about preventing unwanted pregnancies. While a midwife Marxen interviewed described this abortion rate among Filipina immigrants in her health center as “alarming” (Tuaño 2013:1), it is worth noting that about 30-40% of all women have at least one abortion in their lifetimes, many in their teens and twenties (AGI 2012).

Literature predating the abortion law reforms suggests that immigrant women in Spain and Catalonia perceived difficulties getting the information and institutional support needed to seek abortion services, that they were more likely to experience an unintended pregnancy to begin with, and that they perceived social and cultural obstacles to abortion care, specifically related to fear, stigma, and a lack of social support (Magarolas et al. 2008). In my research conducted after the 2010 reforms, several differences in the perceptions of obstacles to abortion access between immigrants and Catalans were apparent. In interviews with women who had obtained an abortion at the Today Clinic, I found that immigrant women (mostly from South America, but a few from other parts of Spain, and one from Romania) had arrived at the clinic two weeks later in gestation, on average, and were more likely to have arrived already in the second trimester of a pregnancy.
In my interviews, I learned that immigrant women had to go to their *CatSalut* center at least one and a half times more on average than did Catalans, to obtain a voucher. In the overall interview sample, all women had to make more visits on average than in the survey sample, with Catalans making an average of three visits, and immigrants making an average of 4.6 visits. No immigrant women that I interviewed explicitly mentioned having to wait for a permanent *CatSalut* card before being able to obtain an abortion, but at least a few of them applied for *CatSalut* for the first time after learning they were pregnant, so it is possible this was a factor in the apparently greater delays for immigrants. Of note, however, in interviews Catalans were actually far more likely than immigrants, to indicate that they encountered problems with the health system. Perhaps immigrant women from countries without public health systems were simply grateful to be able to obtain free care, regardless of the hoops they had to jump through, or perhaps Catalan women were more accustomed to being able to walk directly into a *CatSalut* center to be seen for all their medical needs on the spot, without getting a voucher or seeking a contracted provider.

Immigrant women I interviewed shared stories about a wide array of *CatSalut* miscommunications, misunderstandings, and delays. A 34 year old Colombian woman, who chose the pseudonym “Mari,” had been in Barcelona twelve years, had a five year old daughter, and had recently lost her job when she found out she was pregnant. To make matters worse, her partner had purposely gotten her pregnant after telling her he was sterile, making her loathe to accept his help or support while dealing with logistical challenges. Mari reported that *CatSalut* delays meant she had no choice but to get a surgical abortion, when she had wanted a medication procedure instead. She had contacted her ASSIR to ask for an appointment to do the pregnancy verification and initiate the multi-stage process of a medication-induced abortion, but the ASSIR staff scheduled her appointment several weeks out, without asking how far along she thought she might be. Because she had believed her
partner incapable of getting her pregnant, her estimate of her own gestation was uncertain, and by the time she saw her midwife, she found out she was too far along for the medication option.

Even though it was the fault of CatSalut staff that Mari was farther along when she was finally seen, her midwife blamed her:

*When I went to the midwife she already told me, “Why did not you do this much faster? [sooner]” Because she told me, if not for arriving at that point [already far enough along] to do the surgery, I would have taken the pills!*

Mari told me about this as we sat in the relatively private upstairs mezzanine of a bustling cafe facing the top of Las Ramblas, a popular tourist destination near one of the main metro stations in Barcelona. Slowly jostling her iced tea cup to move the melting ice cubes around, Mari recounted how the CatSalut midwife, who she had previously trusted and liked, acted irritated with her need for the voucher to take to the Today Clinic, and made her feel bad about being at nearly 12 weeks gestation, when Mari would have much rather been early enough to have a medication abortion anyway. Being made to feel embarrassed or irresponsible in a situation that was the combined result of a duplicitous partner and CatSalut staff who scheduled a pregnancy verification appointment several weeks out without informing her she could come in sooner for walk-in care, was the last thing Mari felt she needed to deal with.

I asked Mari if she thought the midwife was upset that she was terminating the pregnancy, but she said she did not think so. Perhaps, I speculated to myself, the midwife was simply irritated that the money for the procedure would go to the contracted clinic, rather than staying within CatSalut’s own center, as it would if a medication procedure were initiated on-site. The suspicion that CatSalut staff encourage all women to have a medication abortion instead of going to a contracted clinic for a surgical procedure, whether or not this is always an appropriate method, was often heard from Dr. Barcelona and other providers.
Clinic and NGO staff shared many accounts of women being pushed to have a medication abortion on-site at a *CatSalut* center, rather than going to a contracted clinic for a surgical procedure, despite the higher complication rate, higher failure rate, and arguably more drawn-out, painful process entailed by a medication-induced abortion. My field notes from November 2012, for example, include the story of a woman who called the clinic to complain that she had gone to her *CatSalut* SRH center and requested a voucher for a surgical abortion at the Today Clinic, only to be told she could go to another *CatSalut* center for a medication abortion, and that she was refused a voucher for a surgical abortion. All we could do was to suggest she go back in at another time of day, when a different midwife or doctor might be more inclined to actually do their jobs properly.

If *CatSalut* realized that having its own staff, who are already paid to be there, hand a woman some pills (with or without adequate counseling), rather than sending the woman off to a contracted clinic with a voucher, would mean the money for that procedure would stay on-site as well, I would not be surprised if there is in fact an unofficial policy of biased counseling to encourage women to go the medication abortion route. Dr. Barcelona publicly accused the Catalan Health Department and the association of Catalan midwives (who provide the majority of front-line reproductive health care at the ASSIRs and other *CatSalut* centers) of just that, in a round-table/press conference organized by the NGO, shortly before I left the field. Predictably, representatives of both entities denied that their staffs engage in biased counseling, and maintained that medication abortion is the safest or best option for all early pregnancies, despite ample clinical evidence to the contrary.

Duran, the Andalusian immigrant mentioned in the first field note excerpt at the beginning of my introduction, experienced the particular unfortunate combination of *CatSalut*

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26 This dynamic is commonly seen in the United States too, where many abortion clinic workers suspect that a large chain of women’s clinics pushes medication abortion even when women are not good candidates, because of the cost-savings in staff time and counseling this option represents (Singer & Ostrach n.d.)
delays, and the need to travel to obtain care. Duran initially sought care at her local *CatSalut* center in a small town about an hour’s train ride from Barcelona, but wanted a medication abortion, for which she was told she would have to go to another town. By the time she could get an appointment there, she was too far along for the medication procedure. Then she had to return to the first center to request the voucher for a surgical procedure at the Today Clinic, which she ended up waiting about a week for, and then had to go to Barcelona on two different days for, the full surgical procedure. Duran was extremely frustrated by how long it took for anyone to tell her the procedure would be paid for, as she had lost time raising money from her in-laws to pay cash.

In contrast, a young Argentinean immigrant who chose the pseudonym “Sofia,” reported that her good experience with *CatSalut* made everything about the process easier. Twenty-four years old, Sofia had come to Barcelona was she was just 14, so she was very familiar with *CatSalut*. As she told me,

> *The best thing was the speed, the speed of the [CatSalut center]. Really, at CatSalut, it was intense, before going, I had that doubt, what are they going to say to me, or what stops will they put in my way? Saying what I want, with the staff at the [CatSalut center] already complying with the health system, what if they put stops [in my way]? But really, with my doctor, my main doctor, super good. I went to the doctor, first I told the doctor, he did my voucher, but in less than five minutes, and without waiting. They did not make me see a midwife [in addition to the physician, as sometimes happens].*

Sofia, as a young immigrant woman, worried about abortion-related stigma, but was pleasantly surprised at how quickly and easily *CatSalut* prepared her voucher. Even this was framed in the context of a larger narrative about the importance of the abortion law reforms for normalizing and destigmatizing abortion, something she said she hopes will happen in her home country of Argentina someday. If only all the immigrant women I interviewed could have reported such positive experiences with the Catalan health system!
Observations about the health system, from inside the clinic

In my research within the clinic setting, certain patterns emerged that confirmed results from the surveys and interviews. In the Today Clinic, on a daily basis, women reported delays and problems with obtaining the required *CatSalut* vouchers. Frequently there were problems with vouchers that were filled out incorrectly (wrong date, wrong diagnosis code, wrong article of law cited, etc.), requiring women to go back to their health center and request a new voucher. This happened several times a week, if not every day, during the busy months prior to the redistribution of the *CatSalut* quotas. In the survey data, there was a statistically significant correlation between women’s gestations when they arrived at the clinic, and the number of visits they had to make to get a voucher. Gestation was also loosely correlated in a statistically significant way with the amount of time women had to wait for the voucher. Moreover, based on my participant observation and the interview data, it appeared that women who arrived already at later gestations, women who had traveled to the clinic from rural areas, and immigrant women, had previously encountered more problems and delays getting a *CatSalut* voucher, even when they did not explicitly describe such delays and bureaucratic hassles *as* obstacles.

In the survey data, there was not a statistically significant correlation between how far women traveled to reach the clinic and their gestations when they arrived. However, both clinic and NGO staff, and my field notes, yielded many anecdotal accounts suggesting a link between the need to travel, and encountering various obstacles. For example, the location of the only contracted clinic that could offer second trimester procedures in Barcelona meant that women who were already farther along when they obtained a voucher and who also lived at a distance from the city, faced multiple and greater burdens related to travel, time off, and expenses.
Women in need of second-trimester care seemed to be more affected by misinformation/disinformation within CatSalut centers, as well. My early field notes include a typical account of one teen woman who sought a voucher for second-trimester care at a CatSalut center, where the midwife thought abortion after 14 weeks was illegal, and would not give her a voucher:

*Midwife at CatSalut saw teenager, said she was 16-17 weeks [pregnant], thought she could not get [an abortion] anymore so did not give her the derivació [voucher], referred her to [the organization that is meant to help low-income women in need of financial assistance]. Came to Today Clinic today for preoperative testing and is 20 weeks [pregnant] by ultrasound, next appointment [for that procedure] not for a week and limit is 22 weeks. Woman has to go back to CatSalut to get paperwork.*

- Field notes, November 5, 2012

In the margins next to that field note, I wrote a question, “Why did not [the government-sponsored program] tell her to get the [new] papers at CatSalut?!” – indicating my own quickly learned frustration with the lack of coordination between various entities. The agency that ultimately told this woman she could get a legal abortion even at 20 weeks gestation knew that she would need an Article 15 voucher, but sent her to the clinic without it, producing further delays and hoops for her to jump through, on top of the misinformation and outright denial of care from CatSalut initially. What struck all of us in the clinic that day, as it did every time such a situation (frequently) arose, was how close the CatSalut and other delays came to preventing a woman from obtaining care, at all. Two more weeks of delays or misinformation, and she would have had no option but to go before a hospital review committee to make the case for an abortion after 22 weeks gestation, which are rarely granted.

My field notes reflect that women very often arrived at the clinic under mistaken impressions, created by CatSalut staff, that they could not legally obtain an abortion after 14 weeks, or that having an abortion would have deleterious health effects. One woman who had arrived at the clinic with a voucher that her midwife had put the wrong date on (a date in the
future, making the form invalid) had to return multiple times to wait for a corrected voucher, and eventually was able to obtain her abortion more than two weeks after her first appointment. This sort of careless mistake happened all too often. I documented other similar incidents, just in one week:

- Woman experienced, “... two weeks of bureaucratic nightmares” getting her voucher
- A 17 year old Moroccan woman was 10 weeks by her last period, but measured 21+ weeks by ultrasound, voucher was for Article 14 so she has to go back to the ASSIR [CatSalut] to get an Article 15 derivació, but we only [have surgeons who can] see patients that far along on Fridays/Mondays. (After next week will be too far?)
- 36 year old woman, first pregnancy, at 17 weeks diagnosed with severe cleft palate (whole face/skull involved) and 20-40% risk of more skull/brain problems, had requested an abortion at the hospital but the committee (including the doctor who diagnosed the malformation) denied her. Here today for private-pay procedure... will cost thousands?! -Field notes, November 2012

This panoply of tales of woe, collected in one brief snapshot, begins to convey the many variations of bureaucratic difficulties, and the time-sensitive impacts these can have, affecting women as they navigate the health system. Staff at the Family Planning Organization and the Youth Center also reported that many women called or came in lacking correct information, or with flat-out wrong information, even after first attending their primary CatSalut centers and talking with midwives or Ob/Gyn staff who are ostensibly trained to orient women in the process of obtaining legal, publicly funded abortion care.

It is hard to say how many women may have never made it to the clinic simply because when they requested a voucher for care at their CatSalut center, they were told by poorly trained or even anti-abortion workers that they could not obtain a procedure they were in fact legally entitled to. Further research to determine the impacts of health system misinformation or denials of care on women seeking abortion in Catalunya and Spain is sorely needed. I would particularly like to return to Catalunya to conduct follow-up research based at CatSalut centers, to follow women who come in for pregnancy testing and collect data on their experiences with the referral process, to determine what CatSalut staff members
are saying to women about their abortion options, eligibility for public funding, abortion safety, complications, and protocols. I also hope to do research with women ultimately denied publicly funded care in Catalunya, either because of a lack of contracted facilities to provide later procedures, or because some women are forced to seek later procedures at hospitals where appearing before a review committee may in fact result in an outright denial of care.

*Implications of CatSalut restructuring of clinic quotas*

It is true that prior to the March 2013 CatSalut restructuring of clinic quotas, some women complained in interviews and in the clinic that the Today Clinic could seem busy and crowded, and sometimes had scheduling limitations, particularly around holidays when the clinic might close for all or part of a week, and then be correspondingly more busy the following week. Several women I interviewed during the months when the Today Clinic was the only contracted provider mentioned the need for CatSalut to contract with more providers, particularly so in areas farther from Barcelona. Members of the Youth Center staff expressed concerns early on that women who wanted to use a health system voucher to obtain an abortion had few choices of where to go. The situation early in my fieldwork, when women from anywhere in Catalunya had to travel to Barcelona to obtain a publicly funded abortion even though there were clinics (not yet contracted with CatSalut) that offered at least first trimester care in towns such as Lleida, Girona, and Tarragona (all at least an hour’s train-ride or drive from Barcelona), was certainly inconvenient for some women. More than half of women I surveyed travelled between a half hour to an hour, to reach the Today Clinic, meaning they likely used the local metro or nearby commuter rail system. But 26% travelled one to two hours, and 16% travelled more than two hours – likely on the more-expensive, less-frequent regional rail lines, or necessitating getting a ride from someone with a car, which many Catalans do not have. Having a contracted clinic nearer to their homes would
have reduced at least one logistical obstacle for such women. One positive result of the
March 2013 quota changes was the inclusion of clinics in Girona and Tarragona (each an
hour or more from Barcelona by train) in CatSalut’s contracted network, a clear improvement
for women in those areas who only need first trimester care.

Some women mentioned the challenge of scheduling their two required appointments
at the Today Clinic on days that were convenient for their work, school, or childcare
situations, particularly in November and December 2012, and in January and February 2013,
when the only other contracted clinic had already exhausted its quota for the year, making the
Today Clinic the only abortion provider in Catalunya that could accept CatSalut vouchers.
But CatSalut’s solution -- to yank a quota of 500 publicly funded procedures per month from
the Today Clinic and divide it equally among this clinic and ten others in Catalunya, even
though the rest had smaller facilities, less staff, fewer surgery suites, and routinely saw fewer
patients, and most only offered care up to 12 weeks gestation, did not serve the women of
Catalunya well. This restructuring left the Today Clinic with a maximum of about 60
reimbursable procedures it could perform per month, moving the clinic from a feast situation
to a looming famine. Even that small quota was used up within a few months of the
restructuring, because CatSalut also did not tell Today Clinic administrators, until March, that
hundreds of procedures performed from mid-January through February (when demand was at
a record high because it was the only contracted clinic), would count against the new, reduced
quota.

To add insult to injury, in the same week CatSalut informed Today Clinic that it would
lose most of its quota for public patients, and that all procedures in the first two weeks of
January 2013 had effectively been performed for free. As it turned out, too late for the Today
Clinic to do anything about it, CatSalut had arbitrarily decided the new quota and contract
would take effect as of January 17th, rather than January 1st, as it always had in previous
years. Not knowing this, the clinic had accepted *CatSalut* vouchers for the new year from the first day the clinic reopened after the winter holidays on January 2\(^{nd}\), throughout the following month, during a particularly busy time when we often saw thirty to sixty publicly funded patients per day. We then learned, two months later, that *CatSalut* actually started the new 2013 quota eligibility from January 17\(^{th}\), rather than from the beginning of January, meaning that all the care the clinic had provided to public patients in the busy first half of January was not going to be reimbursed, and the wages paid and supplies purchased during that period of time were coming out of the clinic’s slim profits for the rest of the year.

In the course of my research, as a direct result of *CatSalut* policies, the Today Clinic went from having an embarrassment of riches in the form of crowded waiting rooms and a packed surgery wing (with, admittedly, some accompanying potential discomforts for patients) to suddenly becoming a virtually empty clinic. This resulted in letting staff go or significantly reducing staff hours, with only a few cash-paying patients still trickling in. As some women I interviewed after March 2013 said, when I explained the quota situation to them in response to comments about how crowded the clinic had been when they came for a procedure earlier in the year or the year before, “well, better a crowded clinic than no clinic!”

By May 2013, clinic administrators were seriously discussing the possibility that the Today Clinic would close altogether, leaving the women of Catalunya with no option for abortion care between 19-22 weeks, except to go before a public hospital’s ethics review committee. This option would require women in need of later care to request an in-hospital “late trimester abortion,” which generally involves a long, drawn-out and painful process of early labor induction and vaginal delivery over several days, rather than the simpler, less time-consuming, (and arguably, less emotional) same-day dilation and evacuation procedure offered in the clinic. For those of us still in the clinic by late June 2013, watching the
schedule dwindle, we knew that the empty exam rooms and surgery beds meant that more women were left with no choice but to face the complicated process of seeking a late second-trimester abortion through a hospital, which in Catalunya at least, have the reputation of making this process punitively difficult or impossible for women. Even as of this writing, the Today Clinic is limping along, barely staying open with a drastically reduced staff and schedule, and awaiting news about the likely overturning of the law. The clinic’s dwindling business after March 2013 subsisted on cash payments from a few private abortion patients who were wealthy enough to avoid the CatSalut system, or who travel from other parts of Europe for later care. The clinic also tried to stay afloat by renting out surgery rooms to plastic surgeons, aestheticians, and mohels (who perform circumcisions for converts to Judaism). No public patients are seen at the Today Clinic anymore, and the few remaining staff worry about what is becoming of women in need of abortions between 19-22 weeks, even in advance of the likely outlawing of almost all abortions in Spain and Catalunya.

Moreover, many of the later procedures performed in the Today Clinic prior to March 2013 were for women who had only recently been diagnosed with severe fetal malformations, including some incompatible with life. According to de-identified clinic records I was given access to during participant-observation, close to 5% of all procedures performed at the Today Clinic were performed for women diagnosed with fetal malformations (during the years such records were kept). The previously reliable funding from CatSalut-subsidized procedures allowed the Today Clinic to stay open for all women who needed late second-trimester abortions, including women who could not get public health coverage in time or at all, but for whom the clinic covered some of the cost, or helped them raise funds.

Thus some of the women who were most likely to experience more delays getting an abortion, or to be denied one altogether, because of CatSalut’s 2013 policy changes related to vouchers and quotas, were very likely to be women who had just learned their wanted fetus
lacked limbs, a face, a brain, a heart, or all of the above, or very young teenagers who frequently travelled from France, Italy, Andorra, and other surrounding countries where abortion was illegal after 12 weeks or banned altogether. In these ways, the public funding of abortion in Catalunya did reduce costs for women seeking care, while not noticeably increasing the abortion rate. But CatSalut’s approach to managing the public financing of abortion did not make it as accessible as had been intended by those who fought to reform the abortion laws, and in fact may have, or may yet, seriously reduce access to second-trimester abortion. Of interest are the parallels between this situation, and the impacts of shockingly low reimbursement rates for abortion in the few (sixteen) American states that offer abortion care through state Medicaid programs (AGI 2012). The United States has also witnessed the reluctant closure of many clinics that were unable to stay open with the increasing weight of legal restrictions and requirements, facility requirements, competition from a corporate chain, and reduced Medicaid payments for abortions performed for public health plan patients (Weitz & Yanow 2008, E. Singer & Ostrach n.d.).

Whether CatSalut’s removal of the Today Clinic from the current equation of public abortion provision in Catalunya was a calculated bureaucratic cost-savings move, a deliberate anti-abortion strategy, or simply another example of the civilized oppression of women in need of abortion care by a bureaucratic health system, is hard to say. Perhaps the truth lies somewhere in-between, or is a combination of all the possible explanations. At any rate, the impact of policy changes and individual biases within CatSalut on women in Catalunya, particularly on immigrants affected by both austerity cuts and potential CatSalut delays, is an egregious example of institutionalized oppression that functions to produce health care inequality, through the perpetuation of structural violence and civilized oppression.
Chapter Three – *Las Dones* (*The Women*)

First... you are very confused, going through a time that is not simple, and the truth is that the last thing you want is for them to tell you contradictory things, that does not help, it's a big obstacle. I believe there is a big obstacle and it is to think that a woman is simply, how to say it, a receptacle for a baby... like an object. Yes, and the fact that they don’t let you do it all [the abortion] in one place, which is what requires harmonization between the two entities [CatSalut and the clinic], that each go their own way, so that information is contradictory. The information, including how they calculate the weeks, the steps you have to take, when to come back, where to go, how much time you have used [wasted], that is not simple, not even one little bit. But everything needs to be coordinated a bit better, up until the end, until the last day [of the process]. But no, there is a lot of poorly coordinated fragmentation.

- Frida

Even in the context of legal, publicly funded abortion care offered through a health system widely available to all pregnant women, women in Catalunya reported encountering obstacles when they sought abortion care through this health system. Women described such delays and difficulties as specific to abortion-seeking (as opposed to what they encounter when in need of other types of medical care). In an earlier ethnographic study of low-income and immigrant women in Catalunya seeking funding assistance for private abortion care prior to the 2010 legal reforms, Martinez Morant (n.d.:6) found that:

Many of the immigrant women and Spanish and Catalan women referred to the problems and barriers they had to face to have access to reproductive and sexual health services. These restrictions and setbacks affect immigrant women even more so, for often they do not know how the health system works and how to use it.

Unfortunately, within two years of reforms ostensibly designed to make abortion more accessible, many of the same patterns were echoed in my data, particularly in terms of women’s delays and difficulties related to navigating the health system, and a lack of understanding of their rights within it. Martinez Morant’s research (n.d.:6) also identified the barrier that my research demonstrates persists, namely “the poor transfer of information by certain sectors of medical personnel,” as described in Chapter Two.
Women who obtained publicly funded abortion care in Catalunya and participated in my research were largely poor, many were immigrants, and some traveled long distances to reach the clinic. From survey data, a picture emerges of low-income women from both Barcelona and surrounding areas who overcame health system, economic, logistical, and social obstacles to successfully obtain a publicly funded abortion. Interviews with women, providers, and advocates offer an expanded nuanced, vivid portrait of the actual process of seeking abortion services in Catalunya, and the continuing problems and threats facing both those who try to facilitate the provision of this option and those who wish to access it.

The demographic profiles of women in my study closely mirrored those found in other research with this population, albeit with a smaller representation of immigrants versus locally born women reflected in the surveys. Close to a quarter of women who completed my surveys in 2012-2013 identified themselves as immigrants (not Catalan), while the Spanish Ministry of Health’s official statistics on abortion utilization in Catalunya in 2010 reflected the proportion of abortions performed for immigrants at slightly more than half of the total (Ministry 2010). Possible explanations for this discrepancy include that immigrant women may have been less inclined to fill out a self-reporting survey, while national statistics are collected directly from abortion providers (Ministry 2010). Further, some immigrant women seeking care at the Today Clinic speak neither Castilian nor Catalan, and accompaniers who helped them fill out clinic paperwork may have decided not to go over an optional survey with women. Overall in-migration of non-native residents to Catalunya has also slowed, and out-migration of previously arrived immigrants has increased (Barambio 2012, APFCiB 2011).

Nearly half of the 350 women who filled out surveys came from Barcelona or nearby surrounding areas accessible by a short metro ride or commuter rail trip. Slightly less than half came from one of more than seventy other towns farther away in Catalunya,
demonstrating that, during the study period, the Today Clinic was the only option, or the first choice, for women from all over the region. More than 10% of women travelled from one of two towns each about an hour away, where local clinics were not yet contracted with the public health system. The inclusion of those clinics in the CatSalut contracts as of March 2013 likely reduced at least some travel-related obstacles for women in those areas.

Most women I surveyed were citizens and nearly a quarter were registered immigrants legally entitled to public health coverage. Only 2% identified as unregistered immigrants, or sinpapeles (literally, without papers). Highlighting again the importance of national and regional identity at this time in Catalunya, 35% of respondents identified as Spanish, while 21% identified only as Catalan, and 12% identified as both Spanish and Catalan. These are cultural and political distinctions that could easily have been missed if my survey had not given both options, something I decided to do in consultation with Dr. Barcelona before I arrived in the field.

Twenty percent of women who completed a survey identified as South American, with very small numbers of women each identifying as “other European,” African, Central American, Asian, or “Spanish, Catalan and European.” Illustrating the diversity of the patient population, just in my first few days of participant-observation at the Today Clinic, my field notes reflect interactions with Argentinean, Ecuadorian, Chilean, Moroccan, Russian, French, Nigerian, Bolivian, Portuguese, Italian, Slovakian, Dominican, Indian, Guinean, and Honduran patients. And this is by no means an exhaustive list of the countries of origin of immigrant patients over the course of the study. The clinic had one interpreter on staff who speaks Italian, French, Catalan, Castilian, and Portugese. If patients spoke another language, or if the translator was unavailable (as routinely happened, with multiple French or Italian patients often coming on the same clinic day), patients were expected to bring a family member or friend along who could translate for them during the intake and counseling
processes. ‘Translation’ during surgeries was primarily done through gestures and Castilian or Catalan phrases being repeated increasingly loudly by surgical staff. When the schedule and clinic flow permitted, I tried to be present to translate for English-speaking patients, and/or to be present for any women who were alone without any translator, but sometimes my positionality as a researcher was at odds with my background and inclinations as a clinic worker.

Table 5, Characteristics of survey respondents

<table>
<thead>
<tr>
<th>Nationality</th>
<th>Residency</th>
<th>Citizenship</th>
</tr>
</thead>
<tbody>
<tr>
<td>35% Spanish</td>
<td>46% from Barcelona/surrounding</td>
<td>75% citizens</td>
</tr>
<tr>
<td>21% Catalan</td>
<td>11% from two towns 1-2 hours away that had abortion clinics not contracted with the health system during most of the study</td>
<td>23% registered immigrants</td>
</tr>
<tr>
<td>20% South Americans</td>
<td>43% from one of 72 other towns</td>
<td>2% unregistered</td>
</tr>
<tr>
<td>12% Spanish-Catalan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4% other European</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2% of each of: African, Central American</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1% each of: Asian, Spanish-Catalan-European</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Women I interviewed represented a mix of nationalities, and immigrant women had been in Catalunya for varying lengths of time. Six of the eleven women who participated in interviews were born and raised in Catalunya, while five identified as immigrants. Immigrants included the Andalusian woman who clearly stated she had moved to Catalunya from Spain, distinguishing between the two nations as separate countries and cultures. Several immigrant women had been in Catalunya since they were teenagers or young adults (nearly half their lives), others had been in the region only a few years or less. Contrary to the findings of some of the other limited ethnographic research with women seeking abortion in
the region (Martinez Morant n.d. 2), several women experienced the unwanted pregnancy that prompted them to seek an abortion after being in Catalunya for many years.

Also contrary to some other research on low-income women who seek abortion care in Catalunya (Martinez Morant n.d. 2), most women I interviewed were married or in a stable, long-term committed relationship; only three were single. Four were students in college or graduate school, seven were working at least sporadically, three were unemployed due to a recent lay-off or were on some kind of medical or government-sponsored leave (these categories overlap). Seven currently have at least one child, or had a child in the past – Alina’s daughter had died as a baby, in Rumania.

Table 6, Characteristics of interview participants, by pseudonym

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Country of origin</th>
<th>Age</th>
<th>Years in Catalunya</th>
<th>Family/relationship</th>
<th>Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frida</td>
<td>Colombian</td>
<td>27</td>
<td>1</td>
<td>Boyfriend, no children</td>
<td>Grad student, working</td>
</tr>
<tr>
<td>Alina</td>
<td>Rumanian</td>
<td>25</td>
<td>6</td>
<td>Single, one child passed away</td>
<td>Sex worker</td>
</tr>
<tr>
<td>Mari</td>
<td>Ecuadorian</td>
<td>34</td>
<td>12</td>
<td>Lives with partner, one child</td>
<td>Janitor</td>
</tr>
<tr>
<td>Duran</td>
<td>Spain (Andalusia)</td>
<td>35</td>
<td>4</td>
<td>Married, two children</td>
<td>Stay at home mom</td>
</tr>
<tr>
<td>Sofia</td>
<td>Argentina</td>
<td>24</td>
<td>10</td>
<td>Boyfriend, no children</td>
<td>Nursing student, working</td>
</tr>
<tr>
<td>Afrodisia</td>
<td>Catalunya</td>
<td>25</td>
<td>n/a</td>
<td>Married, one child</td>
<td>College student</td>
</tr>
<tr>
<td>Yolanda</td>
<td>Catalunya</td>
<td>27</td>
<td>n/a</td>
<td>Boyfriend, no children</td>
<td>Unemployed (laid off)</td>
</tr>
<tr>
<td>“Superwoman”</td>
<td>Catalunya</td>
<td>24</td>
<td>n/a</td>
<td>Single, no children</td>
<td>College student, two jobs</td>
</tr>
<tr>
<td>Leyre</td>
<td>Catalunya</td>
<td>41</td>
<td>n/a</td>
<td>Married, three children</td>
<td>On medical disability</td>
</tr>
<tr>
<td>Montse</td>
<td>Catalunya</td>
<td>34</td>
<td>(recently returned after 10 years away)</td>
<td>Single, one child</td>
<td>Unemployed</td>
</tr>
<tr>
<td>Carla</td>
<td>Catalunya</td>
<td>36</td>
<td>n/a</td>
<td>Married, one child</td>
<td>Janitor</td>
</tr>
</tbody>
</table>
Social support & stigma obstacles

Seventy-four percent of women indicated on surveys that they perceived enough support from their partners for their decision to seek an abortion. This was despite the apparent contradiction in the data that most women also reported a lack of partner support as a (potential) challenge. Nonetheless, a small minority (13%) reported they did not perceive enough support, while 5% did not tell their partner. Fully 20% of clinic and NGO staff told me in interviews that they believe a lack of support is the biggest obstacle for women. As Mari described in our interview, relating the lack of support she encountered from her partner and from a friend, “It would help [to tell someone, if they are supportive], it relieves you of the emotional weight. Like it or not, it weighs on you, well, you need to talk to someone.”

Fifty percent of women surveyed did report adequate support from their families, and women I interviewed largely reported enough support from partners. Frida, Sofia, Afrodita, Yolanda, “Superwoman,” Leyre, Duran, and Carla (8 of 11 interview participants) all had support from their partner, husband, or the man who got them pregnant. Montse, Alina, and Mari (3 of 11) did not have support from the men who got them pregnant, or had not told them (in Alina’s case, she may not have known who he was). More than half of women I interviewed (55%) said social support is what most helped them overcome obstacles, and a similar percentage of clinic and NGO staff (54%) perceived that social support is crucial to women’s ability to overcome obstacles to care. As Sofia said, describing how her partner’s support made the whole process better, “I think it’s harder if I were to go through this on my own, but facing it together is much easier.”

The issue of support was also not simple for “Superwoman,” Leyre, and Duran, partially because of their internal conflicts about whether or not to have an abortion. In “Superwoman’s” case, the man in question was not a regular partner, but rather, in her words,
“un lio” (local equivalent to the U.S. concept of a ‘hook-up’). While his agreement with “Superwoman’s” decision, and his offer to pay for the abortion if needed, made the decision easier for her, she still struggled with a lack of support from her family, and with strongly biased reactions from her close friends. As she related to me at length in an intense conversation that stretched on while a December afternoon turned into evening and the Barcelona park we sat in grew darker, she had initially considered carrying to term.

“Superwoman” stated her own “personal ethics,” and her academic and professional work in biological sciences (and thus familiarity with fetal development), made the choice to terminate a poorly timed pregnancy a complex one. “Superwoman” was well aware, and articulated clearly, that with her work schedule, the need to complete her studies, and the broader economic situation (including La Crisis) it was not a good time to have a child. Nevertheless, part of her wanted to continue the pregnancy, as she told me she imagined what a potential child would be like, and idealized a vision of the future in which she would have a much closer relationship with her own child than the strained relationship she described having with her parents and older sister.

Ultimately, “Superwoman’s” decision to seek an abortion was a pragmatic and economic one, but one she emotionally struggled with nonetheless. This internal conflict meant that her friends’ biased reactions while she was deciding what to do upset her very much. “Superwoman” told me that her friends were extremely supportive of the idea of her having an abortion, but were less receptive to the idea she might continue the pregnancy. She felt they did not want to hear how she felt, but just wanted her to “be reasonable,” and that she felt they would only help her figure things out if she chose an abortion. “Superwoman” insisted she did not feel pressured to have an abortion, but that her friends’ reactions prompted her to choose to “close [her]self off” and deal with the decision, and the process of seeking care, alone:
One day I talked with my friend, and she told me, “Abort, of course!” After ten or twenty minutes talking on the phone, just a little indirect, a little this way, she insinuated it was not an appropriate moment for me, and that, fine. She is one of my best friends, at that moment I did not say anything, but really I felt fatal [local expression meaning overwhelmed, struck], I went home crying. I don’t know, like I wanted her, of all people in the world, to tell me, “Yes, have it [a baby], I’ll help you if you need!” or “You don’t have to have an abortion,” you know?

Meanwhile, Duran and Leyre reported substantial support from their husbands. As Leyre said,

*He supports me in everything. Well yes... when these things happen you evaluate more what you have at your side... [but] but I felt very alone, the truth is that I felt very alone there inside.*

Both women felt they ‘had’ to terminate their pregnancies. Duran did so for economic reasons, and Leyre’s decision was due to a high likelihood of fetal anomalies from medications she had taken before she knew she was pregnant. While each woman felt she did receive support, in their cases it was not enough. Neither had really wanted to need an abortion, and so their husbands’ supportive presences did not mitigate their sadness, and/or the compounding frustrations about having to jump through hoops and wait out *CatSalut* and clinic timelines.

Such nuanced experiences are part of why the term “pro-choice,” or a Castilian or Catalan equivalent, is not really used in Catalunya and Spain. The closest corollary I heard in Barcelona was “*dret al propi cos*” (“right to your own body”), which carries a slightly different meaning. Women and reproductive justice advocates I spoke with did not find that the idea of “choice” resonated. Rather, they viewed abortion as a tool for managing difficult situations, and for prioritizing available resources to enable women to care for children they already have, for allowing women in economic *extrems* to not become even more poor or precarious, or to enable young women to finish their educations and begin careers. Even feminist activists that I met during the early period of my participant-observation with
community and feminist organizations working on abortion rights issues did not talk about “choice,” but rather relied on slogans related to bodily autonomy and independence – echoing rhetoric also used in the Catalan independentist movement.

“Superwoman” ultimately sought an abortion so that she would not feel economically beholden to her parents, and so that she could focus on her own growth as a scholar and biological researcher. In Duran’s case, she decided to terminate a pregnancy so that she could use her body, and by extension, her limited economic resources, to care for the two children she already had. In Leyre’s case, she did not allow her body to continue nourishing a pregnancy that might be damaged, or suffer later on. In my experience, many Catalan women’s discourses about an abortion decision mirrored dominant cultural discourses about the economic crisis, survival under austerity, autonomy, and independence also prevalent at the time.

Montse also did not feel that she received enough, or, according to her own estimation, any support while seeking care. When asked, she allowed as how a friend in Spain had spoken with her on the phone and been sympathetic, but Montse’s chief grievance was that the ex-partner who had convinced her to try for a baby together, after he had been a supportive friend while she went through the difficult process of seeking an earlier abortion while breaking up with a different partner, disappeared as soon as she told him she was in fact pregnant. Her attempts to track him down and seek his support provoked threatening reactions from his Roma (“gypsy”) community. Not only did Montse’s most recent partner not offer her support while she sought an abortion, the reason she felt she needed to seek one was because he had strongly encouraged her to get pregnant, and then abandoned her, followed by threats of violence from his social network. To make matters worse, the only person around who did offer to help Montse get to the clinic (which was not accessible by public transportation from her small rural town) was another previous partner, her ten year
old son’s father, whose help, Montse said, came “with strings attached.” Actively trying to coerce her into getting back together, this man offered to take her to her appointments in Barcelona as a way of obligating her to view his entreaties more sympathetically. Montse described how she was leery of accepting his logistical support, because he was offering it, “for his own reasons.” However, she ultimately did accept his logistical help, because she literally saw no other way to get to Barcelona.

Aside from how locals in her very small, insular town treated Montse when they learned of her most recent pregnancy, which actually appeared to be more a reflection of Catalan attitudes about romantically mixing with “gitanos” (a pejorative emic term widely used for both Spanish and Rumanian Roma peoples in Catalunya and Spain) than an example of pure abortion stigma, the issue of abortion-related stigma was largely absent from women’s contributions to my data. I had anticipated that it likely would not be much of an issue. Contrary to IRB assumptions about attitudes in “a Catholic country,” most people in Spain and Catalunya believe church doctrine should not influence social policy, and prefer secularist approaches (Bruni 2011, Tremlett 2008, Crow 1985). The expanded legalization of abortion in 2010 was broadly supported in Spain (Hughes 2011).

Women I spoke with in the clinic and interviewed did not talk explicitly about feeling stigmatized for seeking or having an abortion. Everyone I encountered, both in the context of my research and in my daily life in Barcelona, was entirely comfortable talking about abortion. This was quite unlike in my experiences researching the topic in the United States! People in my neighborhood, synagogue, and general social life in Barcelona did not bat an eyelash when I told them what I was there to study. Rather, people were incredulous at my descriptions of the widespread levels of abortion restrictions and abortion-related stigma prevalent in the United States.
In terms of stigma, the only clear evidence of the effects of abortion-related stigma in my study were evident in women’s concerns about the possible presence of protesters at the clinic, and a few women’s internalized feelings of stigma that seemingly provoked them to insist to me that abortion was okay for them, but not for other women. That refrain is one also heard in clinics in the U.S. (Henshaw & Kost 1996), and likely in other countries as well. Although the Today Clinic has not been the target of anti-abortion protesters for many years, and last experienced a violent anti-abortion attack in 1997\(^{28}\) (when a man opposed to abortion somehow got into an exam room and set off a bomb that resulted in fire damage), 48% of survey respondents indicated they had felt nervous about the prospect of encountering anti-abortion protesters outside the clinic. Given that no women arriving at the clinic during the study period actually encountered protesters, this anxiety about the possibility that they might suggests a degree of abortion-related stigma may have affected women during the process of preparing to seek care, if they assumed they might encounter opposition.

Fourteen percent of survey respondents indicated that worries about protesters were a “very or somewhat challenging” obstacle, but no women mentioned this concern in interviews. Moreover, this level of response on surveys may have been an artifact of my study design. Prior to arriving in the field I had not realized that clinics in Barcelona are not usually targeted by protesters, which is why I had this question on the survey. Half of women in two studies I conducted in the U.S. did encounter protesters at clinics, so I routinely include that question. It is possible that women who completed surveys at the Today Clinic in Barcelona had not even thought about the prospect of protesters, but that, upon reading the

\(^{28}\) After working in two previous clinics in the United States that were targeted for arson, sabotage, and physical attacks on staff, I actually felt safer walking in and out of the Today Clinic on a regular basis than I have ever felt at any clinic in the United States, even without locked doors or security systems.
question, they instead imagined how they would have felt had there been a gauntlet of protesters when they arrived, and responded accordingly.

Frida, the Colombian immigrant, mentioned that immigrant women from Central and South America may bring with them to Catalunya beliefs about the illegality or dangers of abortion as they understand it. She thought immigrant women might transfer their anxieties about the dangers of illegal abortion (very relevant in the countries they come from) onto the process of seeking an abortion in Catalunya. Specifically, Frida suggested that CatSalut staff should pay attention to where a woman is from, and seek to reassure South American women requesting a voucher for a publicly funded abortion that the abortion she will receive will be legal and safe. As Frida emphatically exclaimed, speaking of CatSalut staff, “First of all, they should tell South American women that [we] won’t die, that [we] will still be able to have children!”

Frida’s astute observation that immigrants may bring to the process preconceptions about the risks of abortion, or a persistent sense of abortion stigma, reminded me that some women may have fears or misconceptions about abortion that essentially result from stigma, even if these are not expressed as such. For example, Alina, who had been in Barcelona for six years, was familiar with CatSalut, and already had a health card, did not go to a CatSalut center to confirm her pregnancy or ask about getting an abortion. She thought abortion was illegal, until she spoke with volunteers who distribute condoms to sex workers in the area near the Ramblas where Alina works. It was one of these volunteers who directed Alina to the government-subsidized advocacy office that connects low-income and immigrant women with information and government funding for reproductive health services.

Contracted with CatSalut to do pregnancy verifications, vouchers, and post-abortion

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29 This was the reportedly racist center I sought to compare data with, to no avail. For more discussion of this office, and my experiences with it, see Appendix 2.
contraception counseling, the agency directed Alina to the Today Clinic, and supplied her with a voucher. However, they did little to prepare her for what the process would be like, or even tell her that she would need an accompanier in order to be seen. Alina’s hesitation to go directly to *CatSalut* may indicate a degree of abortion-related stigma that trickled down through her social network. The treatment Alina received in the health system did little to reassure her.

Nearly half of women I interviewed highlighted the importance of institutional support (when provided) in the form of advocacy from Today Clinic staff, workers at the Youth Center or Family Planning organization, helpful *CatSalut* workers, and even from the above-mentioned government-sponsored office (that has a reputation for being at best brusque and at worst racist/coercive). Unsurprisingly, clinic and NGO workers reported that institutional support helped women more than women themselves reported (81% versus 45%). Most immigrant women interviewed (80%) mentioned institutional support, but only 17% of Catalan women did so in interviews. An important question is what happens to immigrant women who are wholly unaware of their right to *CatSalut* coverage in the event of coverage, and what happens to immigrant and other women who encounter obstacles when they attempt to procure *CatSalut* coverage but encounter obstacles and delays and ultimately give up without succeeding. While some immigrant women, in particular, seem to hear about their eligibility for health coverage, and about legal abortion, through word of mouth in their communities or from community agencies, others whose experiences are necessarily not captured in this clinic-based study may well become so discouraged that they do not obtain coverage, or do not even try to get it.

Even women who had just complained to me about specific delays or misinformation related to *CatSalut*, would then go on to say that simply finding out that *CatSalut* would pay for the abortion helped them overcome economic obstacles to getting care. Eighteen percent
of women said in interviews that logistical support helped. Based on participant-observation and interviews, I argue that logistical help in this sense can be seen as a proxy for, or another form of, social support.

Table 7, Survey responses about social support and stigma (in the form of clinic protesters)

<table>
<thead>
<tr>
<th>Social Support – Partner</th>
<th>Social Support – Family</th>
<th>Protesters</th>
</tr>
</thead>
<tbody>
<tr>
<td>74% perceived enough</td>
<td>50% perceived enough</td>
<td>48% concerned would encounter protesters</td>
</tr>
<tr>
<td>13% did not perceive support</td>
<td>31% lack of support as obstacle</td>
<td>14% concern about protesters was an obstacle</td>
</tr>
<tr>
<td>87% lack of support as obstacle</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Travel, time off, and childcare obstacles

More than half of women who filled out surveys for this study traveled less than an hour to reach the clinic, just over a quarter traveled one to two hours. A small but significant 16% traveled more than two hours. With almost half of respondents living in or around Barcelona, the typical travel time of less than two hours reflects many women’s relative proximity to the clinic. However, 43% of respondents came from one of 72 other towns in Catalunya, and some women traveled from other countries in Europe where abortion is illegal after 12 weeks gestation, or even from North African countries. Importantly, 11% of respondents traveled from one of two towns that are located, respectively, an hour to three hours’ travel time from Barcelona. Each of these towns have abortion clinics that were not yet contracted with the public health system.
According to my surveys, the average time women had to take off from work or school to seek abortion care was one day, but 67% of respondents reported taking no time off. Nearly a quarter of women took one day off, close to 10% each took off less than a day or two days. Only 5% of women took more than two days off, and 13% indicated they were unemployed or that the question did not apply to them.

Fifty-five percent of respondents reported that they did not need to seek childcare to attend their appointments, 29% indicated that family members cared for their children while they came to the clinic. Less than ten percent paid for childcare. In my time in the field, I noted that many women arrived at the clinic with children who were then obligated to wait out front with the woman’s partner or a family member (children are not allowed in the clinic because of the lack of space in waiting areas, and to avoid upsetting patients). Because women are required under the anesthesia protocols to have a responsible adult present to take them home, and because this accompanier must be present in or near the clinic for the duration of the surgery in case adverse reactions require the woman to be transported to another facility, a woman’s accompanier was often also her only available childcare provider. It was not uncommon to see a collection of ten or fifteen male partners, elderly parents, and chatting friends, waiting out in front of the clinic, jiggling prams and corralling toddlers noisily running around.

Part of my role on clinic days was to inform accompaniers when a woman was safely out of surgery, so that they could go to a cafe nearby for a coffee or a snack during the half hour or so until the woman would be discharged. The look of relief on harried accompaniers’ faces when they heard they could take rambunctious children to the park around the corner or to get something to eat, rather than staying in eyeshot of the clinic as they had been required to do for the preceding hours, was striking. The grim reality that most women with children who came in for care apparently did not have even two people they felt they could ask for
help (one to accompany, one to watch a child or children) highlights just how big an issue social support was in this study.

Table 8, Survey responses re: Time off, travel time/costs, childcare

<table>
<thead>
<tr>
<th>Time off work/school</th>
<th>Travel time</th>
<th>Childcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average: one day</td>
<td>22% half hours or less</td>
<td>55% did not need it</td>
</tr>
<tr>
<td>67% none</td>
<td>36% half hour to one hour</td>
<td>29% family members provided</td>
</tr>
<tr>
<td>13% less than one day</td>
<td>26% one to two hours</td>
<td>7% paid, average cost: €32</td>
</tr>
<tr>
<td>23% one day</td>
<td>16% more than two hours</td>
<td>8% “does not apply”</td>
</tr>
<tr>
<td>10% two days</td>
<td>Average travel cost: €17</td>
<td></td>
</tr>
<tr>
<td>13% “does not apply”</td>
<td>“unemployed”</td>
<td></td>
</tr>
</tbody>
</table>

Women’s perceptions of specific obstacles

The difficulty involved in finding information on where to go for an abortion and how to apply for financial assistance, if necessary, was mentioned. So was mistreatment on the part of certain health care professionals when they expressed a desire to abort, the kind of attention they received at the hospitals (respect, anonymity, waiting time, personalized or mechanical care, unpleasant incidents with the staff, post-abortion complications, etc.), and the anxiety with which they endured the process were some of the factors most frequently mentioned by the interviewees. (Martinez Morant n.d.:9)

Martinez Morant’s research with low-income and immigrant women, conducted in Barcelona prior to the 2010 legal reforms, predicted findings similar to those echoed in my research, particularly as outlined in Chapter Two. In addition to discussing obstacles related to getting information about and access to the health system, women I interviewed also talked about
mistreatment or carelessness on the part of health system workers, a form of civilized oppression. Twenty-six percent of women who filled out surveys at the Today Clinic indicated they encountered some level of obstacles in the process of accessing abortion care. Seven percent reported these obstacles were “very difficult” to overcome. Half of women surveyed did not realize the voucher they arrived at the clinic with would fully cover the cost of the abortion. This indicated a high level of confusion related to, or a basic lack of information about, CatSalut’s relationship with contracted clinics. Every woman I interviewed had to make more visits to a CatSalut or contracted center than they should have according to established policy to get their voucher. Most waited longer for a voucher than the average found in surveys.

My fieldnotes also reflect just how often women arrived at the clinic with vouchers that had been filled out wrong. One woman arrived with paperwork that the midwife or doctor had put two different dates on (rendering it invalid) after making her wait until a third visit to get it in the first place, and when we called to ask if CatSalut staff could fax over a corrected voucher, they said no and demanded the woman come back in person. Another woman had a voucher for Article 14 but was only a few days away from being too far along for Article 14, and her accompanier did not show up by her appointment time, meaning that not only would she have to reschedule, she would also likely have to get a new voucher. This sort of problem reinforced the perception that CatSalut’s system of having two different vouchers for two different stages of pregnancy complicates matters. Moreover, these anecdotes were not the exception -- similar incidents made frequent appearances in my daily and weekly notes. Overall, from my perspective, the greatest number of obstacles to abortion access in Catalunya, and the most avoidable ones, related to CatSalut.

Even so, the most challenging obstacle, as perceived by women who completed surveys, was a lack of partner support: 87% of respondents indicated this was a “very or
somewhat challenging” obstacle. However, most survey respondents (74%) also indicated they had enough partner support – why the apparent contradiction? Based on participant-observation, qualitative interview responses, and conversations with clinic staff, one explanation may be that women who reported this seeming paradox were initially concerned they would not perceive adequate support from their partners, before they informed partners of a plan to seek an abortion, making the concern about a lack of such support a challenging obstacle. Then, when they did tell a partner about their intention to abort, they were relieved to actually receive support.

Many women I interviewed described just such a process of being nervous about what their partner’s response would be, and then being pleasantly surprised or relieved when a partner was immediately supportive. Several women told me that they had never discussed with a partner what they would each want to do if an unplanned pregnancy occurred, while others said that as soon as the pregnancy was confirmed, “we both knew what we had to do.” Conversely, women I interviewed whose partners were ambivalent about, or overtly hostile to, the idea of an abortion were particularly upset about the lack of support they received, and found that their partner’s attitude made it harder for them to face other obstacles, overall. This echoed my earlier findings in the United States about the role of social support in helping women overcome barriers to care (Ostrach & Cheyney n.d.). Women’s specific comments about partner support are detailed below.

The need to take time off and the need to travel were both seen as “very or somewhat challenging” obstacles, according to nearly half of survey respondents. Nearly a third of survey respondents saw the need to arrange childcare as a “very or somewhat challenging” obstacle. Mari combined her experiences with more than one of these potential obstacles in one comment, succinctly stating:
To get to the clinic, yes that was difficult, because I live far away. They told me, “You have to be here at 8:30am.” For me that is impossible, I have my daughter, at 8:30am. I leave her at school [her only childcare option]. They told me, “If you don’t come at the latest at 9:30am., you can’t do the procedure.”

An Ecuadorian immigrant who had lived in Barcelona for 12 years, Mari’s frustrations with CatSalut delays are outlined in Chapter Two. To add insult to injury, when Mari ultimately obtained a voucher for care and called to schedule an appointment for a surgical abortion at the Today Clinic, it was an especially busy time of year and few appointments were available. Although Mari did not know it at the time, the reason the Today Clinic offered her limited appointment times that conflicted with her childcare and transportation options was because the only other contracted clinic at that time had just used up its 2012 quota, leaving the Today Clinic as the only contracted abortion provider for more than two months, resulting in very high demand and few openings in late 2012 and early 2013. As in Mari’s example, travel, logistical, and other scheduling obstacles often resulted from the combination of aspects of women’s individual situations, and larger systemic or structural issues with the way CatSalut functioned, or the way the Today Clinic was affected by CatSalut policies.

Even the Today Clinic’s protocol of doing preoperative testing and surgery on two separate days was described by clinic staff as a response to CatSalut’s poorly managed referral process, and the reality that some quantity of women arriving with vouchers for care would not actually be good candidates for surgery, would have the wrong voucher, or would be further along than anticipated, requiring a different type of procedure. Clinic administrators decided to allow for these possibilities by scheduling women for initial screening prior to the date of the surgery, so that the surgery schedule would not be left with unexpected and expensive gaps. Today Clinic surgeons are paid per procedure, but also for their time in the clinic. Time spent sitting around waiting for a ‘good’ candidate for surgery is
time that the clinic pays surgeons and anesthesiologists for, without having a patient for whose care they could bill *CatSalut*.

Several clinic staff mentioned that allowing women to schedule their whole appointments in one day would obviously reduce obstacles related to travel, time off, and childcare, but this solution was seen as unfeasible because of *CatSalut*’s structuring of referrals, quotas, and reimbursements, and persistent problems with vouchers. Clinic staff (accurately) assessed that allowing for two days with each woman budgeted time for social workers on the clinic staff to work on getting women’s vouchers re-issued correctly, or for rescheduling a surgery for a day when a women who turned out to be farther along could be seen by a more qualified surgeon (only one of the three regular surgeons did the later procedures), and so on. In this way, *CatSalut*’s benign neglect in the form of inadequate screening for preexisting or contraindicating conditions, and frequent mistakes on vouchers, compounded into another form of civilized oppression. The resulting convoluted bureaucracy inconvenienced women and subjected them to increased potential economic losses stemming from needing to take more days off work, find more childcare, and travel to the clinic more than once. The structure of *CatSalut*, in turn influencing the structure of the clinic, exacerbated the effects of larger structural (economic, etc.) constraints.

Of the eleven women I interviewed, nearly a third discussed a lack of support as an obstacle to care, and the same number discussed logistical problems. As outlined in Chapter Two, most described some sort of delay, difficulty with, or confusion about the health system. Many did not see this as an obstacle – likely because they did not know that the information they had been given, or the process they had to follow, was not correct. Even so, nearly 10% of women I interviewed specifically mentioned a lack of information as an obstacle to care. Even Sofia, who explicitly said she had a good experience with the health system, had not been aware she could get a voucher for care without making an appointment.
Fewer than 20% of women I interviewed mentioned anything about their internal process of deciding whether or not to have an abortion as an obstacle, despite a preoccupation with ‘the decision’ often seen in U.S.-based literature on abortion. Women did not describe struggling with knowing whether or not they should have an abortion, but rather mentioned their frustrations with the basic fact of being in a situation where they felt an abortion was the best, or only, option. As is borne out in other medical-anthropological literature on the topic (e.g. Weitz), women did not see the abortion as the problem -- rather the unplanned, unwanted, ill-timed, or complicated pregnancy was the problem, and an abortion was the (sometimes reluctantly chosen) solution (Weitz 2012). This distinction is particularly important in light of how discussions of abortion, like other contested topics, often lack nuance or room for grey

Clinic and NGO staff emphasized the importance of respecting women’s ability to decide what step makes the most sense for themselves. Women also evaluated how their larger networks would be affected if they carried a poorly timed pregnancy to term, as eloquently stated by Jorge, the Today Clinic psychiatrist:

Women approach pregnancy and evaluate what they have in their lives, what they are capable of, what they are prepared for, and decide based on how prepared they feel according to their values about motherhood and what kind of mother they feel prepared to be. Wanted or unwanted isn’t the right word for it, it’s prepared or not prepared. It has to be taken into balance based on what the women is ready for, not what her partner, her family want, not what the neighbor thinks, not anyone else, it must be taking into account her balance. Period.

My research reconfirmed that women typically move through several stages of evaluation when facing an unplanned, ill-timed, or unwanted pregnancy, considering their economic and social resources and carefully evaluating what is best for themselves and their families before determining what step to take.

A small but vocal 9% of women I interviewed talked about a strong sensation of wanting to face the process alone and not seek support. Even more women referred to this in
oblique ways. Simultaneously dubbed “the superwoman complex” by me and by clinic and NGO staff members I discussed it with, this apparent cultural, generational, and/or feminist ideal of wanting to be able to handle something challenging through sheer determination, without asking for help, was characteristic of young Catalan women, and of immigrants who had been in Catalunya for a long time. It was often verbally linked to women’s concerns about La Crisis, and a reluctance to ask people to risk taking time off work from precious and precarious jobs to help them access care. To the extent that this mindset served as both an obstacle to care (by making it harder for women to feel able to mobilize social support in order to overcome logistical obstacles), and as a way that women themselves resolved problems and overcame other obstacles (by choosing to approach the process in a deliberately independent way), it will be discussed at length as a separate theme, below.

**Differences in perceptions of obstacles between immigrant and Catalan women**

Interesting patterns emerged in the different interview responses of immigrants and Catalans. More of the Catalans said they encountered a lack of support, a lack of information (or misinformation), or logistical problems. More Catalans also indicated that social support from a partner, friends, or family helped them overcome obstacles, while two of the three women who said “nothing helped” and that they were “not yet over it [the abortion]” were Catalans -- the other was Andalusian (Spanish). Meanwhile, more of the immigrant women I interviewed said institutional support from the clinic, a supportive CatSalut worker, or from an NGO is what helped them overcome obstacles: 80% of immigrants indicated this in interviews, while only 17% of Catalans did. Simply learning that CatSalut would pay for the abortion was seen by some women as a form of institutional support. However, sometimes

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30 I differentiate between “Superwoman,” the pseudonym chosen by a research participant, and the idea of being a “superwoman” as described by multiple women, by using a lower-case “s” in the generic, and the capital “S” in the specific moniker.
women’s comments about institutional support damned with faint praise, as in the following from Mari:

Well, before you had to pay... it was a relief to learn, when I called the clinic, that it would be free with the paper! It would have been better if someone [at CatSalut] had told me it would be free with the voucher.

In the interview sample, immigrant women, objectively, waited longer on average for their CatSalut vouchers, had to make more visits to their health centers to get the vouchers, and were, on average, two weeks farther along in gestation when they ultimately obtained an abortion, as compared to Catalans I interviewed. However, despite apparently encountering more measurable obstacles, immigrants actually talked less about these aspects as obstacles, than did their Catalan counterparts. This conundrum, in which immigrant women, from my perspective, encountered more obstacles and delays, but perceived fewer, can perhaps be explained by remembering that Catalan women seeking abortion care are already familiar with CatSalut, and are accustomed to being able to receive health care on the spot, in one location, without waiting or having to request a voucher for care.

Immigrant women came to Catalunya from countries without public or national health systems, and may simply have been so relieved to have some kind of free health care that jumping through a few hoops, and waiting a few weeks, did not seem as upsetting as if they had expected the process to be faster or easier. Overall, it appears from the interviews and from participant-observation that immigrant women in fact do encounter more delays in the process of navigating CatSalut to get a voucher for care. This is not least because an immigrant woman who first applies for a CatSalut health card when she is already pregnant must now wait at least a month for a permanent card before she can go to a contracted clinic. As Ariadna, the Today clinic receptionist, explained:

In those cases, it’s at the [CatSalut center] that they don’t explain, they give [women] papers [sic] and it takes a lot for us to have to tell women that those papers [the temporary, initial health card] serve for coverage at CatSalut, but not for the
abortion. When it’s a provisional [health] card, we can’t accept it, it has to be the [permanent] CatSalut card.

The project coordinator of the NGO, Greta-Maria, who helped draft the legislative language for the 2010 abortion reforms and lobbied long and hard to get abortion included in CatSalut coverage, allowed as how some of the bureaucratic problems for immigrant women may have resulted from the well-intentioned haste with which CatSalut cobbled together a response to the most recent austerity cuts. Greta-Maria recounted how the provisional card system, in which new applicants to CatSalut get a temporary card for the first month that cannot be used outside of the main centers, was a product of how CatSalut tried to rapidly address potential problems caused by the PP’s austerity-related demands that Catalunya cut all health care for immigrants as of August 2012. Everyone involved in monitoring Catalunya’s refusal to do so, and in crafting the subsequent compromise of instead instituting delays in coverage for immigrants, knew that immigrants would begin to be affected by a waiting period and/or delays in getting a permanent health card. Though it was designed to safeguard at least some coverage for immigrants, rather than to deliberately prevent immigrant women from accessing abortion without delays, Greta-Maria said of the stop-gap system, “it was not well thought-out, and they [CatSalut] did not consider pregnant women in need of abortion.” This aspect of health system cuts and reforms resulting from La Crisis is then, whether purposefully or inadvertently, a uniquely segregating form of civilized oppression that amplified the impact of structural violence on the likely already most-marginalized: immigrant women.

Rural women

Clinic and NGO staff mentioned that women in rural areas may face special difficulty getting a CatSalut voucher, either because of limited hours at rural health centers, or because
of increased concerns about confidentiality in small towns. As the social workers and technicians at the Today Clinic, who chose the pseudonyms “Maria” and “Pepa,” and did most of the medical intakes and discharge procedures pointed out, some rural women may put off going to the one CatSalut center in their towns for a pregnancy verification and to request a voucher if the town is so small that being seen walking in would evoke comment, or if their mother-in-law, sister-in-law, or another acquaintance works in the center. Anecdotally, it could be surmised that women who must travel from farther away also face more obstacles related to travel time, travel costs, getting time off work or school, finding an accompanier who can also take time off for as long, and the need for extended periods of childcare. In interviews, the two women who lived farthest from Barcelona, Montse and Duran, did experience delays in receiving care, as a result of both CatSalut infrastructure and scheduling problems, and because of needing to arrange their travel to Barcelona around children’s school schedules, accompaniers’ work schedules, and train schedules. Though a correlation between distance/time travelled to reach the clinic and gestation upon arrival was not found in the survey data, there is ample qualitative data to demonstrate that the need to travel to reach the clinic did make the overall process of seeking care more difficult for some women.

Duran, the Andalusian, initially had to travel to one town nearby to seek a medication abortion, and upon learning there that she was too far along for that option, had to return to the CatSalut center in her home town to get a new voucher for the Today Clinic, and then travel to Barcelona twice to be seen. Each trip to Barcelona entailed an hour or more on commuter rail, “We went on the train... the two times.” Meanwhile, Montse ultimately and reluctantly accepted logistical help from her son’s father (who was pressuring her to get back together with him), because he was the only person she knew with a car. He, unlike anyone else, was willing to drive her first to the town where she could verify her pregnancy and get a voucher, and then twice to the clinic in Barcelona, more than an hour and a half’s drive from
her small town that cannot be reached on public transportation. In both cases, the amount of traveling, and number of trips, these women from farther outside of Barcelona had to face were essentially because of the limitations of CatSalut’s rural infrastructure.

While such delays and increased difficulties may have been partially alleviated for some rural women by CatSalut’s March 2013 move to contract with clinics in Tarragona and Girona (respectively, an hour and three hours’ travel from Barcelona), these clinics only provide care in the first trimester. Any woman in Catalunya who is beyond about 12 or 14 weeks of pregnancy still must travel to Barcelona and pay cash at the Today Clinic, go to another contracted clinic in Barcelona that offers care up to 16 or 17 weeks (of which there are few, with few appointments), or go before a hospital review board in her own area to request a public, in-hospital abortion. How frequently women appearing before such review boards are denied care is unknown, and is something I hope to study in the future.

Women in need of second-trimester care

A particular subset of women whose experiences with obstacles and delays may particularly illuminate the intersecting nature of many of the factors mentioned so far are women who arrived at the clinic already in the second trimester. In the larger literature on barriers to abortion and delay factors, the links between poverty, Medicaid [public health system] eligibility, living farther from a clinic, a lack of social support (particularly in the form of intimate partner violence) and a greater likelihood of needing second-trimester abortion care are clear (Ostrach & Cheyney n.d., Kiley et al. 2010, Jones & Weitz 2009, Weitz & Yanow 2008, Foster et al. 2008). In my data from Catalunya, there are similar links between the experiences of women who had to navigate more delays in, or confusion about, the health system, and those who reached the clinic already in the second-trimester. As stated earlier, there were statistically significant correlations between gestation and waiting times
for a CatSalut voucher, and gestation was even more highly correlated to the number of visits women had to make to get the voucher.

While the percentage of women completing surveys who accessed care after the first trimester is small (less than 10%), the numbers of women seeking second-trimester care at the Today Clinic represent a greater proportion of second-trimester versus first-trimester abortions than are typically seen in large-scale epidemiological or public health studies in the U.S. and elsewhere (AGI 2013a; 2012). This may be due to the fact that any woman in Catalunya who needed second-trimester care during at least part of the data collection period could go only to the Today Clinic for publicly funded, non-hospital care. Nevertheless, the perceptions of this part of the sample, in particular the experiences of women who participated in interviews, reveal some of the reasons women in Catalunya who depend on the health system for abortion services may end up seeking second-trimester care. Four of the eleven women I interviewed were already past or approaching the cut-off between first and second trimester care, for reasons that reflect overlapping delay factors.

For example, Alina was in the first trimester when she began seeking care, but had reached 16 weeks gestation by the time she was finally able to get all the moving pieces to line up so that she could have a surgical abortion. The day she managed to get to the clinic, with a required accompanier, represented at least her third or fourth appointment for surgery with the Today Clinic, and followed countless visits to other government offices and various CatSalut and other health centers. Due to multiple delays with the agency that helps immigrant and low-income women in Catalunya get vouchers for care (where she was referred by sex worker safety advocates), being sent by the clinic and the agency to various other health centers for additional health screenings (that seemed to me at the time to be required based on stigma related to her work in prostitution), and, most importantly, due to a
lack of support, I calculated Alina made roughly six visits to various facilities. This delayed her from receiving care for at least a month.

The time that passed between Alina’s first visit to an agency that could fill out a voucher for her, and her ultimate successful surgical abortion appointment at the Today Clinic meant the difference between a first and second trimester abortion. Of course, like any such story, there are many layers to, and versions of, why and how Alina was forced to reschedule her abortion multiple times, but each level suggests additional delays and difficulties that she faced: as an immigrant, as a woman with little or no social support, and perhaps also as a stigmatized member of society, a sex worker. Following Alina’s first contact with the government-sponsored office that initially filled out her voucher for first-trimester (Article 14) abortion services, she went to the Today Clinic for preoperative testing. Alina disclosed on her health history that she had been diagnosed with and treated for Hepatitis as a child in Rumania. She thought it was Type B, and stated she “no longer had it, and was not contagious.” For some reason, clinic staff listed on another page of her chart that Alina had Hepatitis C, a more highly contagious blood-borne pathogen that sets off particular alarms in abortion care settings because of the risk of contamination for health workers.

Hepatitis C, in my experience, is often seen by reproductive health workers as a signal that a woman works in the sex industry, or of intravenous drug use. During my time at the Today Clinic, I noted that clinic staff often communicated to each other the need to be particularly diligent about taking universal precautions (gloves, etc.) and cleaning up particularly well (with a bleach solution rather than other less caustic cleaners, for example), when a patient disclosed a history of Hep C. However, I do not recall another patient ever being turned away or sent for additional testing for either Hep C or B, as Alina was. From her perspective, without a clear explanation, Alina was sent away after the preoperative testing and told to go to her CatSalut center for a blood-test to see if her Hepatitis was still active. At
the *CatSalut* center, Alina was referred to the nearest hospital’s laboratory, again without an explanation of why the blood-test could not be performed in the health center’s regular laboratory, or why it was required before she could have an abortion.

I suspect these mysteries have something to do with assumptions made about Alina by clinic and *CatSalut* staff, because of her identity as a sex worker – something she never explicitly claimed, but which was inferred because of the perception that she had Hep C, because of her address in an area known for prostitution, and because of her ethnicity (Rumanian women, also openly called “*gitanas,*” are often assumed to be prostitutes in Catalunya and Spain). Even in our intensely personal interview, Alina did not refer to herself as a prostitute or sex worker, but rather, when I asked her where she worked (suspecting, but not wanting to assume), she said vaguely, “*down there... on the street.*” Alina then proceeded to describe to me the vagaries of demand for her business without being explicit about what her actual work was. The only time Alina explicitly told me what she does for a living was when I asked her if it would be difficult for her to comply with the follow-up care instructions (that include no vaginal penetration for two weeks after the abortion). Her response was to list for me all the other things she could do, sexually, with and for her clients. Even though she apparently felt safe enough with me to talk about such things, she never claimed the title, “*puta,*” as other sex workers in her neighborhood and in the feminist scene in Barcelona who I knew from protests and community meetings, often did.

After her first visit to the Today Clinic, Alina was under the impression that she simply needed to call back with the results of her tests, so she waited to hear from the hospital where she ultimately had her blood drawn. Unaware that the hospital had sent the clinic lab reports showing she was negative for both Hep B and Hep C directly to *CatSalut* and to the clinic, Alina lost valuable time waiting to hear something, in addition to the time that had already passed while she attended the various screening appointments. By the time
Alina found out she was cleared to schedule her surgery, she had passed the fourteen-week mark, and had to go back to the agency office to get a different voucher for second-trimester (Article 15) care – something she only learned was necessary when she went to the Today Clinic for a surgery appointment, and clinic staff noted the voucher in her chart was no longer valid. Depending on whether you go by Alina’s version of events, or clinic staff members’ comments, Alina then had to reschedule her surgery several more times. According to clinic staff, this was because she repeatedly arrived without the required accompanier, or after having eaten or smoked (contraindicated for anesthesia). According to Alina, it was because she was not told she could not have surgery unless someone was present in the clinic to be legally responsible for her, and/or because she thought she could have just local anesthesia if she did not have an accompanier.

I perceived that the root of this disconnect between Alina’s failure to comply with clinic protocols (as the clinic staff saw it), and Alina’s frustration that she kept being turned away from the clinic for what seemed, to her, arbitrary reasons, lay to some degree in Alina’s inability to mobilize social support because of apparent social isolation/stigmatization. In my interview with her, Alina became distraught as she told me how she had “no one” in Catalunya to support her, help her, or go with her to the clinic:

*If nobody wants to go with me, I’ll go alone... I don’t have friends, I don’t have anyone, here. If I had someone, that would be good, a sister, a cousin, something. As I’m alone, nobody wants to help me. And in my country, my parents are old, they don’t have [a way] to help me.*

Alina’s desperation was palpable. When I scheduled our interview I assumed she had already had her procedure, as the interview recruitment form she had filled out was from several weeks earlier. I did not learn until I arrived to meet her on the street where she awaited clients that she had rescheduled her surgery appointment (again), and would in fact come to the clinic for another attempt later that same week. Already repeatedly delayed from
obtaining an abortion, Alina poured out her tale of woe as we sat in a tiny make-shift bedroom she rented upstairs from her ‘stroll’ (Sterk 2000). Uneasily living in a flat packed full of other immigrants, Alina gestured at the sloppily constructed plywood half-walls that separated her space (just big enough for a small bed, an old TV, and a locking mini-fridge) from what was once the dining room, as she told me she did not have enough money to pay her rent that week. She related that the woman who rented out sleeping space for about ten people in a two-bedroom flat was threatening to evict Alina on the day her abortion was scheduled.

Alina told me that demand for her work had been steadily dropping since La Crisis began, and that she had noticed a particular slump since the most recent round of austerity cuts in August 2012. As Alina described, not even her Catalan and local Spanish ‘regulars’ could afford to come see her anymore. In her words, they had to be content to, “sleep with their wives instead.” Since the most recent austerity cuts Alina depended entirely on income from tourists, which could vary widely. Aside from her preoccupation with why she kept having to reschedule with the clinic, Alina was most immediately concerned about how she would afford to eat that day, and where she would go to recover from the surgery if evicted. When she told me she had nobody to go to the clinic with her, I asked if she knew the clinic required an accompanier for procedures involving anesthesia (which all second-trimester abortions at the Today Clinic do). She dismissed this tiredly, as though it were just one more thing she could not do anything about, or as though she did not fully believe me.

As it turned out, Alina came to the clinic once or twice more, without an accompanier, and was turned away each time. The day that she finally succeeded in having her procedure, she arrived with an older “gitana” (Gypsy) woman, who, regardless of her actual ethnicity or character, was perceived (and stigmatized) by clinic staff as uncouth and untrustworthy. I heard several workers speculate that perhaps Alina had randomly found this person on the
metro, and paid the woman just to come and play the accompanier role. In fact, when it was time to notify her accompanier that Alina’s procedure had begun, and that she would be ready to go home in an hour or so, it fell to me to give the news. I told Alina’s ‘friend’ that Alina would be able to leave soon, but that she could not leave alone, and that she (the friend) had to stay nearby, perhaps at the cafe on the corner, and leave me a phone number where I could reach her in case of emergency. The older woman was holding Alina’s coat, phone, and the last few euros Alina had planned to use to get back home. I emphasized how important it was to stay nearby. More than two hours later the clinic was on the verge of closing, after a 12 hour day. Alina was discharged, dressed, ready to go, and hungry after fasting all day, but the accompanier had not returned and was not answering Alina’s phone. We called again and again, and when the woman finally answered, she admitted she had gone back home – to the other side of Barcelona. We waited as long as we could, but she never returned to escort Alina home. Eventually, Alina had to sign a form waiving any liability for the clinic allowing her to leave alone so soon after being under anesthesia. She headed out into a cold night without her jacket, phone, or any money. I found myself thinking of her often on long days in the clinic. Every time I walked near her street, the most notorious Barcelona stroll just a few blocks off Las Ramblas, I always found myself looking for her out of the corner of my eye.

Obviously, there was more going on for Alina than just CatSalut delays or logistical problems. Not all women who end up in need of second-trimester care represent such extreme examples. While it is tempting in abortion research to focus on the ‘sob stories,’ the most long-suffering seekers (Weitz 2012), the reality is that many women, for many reasons, could and did have trouble getting the correct voucher, or finding someone to accompany them to the clinic. But in Alina’s case, the combination of health system delays (as represented by medical protocols that apparently, in her case, required additional testing, and inexplicably involved CatSalut referring her to a hospital for routine blood tests) and a
The profound lack of support from anyone she felt she could ask to go with her, resulted in a much later procedure, and more time away from work, than should have been necessary in ideal circumstances.

Of the other women I interviewed who were close to passing the fourteen-week time limit covered by an Article 14 voucher for care, Duran and Montse both reported being at or near twelve weeks gestation when they ultimately got to the Today Clinic – just about two weeks shy of the gestational cut-off. In Duran’s case, *CatSalut* infrastructure and scheduling delays, and a lack of information about *CatSalut*’s ability to full pay for the abortion, meant she was unable to get the earlier medication procedure she wanted to have at a center closer to where she lived. Duran only learned this was the case after making several visits to *CatSalut* centers in two different towns. Mari’s experience was similar, as *CatSalut* scheduling delays precluded an early medication procedure, pushing her closer to 12 weeks when she ultimately got to the Today Clinic. By the time Duran got a voucher for, and referral to, care in Barcelona, she had lost another week. In her own words, if she had been delayed any farther, she felt she would not have gone through with a second-trimester abortion, despite her family’s difficult economic circumstances. Montse, similarly, had to travel to another town to get her voucher for care in Barcelona, and also had to seek accompaniment and transportation help in the face of little meaningful social support. Based on these examples, a further exploration of the impacts of intersecting social and logistical obstacles that increase the need for second-trimester care, particularly for immigrants and women in rural areas, is warranted.

It is also important to note the bidirectional nature of second-trimester abortion delays: women who encounter delays while still in the first trimester may end up needing to seek second-trimester care, and thus encounter even more delays, while women who need second-trimester care are often also affected by factors that make it more difficult to reach an
appropriate provider, and will likely need to take more time off work, arrange for more
childcare, travel more times or farther, etc. The need for second-trimester care compounds
various obstacles, all of which may, on their own, make women more likely to end up
needing and seeking second-trimester care. The ways that second-trimester abortion need can
complicate a woman’s ability to navigate the overall process of seeking care, and even the
quality of care a woman ultimately receives, was evident in my field notes even from my first
few weeks at the Today Clinic:

_The psychiatrist says women who are past 14 weeks have more bureaucratic problems
getting the derivación [voucher for care]. Staff at CatSalut may send them to a public
hospital instead of the clinic [believing or letting women believe that later abortions
can only be performed after committee review]. But the hospitals will only induce,
with Pitocin, and then they leave women alone to labor [sic] and expel the fetus
alone, with no effort to prevent live births, and no support._

-Field notes, October 19, 2013

As this grim summary suggests, clinic staff shared a perception that the health system, and
particularly hospitals (when they did, rarely, provide abortion care), took a punitive approach
towards women seeking later abortion, sometimes making them suffer unnecessarily when
faster, less painful, and more humane care could have been offered at a contracted clinic.

Teen women

For teen women in Catalunya and Spain, the legal requirement to inform a parent of
their intention to obtain an abortion is likely experienced as a potential obstacle, depending
on a teen woman’s particular family situation. While IRB limitations did not permit me to
interview women under the age of 18, I explored this issue at length through interviews with
clinic and NGO staff, and during my participant-observation at the Today Clinic and the
Youth Center. The Youth Center, dedicated to providing sexual and reproductive health care
and information to people 25 and younger, was a particular source of information on this
topic. In addition, the national association of accredited clinics in Spain, of which Dr. Barcelona was the president, recently conducted a study with women 16 and 17 years old who reported they could not inform a parent of their decision to seek an abortion, and sought the legal alternative of seeking care by declaring to health system or clinic staff that doing so would put them at risk of harm (an option only available to women between 16 and 18 years of age).

I received a report from that study soon after arriving in the field, when the Family Planning Organization suggested I could help them by collecting more detailed, ethnographic data on the reasons that teen women coming to the Today Clinic felt they could not inform a parent of their plan to have an abortion. Unfortunately, I was unable to collect such data during the period of this study, due to IRB delays and constraints, and lack of time. However, my participant-observation yielded some data that reinforces the findings of the clinic association’s study. Specifically, the national study found that less than 4% of abortions performed from mid-2010 to late 2011 were for women in this age-range (16 and 17 years old), which represented a total of 1,186 women (ACAI 2011). Of these, 151 (13%) reported they could not inform a parent or legal guardian, representing less than half of one percent of all abortions performed in Spain during the time period. Thus, the total number of women, and percentage of abortions, in which the issue of parental notification is an issue is small, but the reported reasons for not being able to tell a parent about an abortion, or more realistically, about an unplanned pregnancy, are compelling.

Teen women surveyed by the association of clinics reported the following motivations for requesting a waiver to the notification requirement, on the grounds that such a notification could result in harm to them: serious conflicts, family violence or threats, maltreatment, fear of being kicked out of the house, parent(s) in prison, mentally ill/unstable parent(s), parents openly opposed to abortion, and/or parents refusing to accompany them (ACAI 2011). Some
teen women also reported being in the country without their parent(s), being emancipated on account of adolescent marriage, or not knowing where their parent(s) were (ACAI 2011). Many of these reasons were subsequently reflected in interactions I witnessed or heard about, between adolescent women seeking abortion care at the Today Clinic, and clinic staff.

Although most teens did come to the clinic accompanied by a parent, a noticeable number, upon being given consent forms to fill out in the ultrasound room, responded to an inquiry about having a parent sign the form by asking if there was an option to avoid doing so. An Ob/Gyn and counselor at the Youth Center who also worked in a CatSalut SRH center for more than 30 years, and used the pseudonym “MariDos,” mentioned that a large part of her job is to encourage teen women to evaluate where they might be able to seek support when dealing with an unplanned pregnancy, but that she often hears reasons why teens feel they cannot tell anyone:

As we have very young women [that come to the centers], their biggest obstacle is the lack of understanding from their family, right? Because once you tell them nothing [bad] will happen, that at the legal level they can [have the abortion], their worry is the reaction of the parents, basically. [They say:] “My dad will kill me!” That’s their main [preoccupation], that [their] parents will kill [them]... and yes, for some it really is a [danger.]

In MariDos’ experience, and that of many clinic and NGO workers, teens are explicitly, and with good reason, worried about the risk of violence from their parents if they disclose a pregnancy, or plans to seek an abortion.

According to clinic and youth center staff I interviewed, and based on the brief interactions I witnessed as teen women were escorted from ultrasound to the counseling room or in the discharge room (where social workers also worked with families to resolve paperwork issues), many teens told clinic staff that they could not tell a parent of their intention to have an abortion, for fear of physical abuse, being kicked out of the house, losing parental support in the form of childcare for children they already had, and all of the other reasons mentioned above. Immigrant teens who came to the clinic, in particular, often stated
they were in Catalunya alone, or with older siblings, and that their parents were back in their home countries with younger siblings. For this population, the need to notify a parent and seek a parental signature on a consent form could be a significant obstacle to accessing care, if teens are aware of the notification requirement but are not told by CatSalut staff or others that there is a waiver option.

Obviously, the lack of such a waiver available for teens younger than 16 is also a potential obstacle. The age of sexual consent in Spain and Catalunya is 13 (Penal Code), but even though women this young are considered capable of choosing to have sex, they are not trusted to make decisions about seeking an abortion. Of younger teens that came to the Today Clinic during my fieldwork, many tended to be much farther along in a pregnancy, even nearing the end of the second-trimester and the legal cut-off for having an abortion at all. Some twelve and thirteen year old girls who each spent several days in the clinic undergoing drawn-out late second-trimester induction abortions came with their parents, others initially arrived with (apparently much older) boyfriends, and were dismayed to learn they would need to return with a parent.

A few young teens reported that their pregnancies had resulted from a rape. In one memorable case, a very young Moroccan Muslim woman came for a late abortion with her mother, who, dressed in traditional clothing that covered all but her face, insisted that her husband could not learn of either his daughter’s rape or the abortion, or he would try to kill the (adult male) teacher who had impregnated his daughter, and end up in jail. Such stark examples of the difficult psychosocial circumstances in which young teens may seek abortion care illuminate the many levels of barriers to care that women may face before and after they address comparatively simpler aspects such as getting a health card, getting the CatSalut voucher, and getting to the clinic. In the case of the young Muslim girl, the clinic was ostensibly obligated to report the rape to authorities (because the girl was 12, not 13), but the
mother pleaded with us not to. She said the school counselor was aware and would report it, and that the teacher had been questioned by the school principal, and subsequently fled the country. In this example, the pregnant teen waited a very long time to tell her mother she was pregnant, and to seek the abortion, because she was afraid she would have to notify both her parents, and she did not want her father or other male relatives to go to jail for the violent retaliation she was sure they inflict on her rapist. Perhaps, if there had been a clear option for her to confidentially request assistance from a CatSalut representative with the discretionary ability to waive a notification requirement, this young teen could have had a much earlier (and likely less disruptive procedure), and/or received more support in the process of informing her mother.

Given that the larger literature on sexual activity among teens reveals that adolescents are waiting longer, on average, to have sex, but that very young teens and preteens who report sexual activity are more likely to have been coerced into it, and are also unlikely to use any contraception in their first sexual encounters (Finer & Philbin 2013), any reporting or notification requirements that deter younger teen women from seeking sexual and reproductive health care, including abortion, may also delay their access to appropriate counseling and psychological support for sexual assault.

There is little evidence that mandatory reporting requirements for suspected sexual assault of minors (specifically, statutory rape reporting) reduces teen pregnancy rates (Donovan 1997). Significant concerns that such requirements actually result in adverse consequences for teen women persist (Donovan 1998). This extremely complex issue reveals another possible dimension of structural violence and civilized oppression in health care bureaucracies. When government or health system representatives, or care providers, are required to demand proof of parental notification from young women seeking abortion, this policy ostensibly intended to increase the support available to women or to identify the
commission of a crime, may instead isolate a woman in a dangerous situation, cutting her off from resources that could help her extricate herself from an environment in which she may be extremely vulnerable to more abuse, particularly as a pregnancy progresses (Moore et al. 2010, Bacchus et al. 2006).

The “superwoman complex”

I myself realized that third parties can’t influence my opinions on something so important in my life. So I decided to close myself off. I consider myself a Superwoman. When I have problems, I [deal with them] myself. - “Superwoman”

A self-professed desire to “handle it alone,” “deal with it myself,” or to “feel strong by facing things on my own” came up as a subtheme in multiple interviews, particularly with younger Catalan women, and with immigrant women who had been in Catalunya for a long time. Some women said that they responded to a perceived lack of support, or a lack of the kind of support they wanted, by choosing to turn inward and find within themselves a determination to “just figure it out.” This idea was such a key factor in “Superwoman’s” strategy for overcoming various obstacles to successfully obtain an abortion, and also came up in so many other conversations with and about women seeking care, that I soon began asking clinic and NGO staff (and really any Catalan who would hold still) about it. Feminist activists in the larger abortion rights scene suggested to me that it was part of a Catalan-feminist ideal that, in the wake of Franco’s rule, elevated for women the idea of handling things on their own and being strong enough to do anything, rather than relying on a patriarchal figure to help them.

A good friend who I met at an abortion rights march early on even advanced the hypothesis that this “superwoman complex” (as she and I and others called it) grew out of Catalunya’s early industrialization compared to Spain (Tremlett 2008), and the crucial role of women in factory production and economic growth in the region. Others, including Dr.
Barcelona, saw it as an essentially ‘foolish’ belief among young Catalan women that they should be able to do everything alone, without help. Dr. Barcelona became noticeably irritated and dismissive when I asked him about it, arguing that a particular brand of Catalan feminism had done women a disservice by creating the impression that they *should* do things alone, rather than that they can do anything men could do, but that sometimes this requires help and support (as it would for anyone). Other clinic workers and feminist activists linked this apparently cultural/feminist valuation of independence to increasing neoliberalism, and saw it as a misguided emphasis on individualism that serves capitalism, but hurts women’s ability to get the support they need and deserve.

Workers at the Youth Center were in fact quite amused and pleased that I picked up on the “superwoman complex,” and said it often comes up in their work with teens and young women. Specifically, several Youth Center workers who do pregnancy testing and abortion referrals for Catalan and immigrant teens and women in their early 20s described how one of the first things they do in a counseling session is to evaluate with a young woman whether there is anyone she can tell, or who might be able to support her. They actually track the numbers of women who arrive alone versus accompanied for pregnancy verification appointments, noting that in one recent year, more than 30% of young women coming in for a pregnancy test came without anyone else. The Youth Center and Family Planning Organization staff actively work to counter some aspects of the “superwoman” ideal, which they accept as a cultural ideal but see as potentially harmful. They respond to it by directly telling young women that while they *can*, perhaps, do anything alone, they indeed *deserve* support, and may find it easier to identify and mobilize it than they think.

Ariadna, the clinic receptionist, spontaneously described this phenomenon when discussing differences between immigrant women and Catalan women who come to the clinic. She stated Catalan women are “proud” to be “self-sufficient” and try to handle
everything alone. Within the Today Clinic, everyone agreed that the “superwoman” complex is likely a trickle-down effect of both the post-Franco backlash against totalitarian, patriarchal rule, and the increasing Catalan embrace of feminist independent thought. My friend who first related it to Catalan industrialism and post-Franco feminism also proposed Foucauldian explanations, and suggested that perhaps young Catalan women, and women who have been here long enough to soak up the Catalan values of self-sufficiency, common sense (seny), and pragmatism, utilize a conviction that they are “superwomen” who can do anything as a subconscious rejection of the observation and control of their bodies represented by abortion restrictions and bureaucratic constraints.

If nothing else, this abortion rights’ advocate’s explanation reinforces my earlier assertions that the average Catalan, and in fact most people I met, think explicitly about political theory and economic shifts, as they relate to everyday life. Be that as it may, women seeking abortion who did not encounter the support they wanted from others instead looked to themselves, and found strength in that. Whether feeling they are “superwomen” objectively helps women resolve logistical problems, the extent to which it keeps them from asking for help with childcare, transportation, or accompaniment at the clinic, is a thornier issue. It was clear to me from interviews that some women who chose to attempt to overcome obstacles alone might actually have been able to do so more easily had they been willing to accept proffered support from people who could provide practical, logistical assistance.

Most women who described adopting the “superwoman” strategy to deal with obstacles explicitly mentioned that people in their lives (sisters, friends, partners) knew about their efforts to obtain an abortion, were in support of it (or at least did not outright oppose it), and offered to accompany them or help in other ways. Even so, these women decided not to ask people for any kind of help. As Mari said, “I went alone, it was not necessary for anyone to accompany me, I did not want anyone to go with me, anyway.” Mari even chose to forgo
twilight sedation (a combination of narcotic and sedative drugs given intravenously), in favor of only a paracervical block with local anesthetic, so that she could receive care without having an accompanier on site (an option only in the first trimester at the Today Clinic).

This sort of response suggested to me that the desire to be a “superwoman” was not a response to stigma or isolation, but rather an attempt to proactively and symbolically head off the need to ask for any help, even when such help might have been, well, helpful. Moreover, multiple women mentioned the “superwoman complex” as both an obstacle to obtaining the care they needed (insofar as it kept them from asking for needed help), but also as something that helped them overcome obstacles (by giving them the determination to just keep trying until it worked out). Almost a third of women I interviewed mentioned the “superwoman” concept explicitly, or talked more generally about the sentiments behind it, and fully 36% of women I interviewed said that a sense of determination to handle things alone and ‘do what they had to do,’ helped them overcome other obstacles. Ten percent of clinic and NGO staff shared this perception that a woman could overcome obstacles through sheer determination and independence. As stated above, 9% of women I interviewed saw their sense of needing to handle things alone and not ask for help as an obstacle, while 10% of clinic and NGO staff saw it this way.

Some women who talked about “just figuring it out” alone related this tendency to La Crisis, demonstrating again that an awareness of the political-economic situation, and a broad interest in autonomy and independence in the context of growing support for Catalunya’s full separation from Spain, pervaded everyday decisions and conversations locally. Two women in particular, “Superwoman” herself, and the underemployed Catalan with one child, Carla, each brought up the “Superwoman complex” in relation to La Crisis. Perhaps women in Catalunya (and even in Spain or Europe more broadly) unconsciously responded to macro-level economic and political threats related to La Crisis and austerity by seeking to assert
their own agency and authority at the micro-level, in their own lives and uteruses. In this reading, we can imagine that women who ascribed to the “superwoman” approach to overcoming obstacles to care—perhaps thinking, “I don’t need a man, or anyone, to help me figure this out. I can do it myself” as a way of explicitly or subconsciously rejecting feelings of helplessness and dependence in the face of economic and political uncertainty on a grand scale.

Along with both echoing the “better to have one child and care for them well, than have two that suffer” trope I discuss further below, the women mentioned above described their “superwoman” orientation as a response to realizing that the person they most wanted to go with them to the clinic could not afford to take time off work or was not sufficiently supportive, and/or as a way of dealing with their own reluctance to ask someone to take time off and potentially risk a precious job in the midst of economic instability. Carla exemplified this in our interview, relating her husband’s (low) income, their precarious financial situation, and their reliance on their aging mothers to care for the child they already have while they work, to a repetition of the “I’d rather have one and care for him well than have two that go through penury” theme. She went on to say that these reasons were also why she did not want her husband to take a day off work to go with her to the clinic, and that she’d be “fine” going alone (and not having anasthesia). Thus, Carla united the ideas that La Crisis meant it was not a good time to have another child, and that her husband should not risk taking a day off work from a job they desperately needed him to keep, merely to accompany her to the clinic. She claimed a sense of independence and self-confidence that she would be okay if she went to the clinic alone.

Simply put, some women who thought they would not receive support, the right kind of support, or who felt the person they would like to ask for support could not afford to be put in that situation, avoided dealing with a need for social support by deciding to handle things
alone. Women who needed and wanted support, but lacked it, chose to see themselves as capable of overcoming obstacles alone, reframing a lack of support as an opportunity to affirm their own will and determination, particularly in the difficult economic time that they felt necessitated the abortion. Ultimately, I argue that for a combination of political, cultural, and economic reasons, women in Catalunya often overcame obstacles to abortion access by mobilizing an internal sense of ability and determination, even when this ideal sometimes complicated the process of resolving logistical issues.

Other telling subthemes emerged in interviews with multiple women expressing the same ideas in nearly the same words. These fell into the following categories:

1) a refutation of the abortion rights discourse by claiming that abortion was okay for themselves, but not for other women;
2) a statement of their preference for having one child and caring for it well versus having more children who might suffer;
   and
3) in both examples, a linking of these sentiments to the situation of La Crisis and resource scarcity.

Frequently, the same woman would mention both not believing in abortion, and feeling strongly that she would rather be able to care well for one child, than struggle to support more. As opposed to my research in the U.S., where participants often insist on justifying to me, as both a researcher and clinic worker, why they seek an abortion even if they profess to be opposed to it in principle, the statements of seemingly anti-abortion women I interviewed in Catalunya were more often made in an off-handed, almost casual way, with no venom or attempt at persuasion behind them. In particular, some version of the phrase, “no soy partidaria [del aborto]” meaning literally “I am not a party to abortion” but intended to convey, “I do not agree with abortion,” was casually said, verbatim, by five of the eleven
women I interviewed (45%), but almost always as an after-thought while discussing the economic or relationship reasons motivating their own abortions.

Of the women who said this, Duran was specifically distressed at needing an abortion herself, and would have preferred to carry to term if circumstances permitted. Afrodita was entirely comfortable with her decision to seek abortion but still wanted me to know that she only needed it because she had difficulty finding effective birth control. Montse wanted me to know that she only sought abortion care because the [men] who had gotten her pregnant had a habit of abandoning her upon learning she was pregnant. As described earlier, Leyre felt very conflicted about her own abortion, and repeated the “no soy partidaria” phrase in the context of describing her disappointment over seeking an abortion for a wanted pregnancy, while other women, in her view, ‘casually’ have abortions without ‘realizing the value of children.’

“Superwoman” had ethical doubts about abortion for herself, and also said, “no soy partidaria,” but without seeming to perceive any contradiction, she claimed as part of her identity the particular brand of Catalan feminism that visibly and loudly demands abortion rights. These perplexing parallel and sometimes oppositional beliefs, identities, and actions are fertile ground for future research in the field of reproductive decision-making. These conundrums also come up in research on abortion in the United States, where many women who have an abortion claim to be opposed to it on principle, or identify as part of a religious tradition opposed to abortion (Ostrach & Cheyney n.d., Arthur 2000, Henshaw & Kost 1996). In each case, women in Catalunya did not seem to repeat ostensibly anti-abortion refrains out of malice towards other women who seek abortions, but rather to express their own conviction that they would not have sought an abortion were it not for La Crisis, a birth control failure, or an interpersonal problem. (The possibility that other women seeking abortion care might be in similar circumstances did not seem to occur to them.)
Along the lines of attributing the need for an abortion to dire economic straits, Afrodita, Carla, and Yolanda each uttered some similar variation of the phrase, “prefiero tener una y tenerla bien, que tener dos y que sufren,” literally, “I prefer to have one and have it [care for it] well, than have two that suffer.” As discussed in an earlier chapter, this statement was typically uttered in the context of talking about La Crisis. Each woman described her interest in having children, or having more children, but worried that in her current economic circumstances, a(nother) child would experience economic hardship.

Afrodita and Carla, in particular, shared this sentiment while ranting about the ludicrous and offensive (in their view) idea that male government officials would prohibit women from having an abortion or limit the parameters of the abortion reforms, during a time when so many people cannot afford to pay mortgages, rent, or bills, or buy food. “Superwoman’s” reluctant admission to herself that it did not make sense to have a child while in college and working two jobs was framed in a similar context, though she did not echo the same phrase verbatim. “Superwoman’s” sense of the financial demands of motherhood, evaluated pragmatically in a time of economic crisis, was expressed in a plaintive rhetorical question: “If I have the child, what will it cost me to feed myself, how will I take him to school,[and] make him food?!

The framing of the idea that women use their best judgment to manage resources and decide how many children they can care for in the context of an economic crisis, posed alongside political arguments about the importance of maintaining legal, publicly funded abortion, was refreshingly nuanced, and heartening for me to hear. That women who considered themselves “not in favor of abortion” nonetheless maintained that women, not elected officials, should have the right to decide when and how many children they should have in the face of financial hardship and uncertainty was enlightening, and a stark departure from my experiences in the U.S.
I maintain that such thoughtful remarks hint at an overall high level of political and social awareness and discourse typical of nearly everyone I encountered in Catalunya. It was not only in the clinic or NGO offices, or with women who volunteered to be interviewed about seeking an abortion (arguably a self-selected reflective group) that I heard narratives and analyses about how legal, publicly funded abortion fit into the larger context of Catalan society, resistance to austerity, or to the push for Catalan independence. These conversations popped up around me very naturally in bars, at the synagogue, at neighborhood cafes, with less-political friends, and so on, even when I did not raise the topic or mention my research focus.

Pragmatic decisions about how best to manage with the resources available, both economic and social, framed women’s strategies for dealing with obstacles and delays in the process of seeking publicly funded abortion in Catalunya. Such pragmatism, and traditionally valued Catalan *seny* (common sense) also framed notable larger responses to *La Crisis* and to Catalan independentism, and at the level most proximate to my research, to questions of which pregnancies could be sustained, and what obstacles or risks were faced by those in need of abortion. Even women who had no doubts about their own decision to seek an abortion, and were seemingly unaffected by stigma, evaluated on a practical level what resources they had in terms of who could help them with logistical issues, and who they could count on for support. Many women successfully mobilized social support from partners, friends, and/or family members to meet logistical needs for childcare, transportation, and accompaniment.

Women simultaneously engaged in both systems-correcting and systems-challenging praxis through their persistence in seeking vouchers for care from *CatSalut* (working within the system to get their needs met), while also subtly resisting the civilized oppression they were at risk for from midwives and case workers who ultimately held the power over their
ability to exercise their right to a publicly funded abortion (challenging power structures in the system). Such resistance took the form of women demanding the public coverage of abortion they were legally entitled to, even when they did not know the full extent of their rights, and not giving in to CatSalut’s various forms of benign neglect or overt anti-abortion hostility even when this meant waiting out delays, making repeat visits, or jumping through other bureaucratic hoops. I perceived that women also resisted the symbolic violence of the ever-present threats against the legal status of abortion by seeking care despite the construct threat that it might become illegal at any moment, and by talking openly about their anger that the government was threatening to retract this right.

Women who felt they lacked sufficient social support found other ways to overcome obstacles, sometimes through sheer force of will. In the face of bureaucratic delays and other stumbling blocks, women asserted their agency to respond to various constraints by estimating what emotional and logistical tools and resources were at their disposal, and decided how to proceed accordingly. Despite structural violence in the form of poverty and marginalization, despite civilized oppression in the figures of deliberately misleading or simply careless health system workers, and despite the symbolic violence evident in the larger backdrop of threats to the abortion laws and the specter of health care cuts, women in Catalunya who successfully made it to the Today Clinic and had a publicly funded, legal abortion had usually overcome multiple obstacles to obtain care.
Chapter Four: ¿I ara que? (And now what?) -- Conclusions and Recommendations

“The most vulnerable women are the most affected by obstacles.”
- “Carolina,” director of a reproductive health center for 20 years

Structural factors in the health system in Catalunya made the process of obtaining a legal and publicly funded abortion difficult for many women. My research identified a clear disconnect between policy and practice within the health system. To reiterate one glaring example, nearly half of all women who participated in my research were not aware the CatSalut voucher they had already obtained would fully pay for their abortion. Like two parallel elevators going to two different floors, one traveling upward and one traveling down, practical access to abortion care in the Catalan public health system began to deteriorate, in part due to austerity cuts and bureaucratic/structural failings, even as policy changes that expanded legal access to abortion in Spain and Catalunya increased women’s right to seek such care. Even apart from the coverage cuts in health care system that ramped up in August 2012, women and providers described difficulties within the health system that had already been affecting how quickly and easily women could navigate the process to get publicly funded care. As the project coordinator of the women’s health NGO who helped draft the reform legislation, Greta-Maria, said,

*When a woman wants to access an abortion, here in Catalunya after the law change[s] in 2010, many things have certainly improved, but also it’s true that we [sic] have created a protocol, a path, a course of obstacles that is even longer for women, that, well, in some way can make access more difficult, no?*

The evident catch-22 of identifying new and different obstacles to care that resulted from the positive move of including legal abortion in a public health system is thus a cautionary tale for reproductive justice and public health advocates anywhere seeking to
include a full spectrum of needed reproductive health services, including abortion, in both new and reformed health systems. Including the procedure in an existing health care framework did not ensure access for all women, nor preclude the possibility that women would continue to be affected by the larger structural forces that shape the landscape of abortion rights and utilization. Even before austerity cuts resulted in changes to coverage eligibility within the Catalan health system, apparent anti-abortion sentiments among some health system workers, or simply institutional misinformation and disorganization, already delayed some women from getting care as easily as they should have been able to under the new laws and policies.

*Progressing from encountering obstacles to engaging in forms of resistance to overcome them*

As shown in Figure 1 below, any woman’s process of seeking a legal, publicly funded abortion care in Catalunya began within a macro-level layer of multiple political-economic contexts. These included the 2010 legal reforms, *La Crisis* and resulting austerity cuts, anti-abortion threats from the Spanish government in Madrid, and the backdrop of Catalan independentism. Several of these contexts influenced the next macro and micro levels faced by women, including the public health system and contracted clinics. Another level of potential obstacles, and ways to confront and overcome barriers, was posed by the social support and resources needed by and available to women, including for meeting logistical needs such as childcare, travel, accompaniment, and the costs of time off work. Within the same micro-level where women assessed what they needed to be able to get a voucher for care and get to the clinic, they also evaluated the resources they could draw on, including moral/social support, and practical logistical help.
Beyond making pragmatic assessments of what it would take to get care, and how to accomplish this, women also engaged in multiple, often combined, forms of resistance to threats to the status of legal abortion, to social inequality exacerbated by the crisis, to civilized oppression in the health system, and to a lack of social support or a reluctance to ask for help (when this affected them). The combination of ways that women responded to the macro and micro level contexts and obstacles that determined abortion accessibility in the Catalan health system thus comprise both systems-correcting and systems-challenging praxis, and illustrate once again the persistence women in this study displayed when seeking care.

While a simplistic figure cannot capture all the nuances, each of the various categories and levels of potential obstacles and ways of overcoming them depicted also overlapped and intersected in a myriad of different combinations.

*Figure 1, Macro-level and micro-level forces and factors in women's experiences of the process of obtaining publicly funded abortion care in the Catalan health system*
As seen in this study, when policies change, even as a result of systems-challenging praxis, the resulting change is not the endpoint of a process, but rather the beginning. On-going training, implementation, and evaluation are needed to achieve the intended effects of any policy change. Expanding the legal right to seek abortion care did not automatically or necessarily make it easier, on a practical level, for women in Catalunya and Spain to access such care. Nor did the resulting inclusion of abortion care in the covered services of public health systems guarantee that all eligible women would benefit from such coverage. As with research on abortion and other reproductive health care access within state Medicaid programs in the United States (Ostrach & Cheyney n.d., Kiley et al. 2010, Salganicoff & Delbanco 1998), we know that policies on paper do not always translate into improved access to services.

Does this mean that changing policy in ways that adjust or reform existing systems is not beneficial? Of course not. Rather it means that reforms to existing systems are not enough. Short of changing the entire health and policy contexts to dismantle and then rebuilding needed health systems, efforts to make existing systems more equitable and accessible must continually take into account persistent, seemingly intractable flaws that require adjustment and reform. Even so, the particular combination of policy changes, economic and political shifts, and realities of care provision that produced the situation I studied did indeed create a situation, that, for that historical moment, allowed many women to access legal, publicly funded abortion care even while navigating delays and difficulties. While by no means perfect, the landscape of abortion access in Catalunya as it existed while I was there, was far preferable for women’s rights and for public health, than the severely restricted condition now sought by the PP government.

Women affected by disconnects between policy and practice in health care demonstrated their agency in the face of structural constraints by mobilizing support that
helped them challenge and overcome bureaucratic delays and social pressures. While the 2010 legal reforms that paved the way for expanded access to abortion in Catalunya and Spain grew out of a grassroots, feminist-led, community organizing effort to challenge existing power structures, the resulting top-down bureaucratic policy shifts that rolled abortion services into public health coverage from 2010 through at least 2013 nonetheless created contexts in which individual women encountered delays and difficulties that they had to take a “reformist” (Singer 1986) approach to resolving. This meant that, in the Catalan health system, when women did “whatever they had to do” to obtain publicly funded, legal abortion services, their efforts constituted an attempt to reform, or “correct,” an already-corrected system -- one that had been previously altered from the top down.

Rather than an organized effort to collectively challenge or fundamentally change a monolithic flawed system from the bottom up, women in Catalunya instead resisted inequalities in the health system in the wake of policy changes that had, on one side, already been designed to make abortion more accessible, while also being forced to grapple with more recent policy changes from another side that made the health system itself less accessible to some groups of women. Balancing these shifting sands, and benefitting from expanded access to abortion care in some aspects while struggling with reduced access to overall health care, meant that women faced overlapping, sometimes opposing changes in the legal and health system landscapes. That many women were able to nonetheless engage in either or both systems-challenging and systems-correcting praxis in order to successfully obtain a legal, publicly funded abortion, is a measure of their persistence, and a reminder of women’s worldwide need for abortion.

The reality of abortion access in the wake of policy changes in Catalunya was such that an effective use of systems-challenging praxis (Singer 1986) came first, when a community-based campaign succeeded in the effort to compel legislators to change the legal
landscape of abortion in Spain and Catalunya (Hughes 2011). This was followed by the government-led, bureaucratic implementation approach that produced the setting I explored, in which women were forced to continually engage in individual level systems-correcting praxis (Singer 1986) to truly benefit from the changes wrought by earlier challenges to dominant power structures.

Women’s determination to overcome obstacles and delays in order to successfully obtain abortion care in the Catalan health system constituted a challenge to dominant social, political, and bureaucratic discourses about abortion, public benefits, and stigma. Women who persistently sought out health system staff and held them accountable, in visit after visit to public health facilities, until they ultimately obtained the paperwork required to seek publicly funded abortion care at a contracted clinic, viewed their dogged efforts as simply what ‘needed to be done.’ Applying concepts from CMA, particularly considering how marginalized people may unconsciously answer the call to demystify and challenge power inequalities within health systems and in health system-related interactions, I argue the responses of women in Catalunya to bureaucratic delays and difficulties with CatSalut represent a blend of both systems-correcting and systems-challenging praxis. Women who participated in this study, and those who supported them, implicitly challenged dominant social expectations related to women’s idealized roles as self-sacrificing mothers and nurturers (set up in opposition to the stereotype of a irresponsible woman who would abort) and abortion-related stigma, through their determination to continue seeking care until they succeeded.

Given the limitation of this study that participants were only recruited through an abortion clinic, thus skewing the samples towards women who indeed succeeded in getting an abortion, my findings nonetheless suggest that even the most persistent, or best-supported, women may still encounter obstacles to care. As for women who faced so many obstacles or
delays that they never even made it to the clinic, we can, based on this data, only speculate on
their experiences. Luckily, the wonderful research being conducted through the Turnaway
Study at the University of California-San Francisco (Newitz 2012) , to determine the long-
term effects on women and their resulting children when a woman is denied a wanted
abortion (due to gestational limits and other restrictions), will soon be expanded outside of
the United States. Within a few years, there may be more data available on the experiences of
women, in places like Catalunya, who want an abortion and are ultimately unable to get one.

For women in my study who asked for help from members of their social networks to
overcome logistical obstacles, this also represented a challenge to the low but detectable
levels of abortion stigma represented by the misinformation propagated by CatSalut staff. Women mobilized the support they needed to help navigate the process of seeking care,
seeking and receiving both practical and moral support. Alternatively, some women resisted
social expectations about the need for social support during a difficult time, or overcame a
lack of perceived social support, by seeing themselves as “superwomen” who could bypass
various obstacles through sheer force of will and perseverance.

Within women’s overlapping responses to intersecting systemic and social obstacles,
the practical choice to repeatedly ask for what they needed from representatives of a
bureaucratic system typified their attempts to work within a flawed system and ‘reform’ it by
insisting that health system workers do their job of filling out the required forms, even when
it took longer than it should according to policy. I do not suggest that women in Catalunya
knowingly or deliberately set out to either challenge or reform the Catalan health system, the
Spanish legal system, or dominant cultural ideas about abortion, but rather that the ways
women asserted their agency in the face of delays and obstacles to abortion care functioned
as both challenges to, and reforms of, the health system as it existed and implemented
policies related to abortion. It could be argued that this form of persistence/resistance
constitutes a variation of a “weapons of the weak” (Scott 2008) approach to responding to inequality or injustice from below. However, given that all women in Catalunya ostensibly [have] had the right to access public health care, it is likely that at least some of the women who faced delays and frustrations using the health system for abortion may not have been particularly socially ‘weak,’ or without resources, but rather were at the mercy of constantly shifting policy changes that left everyone unsure what their rights were, or how to exercise them. To the extent that women in Catalunya were acting from a place of ‘weakness,’ and challenging a powerful government hierarchy in order to obtain care, their strength was that they had both a legal right to abortion, and the right of all established residents, to health care.

This interplay of women’s overt challenges and subtle reforms to power structures, bureaucracy, and social expectations occurred in the context of economic crisis, growing doubts about the sustainability of capitalism, and ever-louder calls for Catalunya’s full separation from Spain. What each of these elements had directly to do with individual women’s experiences of seeking an abortion in the public health system varied. In addition to the individual extent of the impact of micro-level factors, La Crisis and the threat and/or impact of austerity played the most discernible roles in the greatest number of women’s discourses. But elements of each of the larger political-economic contexts and of the more immediate layers of health system, social support, and personal resource levels, also emerged as powerful themes in interviews and participant-observation with women seeking care, and in conversations with clinic and NGO staff.

Within medical anthropology, a CMA perspective directs our attention to the nature and causes of inequality in social systems, and how institutional structures produce and perpetuate specific forms of health inequities. Disparities in the Catalan health system most dramatically affected women who were farther in gestation, and likely also poor and immigrant women. Across the board, women who succeeded in obtaining publicly funded
abortion care dealt with the need to obtain a CatSalut voucher for care, often with accompanying delays and confusion that emerged in interactions with health system workers. Women also had to figure out some or all of the following: taking time off work or school, making travel arrangements and covering associated costs, scheduling appointments around other responsibilities, finding childcare, and identifying an accompanier who could go with them. Although these factors often produced delays, difficulties, frustrations, and stress, women reported that they mobilized social support to help overcome logistical obstacles, and in many cases, felt that such support (or a determination to figure it out alone) helped them deal with any and all obstacles. Women’s persistence in obtaining vouchers, even when this required multiple visits and delays that violated CatSalut’s own policies, was a specific form of systems-correcting praxis in which marginalized women seeking health coverage in an unequal power relationship worked within the [health] system to get what they needed, resisting civilized oppression.

I propose that many women also simultaneously engaged in systems-challenging praxis, resisting both structural and symbolic violence, by speaking openly and critically about La Crisis, austerity, and threats to the abortion laws. In this way, women ‘unmasked’ larger structural forces shaping their lives, and demystified for themselves the process of seeking abortion care in a particular political-economic context, by ‘speaking truth to power’ and openly telling me the stories of their efforts to use the rights and services to which they were entitled. Hahn (1996:75) exhorted medical anthropologists, “Where injustice and inequity prevail, scholars must strive not to rationalize the system...but to unmask and remake it.” As would-be health care recipients (rather than as scholars), women in my study implicitly undertook Hahn’s directive to reveal and question inequality and injustice, by refusing to keep silent or view the frustrations they experienced in the process of seeking care as something inevitable or of their own making.
Though women’s venting and comments to me in interviews may not have directly challenged the power structures inherent in *CatSalut* as it currently exists, or always explicitly critiqued the Spanish ruling party that many in the wider region hold responsible for the effects of austerity cuts, women’s commitment to talking about their experiences, and lending their perspectives to applied research that is already being used by advocates and stakeholders to push for better implementation and equality in the existing policies, contributes an important piece to the resistance puzzle. Without these women’s stories, and the survey measurements of their experiences, there is little that the association of clinics or the Family Planning Organization could do to demand better training of *CatSalut* employees, lobby for a renewed quota for clinic-based second-trimester services, or simply defend the need for legal abortion. Creating spaces for women’s voices to be heard, and women’s embracing of this opportunity, implicitly challenged some of the inequality in the health system and the policies affecting it.

In the same way, ongoing popular protests of the proposed law change will and do continue to challenge the unjust and dangerous possibility that women in Catalunya and Spain will shortly be relegated again to seeking clandestine, unsafe, illegal abortion or paying exorbitant fees to travel to England or elsewhere to seek care. The Family Planning Organization who helped organize and host my research are actively involved in the current campaigns to mobilize and coordinate local, regional, national, Europe-wide, and international calls to protect and maintain legal abortion in Catalunya and Spain. Just in the few months since Gallardon announced the change to the law likely to go into imminent effect as of this writing, thousands of protesters have already marched in Madrid, Barcelona, small outlying towns all over Spain, and in solidarity marches in London, Ireland, Scotland, Rumania, Puerto Rico, Mexico City, Paris, Italy, and elsewhere. Italian feminist organizers reached out to the Family Planning Organization, offering to help organize a Europe-wide
action that occurred in February, with tens of thousands of feminist activists and supporters from all over Europe converging in Madrid for massive protests.

Particularly moving for me, as I continue to get word of all this from friends and participants still in Barcelona, were photographs of women in El Salvador who quickly organized a solidarity protest in front of the Spanish consulate in the capital, San Salvador. In El Salvador, a country where a woman can be sent to jail merely for seeking an abortion (Jacobson 2013), brave solidarity activists stood up for the reproductive rights of women half a world away, rights they themselves lack even under a Leftist government.31

Meanwhile, cracks are appearing in the PP’s heretofore monolithic control of the Spanish government – ‘the Gallardon law’ is being blamed in both Spanish and international presses for growing splits in the PP leadership, and for the Socialists’ unexpected advance in national polls ahead of 2015 elections (Reuters 2014, Ross-Thomas 2014, The Local 2013). It may be that the unpopularity of the current move to make abortion almost entirely illegal will be enough to unseat the PP in the next electoral phase. The same news reports mentioned recent polls showing that, in the wake of Gallardon’s announcement, fully 80% of Spaniards surveyed profess to support legal abortion, and 86% believe the decision should be left between a woman and her doctor (Reuters 2014). This constitutes a significant apparent increase in support for abortion rights over past polls (Bruni 2011).

Some analysts characterized Gallardon and Rajoy’s earlier announcements of plans overturn legal abortion in Spain as part of a broader “conservative counter-revolutionary attack” that exploited La Crisis as an opportunity to roll back a wide swathe of civil and human rights (Carnicero 2013). This take on things in particular interrogates Gallardon’s

31 All of these examples of popular responses come from my personal correspondence, sometimes explicitly intended to be confidential or anonymous. As such, I am not citing each example individually.
infamous 2013 sound-bite in which he described legal abortion as a form of “structural violence, gender violence, against women” (Carnicero 2013:1). Gallardon’s attempt to co-opt and subvert the very language that human rights and women’s health advocates use to demand access to safe, legal abortion to protect women’s lives and agency, while seen by many of my participants and colleagues as deeply cynical and manipulative, was also offensive enough to galvanize some sectors to take a stronger stance in support of abortion rights in Catalunya and Spain.

As my contacts and dear friends in Barcelona confront the current attempts by the Spanish government to overturn the 2010 abortion reforms (El Pais 2013), women’s narratives about managing their limited resources, and their motivation to seek abortion in the context of economic crisis, paint a compelling picture of the devastation that may be wrought if Justice Minister Gallardon or subsequent office holders succeed in efforts to make abortion illegal in almost all circumstances, as appears likely. If women already affected by poverty and economic hardship so eloquently described their need for legal, publicly funded abortion, what will become of women in just as dire economic straits, just as affected by social inequality, soon to face abortion illegality and very likely pushed to seek unsafe, clandestine care? Gallardon’s planned draconian reversal of women’s rights, if successful, will do nothing to improve the economic realities that motivate many women to seek abortion. Rather, it will just set women up to continue to do ‘whatever they have to’ to get an abortion, even if this will soon mean facing legal penalties, unsafe conditions, and serious complications or even death, outcomes that are common where access to safe abortion is denied (Grimes et al. 2006).

In addition, my research identifies for the first time an aspect of Catalan-feminist culture, likely exacerbated by or interacting with La Crisis, that caused some women to feel they wanted to face the process of seeking abortion care alone, not because of stigma or a
lack of perceived support, but because they placed a high value on being a “superwoman” who could solve her own problems. Some women derived a sense of strength from feeling they could overcome obstacles without seeking or accepting proffered help, thus challenging institutionalized gender roles and assumptions about women’s need for emotional support or potential fragility in times of difficulty. However, not wanting to ask for or accept support also complicated some women’s willingness to solicit concrete forms of assistance that might actually have helped them overcome logistical obstacles more easily. How will the “superwoman complex” shape responses to the overturning of legal abortion, if or when this occurs? Future research on health care access in Catalunya, particularly with young women, should explore the “superwoman complex” in light of health care utilization, and the extent to which it represents a form of systems-challenging praxis, in greater detail.

La Crisis and structural inequality

Nearly half of women I interviewed cited La Crisis as a factor in their decision to seek abortion care, while more than 60% of clinic and NGO staff mentioned La Crisis and resulting health care cuts. The majority of women who completed surveys for my study reported an income that placed them below the poverty level, with at least a quarter reporting no income of their own whatsoever. Nearly a quarter of survey respondents, and half of women I interviewed, were immigrants: vulnerable to social and economic marginalization. The larger backdrop of an economic crisis, its ongoing fall-out, and resulting cuts to social services (including health care) directly affected some women’s ability to use the health system to obtain legal, publicly funded abortion care. A much larger pool of women in need of abortion were likely affected by an awareness of looming health care cuts and the pervasive threats to the 2010 abortion reforms, as evident in many women’s surprise and
relief at learning that the health system would in fact pay for legal abortion care, with proper vouchers from *CatSalut*, at least at that time.

Structural violence was a factor in poor and immigrant women’s ability to gain access to publicly funded abortion in the wake of policy changes that expanded legal access to abortion in Catalunya, a truth perhaps so predictable and obvious that it becomes hard to see without stepping back to look at the larger contexts. We know that women in poverty, immigrants, and other marginalized populations fundamentally affected by structural violence in every aspect of their lives are more likely to need/seek abortion care, more likely to encounter barriers to abortion, and the particular poverty among participants in my study confirms this. While in the case of Catalunya structural violence did not, perhaps, directly result in most women being without access to health care thanks to the existence (for now) of a universal health system, the delays and difficulties particular to obtaining an abortion funded by the public health system disproportionately affected poor women and immigrants.

Moreover, the fact of continued gender inequality, as a form of structural violence, neatly and horribly overlaps with structural inequalities resulting from poverty, as poor *women* are most likely to need an abortion. Individuals in this study for whom structural violence luckily did not mean *no* health care, nonetheless needed a particular kind of care that is more heavily stigmatized and requires that more hoops be jumped through, based solely on the biological accident of being born female (and thus able to become pregnant). I also maintain that political and practical threats to women’s access to safe abortion are violations of human rights (Margolin 2007), and as such, function as particularly insidious forms of structural violence that limits women’s human and civil rights while also endangering their health and lives. Finally, if the abortion reforms are indeed overturned, as appears likely, this will constitute an accelerated form of structural violence, further constraining women’s options, health, and safety.
The overwhelming specters of increasing poverty and unemployment, and diminishing social safety nets, shaped women’s decision-making about whether to seek an abortion when facing an unplanned pregnancy. The emphasis on poverty and precarious employment prospects affecting women and their partners and families, emblematic in women’s comments about *La Crisis*, demonstrate the constant felt impacts of structural violence in the lives of women and communities who rely on the public health system. Clinic staff occasionally observed that problems with the health system were only problems for poor women, as “*anyone who can afford to, buys private [supplementary] insurance ... and goes to the other [private] hospitals.*”

In fact, many workers who had access to private insurance through *mutuas* (collective insurance plans that supplement the public system, and that, according to clinic staff, are estimated to cover 75% of working Spaniards prior to *La Crisis*) lost this coverage as they lost their jobs, thanks to *La Crisis*. This meant even some previously middle-class families who might not have sought vouchers for abortion care at a *CatSalut* center, rather than seeking private care, now saw no other option. A political-economic context in which decisions about family size are shaped by an economic crisis that permeates the national psyche, and options for managing limited resources become dependent on navigating a potentially oppressive bureaucratic system and jumping through hoops, reflects the pervasiveness (and invisibility) of structural violence in various institutions of the state and society. Moreover, the extent to which national health policies and health bureaucracies can perpetuate structural violence (Singer & Castro 2004) and pave the way for both civilized oppression and symbolic violence in interactions between health system workers and health care recipients illustrates that even the comparatively fortunate women of Catalunya who indeed (perhaps only briefly) had the right to legal, publicly funded abortion nevertheless struggled to overcome structural obstacles in order to use it.
What do systems have to do with it?

Health policy may reproduce structural violence... As a result, health-related policies, which have the ostensive goal of improving and protecting the health of the general public or sectors thereof, may, in their service of other masters, harm rather than enhance public health. (Singer & Castro 2004:xiii-xiv)

Health system funding and coverage cuts resulting from crisis-related austerity measures enacted in August 2012 set the stage for immigrant women and others in need of CatSalut coverage for the first time because of pregnancy to experience coverage delays, waiting periods, initial two-tier care, and potential confusion. In addition, I suspect these cuts may have been a driving factor behind CatSalut’s rough-shod approach to restructuring the quota system for contracted clinics. If CatSalut administrators thought that having more clinics provide fewer procedures each would enable more women to obtain earlier, (perhaps cheaper) care, this move to redistribute the quotas could have been a sincere attempt to be in compliance with new laws and policies dictating public funding of legal abortion, while also maintaining control over when, where, and how many women could obtain what type of care. As such, it represented a clear form of bureaucratic control over women’s bodies and options, if not outright civilized oppression. A more cynical interpretation could be that CatSalut deliberately reassigned the bulk of quotas from (the) clinic(s) that provided later care, to instead push women in need of second-trimester abortion to go to hospitals where the staff is already funded (and where fewer abortions will be approved), rather than paying for such care on a per-procedure basis.

A similar calculation could explain the redistribution of contracted clinic quotas for earlier procedures, if CatSalut intentionally reduced the procedures that each clinic could offer in order to make it more likely some women would choose to have a medication abortion at their main health centers (after learning the contracted clinic of their preference
would no longer be able to accept vouchers). In a perhaps well-intentioned, but apparently short-sighted, attempt to make more clinics accessible for women, CatSalut’s implementation of their own new policies in the face of austerity in all likelihood reduced access to second trimester abortion for women in Catalunya.

However determinations are made regarding CatSalut’s response to austerity-related funding cuts, Prime Minister Rajoy’s demands that healthcare to immigrants be cut, and new policies dictating provision of legal abortion care through a voucher system, the impacts on women in the region remind us that a health system that exists within a capitalistic, and structurally unequal context necessarily reproduces and reinforces that inequality. As Critical Medical Anthropologists, as analysts and activists, we “strive to contribute to the larger effort to create a new health system...” (Baer et al. 2003: 51). As Baer, Singer, and Susser wrote, “This system will not promote the narrow interests of a small, privileged sector of society. Its creation requires a radical transformation of existing economic relationships” (2003:51).

A public health system that operates in a nation committed to guaranteeing at least some level of coverage to all residents clearly does not serve only the privileged, but in the example of CatSalut, its existence in the context of global capitalism, widespread social inequality, and apparent reluctance on the part of some health system workers to make abortion easily accessible, confirms the idea that even public health systems reproduce inequality. To fully fix CatSalut and make it meet the health care needs of everyone in Catalunya, without exposing immigrants or other populations to more obstacles or delays, will require not only protecting it from both further austerity cuts and anti-abortion threats, but would also necessitate a “radical transformation” of existing power and economic relationships within the CatSalut administration. Such a shift would be needed within the Catalan Health Department and social security bureaucracy that oversees it, within the Catalan government that sets progressive policies for health coverage from above (but does
not ensure they reach all the way down to recipients), and ultimately, a showdown with, or separation from, the current conservative, pro-capitalist, anti-woman Spanish government in Madrid. This highlights the reality that while governments can offer and guarantee social welfare benefits such as universal health coverage to all citizens or residents, it is all too often left up to the efforts and determination of individuals to succeed in using such coverage.

What does a ‘right’ to health care mean, when access is predicated on ability to jump through hoops, be assertive, challenge power inequalities, and resist civilized oppression? This is a question Catalans and immigrant women who sought publicly funded abortion through a dysfunctional or deliberately oppressive health system may well have pondered.

That CatSalut produced unnecessary delays and difficulties for women seeking abortion care in Catalunya was evident for health care providers, recipients, and reproductive health advocates in Catalunya, and to me as a researcher. That the solution to such obstacles in a public health system lies not only in policy but also in larger social and political struggles, is also clear to everyone involved, from women who had navigated the system to obtain care, to doctors and NGO directors who have worked in the field for more than forty years. I heard social activists in Barcelona say, “nada se gana sin pelear” (“nothing is won without a fight”). Catalunya’s fight to protect and maintain health care, and legal abortion, for all will eventually have to confront and struggle with the realities of structural violence and inequality, civilized oppression, symbolic violence, and the larger systems and policies that reproduce and perpetuate each of these.

Symbolic violence: threats to abortion laws

Almost half of women mentioned the then-current threats to the reformed abortion laws in interviews, as did nearly three-quarters of clinic and NGO staff. Eighty percent of
Catalan women talked about this, suggesting a greater awareness of, or interest in, local politics among this population. The reality that so many women who did successfully obtain care were unsure of the current legal status of abortion, or scared of it changing at any moment, suggests political threats to legal abortion may have shaped many women’s perceptions of abortion accessibility. Whether political rhetoric measurably produced actual obstacles, or primarily functioned as a form of symbolic violence making women and providers scared of what could happen in the future, such political grandstanding certainly at least served to create confusion and anxiety. In CMA terms, the ever-changing nature of threats to legal abortion in Spain and Catalunya did the opposite of demystifying and democratizing women’s legal and social rights. Rather, such threats reinforced women’s marginalized social position, and doubly so for immigrant women especially vulnerable to health system cuts.

As an extension of this symbolic violence, the constant reiteration of their intention to overturn the abortion laws at some undetermined moment in the future also served to allow Prime Minister Rajoy and Justice Minister Gallardon to distract the populace from ever-louder protests against austerity, the banks, and the crisis of capitalism. The Spanish government’s earlier moving-target approach to overturning the abortion reforms -- in which they announced new plans to do so every six weeks or two months, conveniently timed in national news cycles soon before or soon after the latest general strike, anti-bank protests, or austerity measure imposition -- struck many as a thinly veiled attempt to remind women and the Left who was really in charge.

In multiple interviews, women who navigated the health system to access abortion described their anxieties about La Crisis, threats to the abortion laws, and cuts to the health system nearly in the same breath, and frequently in closely related discourses. In this way, the structural violence of austerity (and by extension, of La Crisis and the crisis of
capitalism), was tied to the symbolic violence of threats to the abortion laws. Civilized oppression was often expressed in the deliberate misinformation or delays that women navigating the health system were subjected to, and in careless failures to properly inform some women of their options and provide them vouchers in a timely manner. This was possibly a symptom or side effect of the years of cuts to the health system under austerity, of how threats to the legal status of abortion may have been reflected in health system workers’ (lack of) awareness of women’s actual rights to care, or some workers’ unwillingness to facilitate the exercising of such rights while they last(ed).

Unquestionably, the tangible precariousness of abortion rights in Spain and Catalunya is greater and more dangerous as of this writing than it has been at any time since the planned reforms were announced by the then-Socialist government in early 2010. On December 20th, 2013, Justice Minister Gallardon announced the implementation of a new law to go into effect, pending a Congressional vote to take place any day as of this writing. The new law, expected to be approved, will make abortion illegal except in cases of fetal malformations incompatible with life, in cases of rape where a formal police report was made prior to confirmation of the pregnancy, and only in the first twelve weeks of pregnancy in either case (El Pais 2013). This step backward in women’s rights and health is an unprecedented reduction of women’s rights to legal and publicly funded abortion. Legal abortion has not been reduced so dramatically at the national level in this way since Franco himself overturned the Spanish Republic’s legalization of abortion in the late 1930s (Crow 1985).

If and when it is approved by Congress (which none of my contacts in Barcelona feel would be surprising, given the PP’s super-majority), this law will return Spain to having the most restrictive abortion laws since the beginning of democracy in the country, making it a more restrictive setting for abortion rights even than Ireland (Walsh 2013), and only slightly less restrictive than countries such as the Dominican Republic (Mack 2012) and El Salvador
(Jacobson 2013). On a practical level, this means several things: if approved, the new abortion law will eliminate legal and publicly funded abortion on demand in the first trimester, or for reasons of the woman’s physical and mental health or for disfiguring but non-lethal fetal malformations in the second trimester. This will be true in all of Spain, and ostensibly, in Catalunya. What we know all too well is that countries with the most restrictive abortion laws also suffer the highest rates of morbidity and mortality among pregnant women. The Spanish government seems unwilling to acknowledge what the World Health Organization (WHO) reminds every world government -- restricting legal abortion measurably causes harm to women’s, and public, health (WHO 2011). In response to the announcement on December 20th, 2013, that Gallardon planned to overturn the abortion reforms, the Family Planning Organization’s press quoted the Catalan Parliament’s adopted resolution, “[T]he more restrictive the law, the more clandestine abortions there will be, and because of this, more maternal [sic] morbidity and mortality” (Parlament 2013), reiterating the importance of legal abortion to preserving women’s health. Gallardon’s apparently stubborn commitment to ignoring convincing public health findings, supported by the ruling party, is thus provoking a backlash not only from feminists and abortion providers, but even from a larger pool of perinatologists, Ob/Gyns who work with high-risk pregnancies, and other less-traditionally vocal camps (Nosotras Decidimos 2014a; 2014b; 2013, Mujeres.net 2014).

It is possible that, following a loss of legal abortion, women in Spain and Catalunya will be able to do what they did before 2010, and access abortion care if they have the money to pay for private care and can figure out how to say just the right thing to succeed in getting a documented justification to meet the new legal criteria, or can afford to travel outside of Spain to private clinics in England or elsewhere. But Gallardon’s proposed legal language is so much more restrictive than what was in place from 1985-2010, it is hard to imagine how
even the most sympathetic clinic staff would be able to document a lethal malformation in the absence of a formal, technical diagnosis. Remember also that malformations incompatible with viability are almost always diagnosed late in the second trimester of a pregnancy, making the likelihood that any woman would know before 12 weeks gestation that her fetus has a malformation incompatible with life almost zero. Moreover, it is nearly impossible to imagine a scenario in which all women would have the presence of mind to report a rape prior to confirming a pregnancy, with the reporting rate for sexual assaults already known to vastly underestimate the actual incidence of such attacks. Women’s access to a necessary medical procedure stands to become immeasurably diminished, in the very near future. No less than the health of women in Spain and Catalunya, and the overall status of women’s rights and reproductive autonomy worldwide, hangs in the balance.

Feminist and women’s health movements in Catalunya are already mobilizing to resist and challenge Gallardon’s move. Within hours of the announcement, thousands of activists and concerned residents gathered in Barcelona and other cities, in front of government buildings and the offices of regional branches of the PP. Within 24 hours, the Campanya pel Dret a l’Avortament Lliure i Gratuit (the Catalunya-based Campaign for the Right to Legal and Free Abortion) released a public statement (Appendix III), declaring, “We will not take one step backward!” The statement goes on to refer to the PP’s proposed, “Law of Protection of the Life of the Conceived and of the Rights of Pregnant Women” as a “project... that assumes that women do not have the right to decide about our own bodies and that we are always victims to be told [what to do], and not the subjects of our own lives.” (Campanya 2013: 1). The Campaign predicted,

[A]bortion will return to being clandestine and... in Catalunya [getting an] abortion will become a pilgrimage from doctor to doctor, but in reality it will not be possible to abort neither in public centers nor private, as you can now (Campanya 2013: 1).

And went on to declare,
Women do and will continue to abort, as we have done always, around the world. And we will launch initiatives to do it in the best possible condition, here or abroad. We count on international networks of feminist support. We count on the involvement of professionals who believe in and implicate themselves in what they do. We count on all and each of us. We will not remain passive in front of this new attack on our right to decide about our bodies and our lives (Campanya 2013: 1).

Looking ahead to how to respond to the proposed attack on safe and legal abortion, the Campaign’s statement reminds us that on September 27th, 2013, a broad and unusually diverse coalition of parties in the Catalan Parliament approved the following:

1) The Parliament of Catalonia agrees to initiate the process for the preparation and development of its own law of sexual and reproductive health rights.
2) The Parliament of Catalonia urges the [Catalan] Government to:
   a. Deploy [enforce] in its entirety, with maximum efficiency and effectiveness, the current law guaranteeing the implementation of legislation in terms of sex education, including contraception and abortion. Provide the necessary resources for public health, to ensure equal access to and exercise of, sexual and reproductive rights.
   b. Fully guarantee that the current law provide for the right to protect the confidentiality and security of women and professionals who [seek/perform] a voluntary interruption of pregnancy [abortion], limiting any attempt by the [Spanish] government to retreat in this matter (Catalan Parliament, as quoted by Campanya 2013, translation mine).

As so many participants did during my fieldwork, the organizers of popular and grassroots responses to Gallardon’s attack on legal abortion now look to an independent, assertive Catalunya to preserve abortion access at least for women there. Confident that the Catalan government will uphold and maintain public health by protecting abortion rights even if Spain overturns the 2010 laws, Catalan feminists once again claim separate ground, and count on a fiercely independent Catalan political leaderships to stand up for women’s rights and health, as promised. The actual ability of the Catalan nation to maintain and continue offering quasi-legal (within Catalunya) and publicly funded abortion if the Spanish Congress approves Gallardon’s law, and presumably in the absence of health system funding from Madrid if they do, remains to be seen.
Then again, if Catalunya does continue to offer abortion either in defiance of new Spanish law, or through some alternative, creative process, it could quickly become a destination for women from all over Spain who may travel there to seek care not available closer to home. If Catalan abortion providers find a way to provide private care to those from Spain (and elsewhere in Europe) who can pay, this may be yet another way to support and maintain an alternate system of abortion provision. The coming years will offer many fascinating opportunities to further study the evolution of this dynamic legislative and popular organizing process.

“Spain is Pain”/¡Independencia ja!

During participant-observation, and in formal conversations and meetings, I heard nearly half of the Today Clinic, Family Planning Organization, and Youth Center workers I worked with, including the directors of each health center and the coordinator of the NGO, discuss the movement for full Catalan independence. Many of these comments took the form of lamenting how an extractive economic relationship with Spain hurts the Catalan state’s ability to continue providing health care to all residents, including immigrants. Even the taxi driver who drove me into the city the day I arrived to begin my fieldwork in Barcelona viewed health coverage for all immigrants as an integral part of Catalan values, and decried Spain’s attempts to dismantle this beneficial system.

The recent cuts to health care for immigrants was seen by most people I interviewed as a particularly troubling sign of the deteriorating state of the Catalan social fabric, and as a strong motivator for fully separating from Spain. The possibility that a fully independent Catalan state in the European Union could provide an avenue to protect legal abortion for women in Catalunya (and other women who would presumably travel there) even if/when Spain does overturn the 2010 abortion reforms, as well as offering a context in which to
restore full health coverage for all, was a distant but very vivid dream for many of us who watched support for independence grow and become more vocal. A sign I saw at multiple rallies for full Catalan independence read, “Retallar Sanitat Mata” (“cutting health services kills”) – such confluences of independentist and anti-austerity sentiment were frequent.

As the continuing push for full independence continues toward a planned referendum in September 2014, the role of universal health care and other social services, immigrants’ rights and inclusion in a fully separate Catalan state, and the fragile status of legal abortion will likely continue to be rallying cries. Whether these priorities will retain and acquire enough sympathy to gain a majority vote and eventual declaration of full independence remains to be seen. How the Spanish state and its allies will respond to any formal moves by Catalunya to fully separate is also an open question.

Already, as of this writing, and eerily echoing both the U.S. Patriot Act and Franco’s extreme measures, the PP government recently enacted a law imposing fines on unauthorized protesters, and threatened to move to fine anyone who speaks negatively about the Spanish government, only a week before announcing Gallardon’s plan to overturn legal abortion. But insofar as a fully independent Catalunya could establish itself with a rejection of structural violence (in the form of unequal rights for immigrants and women) as a guiding principle, the ongoing regional political process may be as important to women’s continuing access to abortion in Catalunya as any legislative ruling in Madrid.

If the Catalunya of the future, as a new state in the European Union, eventually establishes itself with immigrant rights, women’s equality, and preservation of social safety nets as cornerstones (as the democratically elected Catalan National Assembly promises it will), this will no doubt be an important place for medical anthropologists and other social scientists to watch. If Catalunya becomes officially or practically the last bastion of abortion access for all women in Spain, it will occupy a powerfully contested and meaningful site for
reproductive justice, public health, and anthropological and feminist research. Moreover, it will serve as a motivator and reminder for others throughout Spain that change is possible and that the will of the wealthy elite can be resisted.

**Recommendations**

¿*ara que*? Now what? What is to be done with and about these findings? We must consider all of the following questions: What did this mean for *CatSalut*, and for abortion providers in the region? What do these findings mean for abortion access internationally? What does it mean for the inclusion of reproductive health services, including legal and safe abortion, in health care reform efforts worldwide? What are the implications for the status of abortion in other settings where access is threatened, either politically or structurally? What do these data collected during a potentially all-too-brief historical moment of legal abortion in Spain and Catalunya, mean for current and coming struggles to protect abortion legality in the region, and beyond?

In terms of pushing practice back in line with policy, if legal and publicly funded abortion indeed continues in Catalunya, it is imperative that health system administrators identify specifically where persistent delays and difficulties stem from. They must then engage in further training with all workers in the primary health and SRH centers, to address and prevent misinformation, and reduce delays and difficulties that affect vulnerable women. Effectively implementing a comprehensive, consistent system for making needed referrals to abortion providers, across all *CatSalut* centers, would go a long way toward streamlining the process of navigating the health system to obtain care, if such an option remains.

Toward the end of my fieldwork period, and since, I worked with Dr. Barcelona and the Family Planning Organization to share the findings of my study with the Catalan Health Department that oversees *CatSalut*, with the association of Catalan midwives (the
professional organization representing the majority of workers who actually perform pregnancy verifications and fill out vouchers in *CatSalut* centers), with the association of accredited abortion clinics throughout Catalunya and Spain, with the Spanish national family planning organization, and with more than forty other Catalan, Spanish, European, North American, U.S.-based, and international organizations focused on women’s health, abortion safety, reproductive justice, feminism, and public health. Unfortunately, the most immediate response from the Catalan health system representatives who heard these findings at a round-table press conference event in May 2013 was a defensive one, categorically dismissing the idea that their employees inconsistently enforce existing policies related to vouchers and referrals. My understanding is that, as of now, the Family Planning Organization continues to use the results of my study to lobby for policy improvements, and to do more and better outreach to make immigrants and other women aware that *CatSalut* vouchers fully cover abortion services. Most immediately, and until the outcome of the pending congressional vote on Gallardon’s proposed new law is known, the Family Planning Organization plans to continue using my findings on the extent to which social inequality and *La Crisis* motivated women to seek abortion as a point of argument in favor of protecting abortion rights.

To address the importance of social support to women’s ability to overcome obstacles, and to acknowledge the possible effects of the “superwoman complex,” staff at the SRH centers who conduct pregnancy verifications and make abortion referrals, and staff in contracted clinics who schedule appointments, should routinely ask women seeking abortion if they have someone they can talk to about it, refer them to resources for social support (once identified), and advise women that they don’t need to face the process of seeking care alone. This should be done even if the only legal abortion dwindles to become available to women in the most extreme circumstances.
More broadly, efforts to connect pregnant women with resources for social support will become even more important if women are soon forced, again, to seek clandestine abortion through confidential information networks. Making reforms within public health structures that, for now, oversee and provide reproductive health care to women in Catalunya, while not fundamentally changing the power relationships that produce delays and inequalities, would still be necessary to make covered services more available to the few eligible women who may be able to access abortion care even if/when/after most types of care become illegal. Reducing the difficulties and misinformation produced by health system staff through better training, evaluation, and enforcement of existing policy, and further empowering clinic staff to advocate for women seeking care when paperwork is lacking or other obstacles arise, if legal abortion continues, would all go a long way to reduce obstacles to care, and improve women’s overall experience of obtaining legal, publicly funded abortion services in Catalunya.

In the larger global context, the increasing trend toward reproductive governance discussed in the Introduction can be seen in: a) the hundreds of U.S. state-level abortion restrictions enacted over the past several years (AGI 2013b), b) recent successful right-wing efforts to exclude abortion care from the new national health program in the U.S (Cohen 2010), and c) current cases of women dying or nearly dying after being denied medically necessary abortion care in Ireland (Walsh 2013), El Salvador (Jacobson 2013), and the Dominican Republic (Mack 2012); and obviously in, d) the conservative Spanish government’s plan to overturn the legal reforms that expanded access to abortion in Spain and Catalunya. Thus, to focus only narrowly on the particular details of the landscape of abortion access in Catalunya during the time period of my study would be short-sighted. The threats to abortion rights and access to safe care in Catalunya and Spain should be seen as part of
growing global threats to the status of women, and to women’s health, rights, and lives, worldwide.

A creeping expansion of governments’ control over women’s bodies, whether it be in the United States, in Spain and Catalunya, or in South and Central America, now elevates the dangerous possibility of losing reproductive self-governance and reproductive autonomy for all women, everywhere. It is not enough to celebrate, as we recently did, the 41st anniversary of the Roe v. Wade verdict in the United States. With more than two hundred abortion restrictions enacted in the U.S. in 2013 (Rovner 2014), 56% of U.S. women living in a state with at least four types of abortion restrictions (Rovner 2014), and only sixteen states with public funding for abortion (AGI 2013a), U.S. women should view the move to fully overturn the right to legal abortion in Spain as a dramatic cautionary tale.

The voices of women and providers in Catalunya offer valuable lessons for how to preserve and improve abortion access in countries where it is legal, and in health systems that cover it. Their experiences and perspectives suggest what factors may be most critical to ensuring increased access to legal, safe abortion in other parts of the world, where this is lacking. The case of Catalunya shows us that grassroots organizing, as a form of systems-challenging praxis, can result in legislative improvements to the legal status of abortion. But it also shows us that improved legal access means little unless an institutional framework is created to support it – such as the decision to roll abortion care into the existing CatSalut system. This framework for translating a policy change into a practical reality, proposed and supported by the same grassroots coalition of women’s health and reproductive justice organizations that fought to win the 2010 reforms, successfully made legal abortion care more accessible for many women in poverty, at least for now, including immigrants who were able to navigate the health system and endure waiting periods.
Nonetheless, offering such care within an existing institution made it nearly unavoidable that at least some bureaucratic problems would arise or persist. What seems to have been missing from the transitional process of converting policy into practice by including abortion care in the public health system was any process of accountability in terms of ongoing evaluation, training, and enforcement. This should serve as a warning to public health advocates and reproductive justice movements in other countries that already include abortion care in a public health system, including in the sixteen remaining states in the U.S. where Medicaid covers abortion with state funds. Access may not be as good as it appears according to policy, without evaluation and enforcement built in. It should also give reproductive justice and public health advocates food for thought as we plan and craft proposals, strategies, and campaigns to increase or ensure coverage of abortion and other reproductive health services necessary to reduce morbidity and mortality, in various permutations of national, public, and community-based health programs.

If women in an ‘ideal’ situation, i.e., with legal and public health system access to safe abortion care, (with even immigrant women eligible for care after a waiting period), continued to perceive and encounter structural barriers, delays, and obstacles to care, what did “access” really mean? Women in Catalunya expressed gratitude for having the option of obtaining an abortion in the public health system, but nevertheless experienced anxiety about the impact of La Crisis and austerity cuts on the continuing availability of such publicly funded services. Both women and providers vented their frustrations and fears about the then-loomining, now soberingly immediate, threats to the legal status of abortion. Many people in Catalunya, including women’s health advocates, thus view a move towards full independence from Spain as a possible avenue for protecting universal health coverage and legal abortion, indeed, perhaps the only viable avenue. It is worth bearing in mind that broad-based popular
political movements for change may hold some promise for protecting and preserving a wide variety of rights.

Structural violence sets some populations of women up for needing more public assistance with health care and other social services. The most marginalized women are the most in need of public health coverage, but are also the most likely to encounter obstacles when attempting to use it for abortion care. Once they begin to navigate the health system, women seeking abortion care are vulnerable to civilized oppression within the health care bureaucracy – as several participants said, “each step is an obstacle.” Finally, constant awareness of the fragile state of abortion legality in Spain, and, by extension, Catalunya, functioned as a form of symbolic violence that limited women’s sense of security about being able to get the care they needed.

My time in the field and my analysis of the data I collected revealed certain aspects of abortion access specific to Catalunya. Namely, how cultural ideals of pragmatism, seny (common sense), and a sense of needing to be a “superwoman” shaped women’s reactions to unwanted or ill-timed pregnancies, and to the logistical obstacles that arise while seeking abortion, in the context of an economic crisis and austerity. More broadly, and with substantial relevance to larger issues of reproductive health care access, women in Catalunya affected by structural inequality and institutional barriers asserted their agency by mobilizing social support, tenaciously jumping through bureaucratic hoops, and generally doing ‘whatever they had to’ in order to access legal, publicly funded care.

The responses of women in Catalunya to policy changes that, on one level, expanded legal access to abortion, while contracting the practical availability of such care by means of austerity-related cuts to the health system resulting from the crisis, also suggest how women in other situations of economic duress, anywhere in the world, may respond to an ill-timed pregnancy in difficult financial circumstances. Women in Catalunya discussed decision-
making about terminating a pregnancy or carrying it to term in relation to *La Crisis* and austerity -- it is likely that similar or comparable assessments of available resources, and ensuing resource management strategies, are employed by women elsewhere. Similarly, the impact of *La Crisis* on health care coverage and the frightening threats to the continued availability of legal, publicly funded abortion, shaped local reactions to the movement for full Catalan independence, among the communities I studied. If economic and political threats to public health services motivate popular sympathies toward political movements more broadly, be they separatist, nationalist, socialist, or otherwise, this too has broader implications for global politics and the prioritization of health care sectors from policy and funding perspectives.

Ensuring all women’s true and continued access to legal, and thus safe, abortion is critical for improving international public health. Including abortion in public and national health system coverage increases the likelihood that marginalized populations will be able to benefit from legal, safe abortion, though this inclusion by no means guarantees that women will not encounter obstacles and delays. For a public health system to truly safeguard women’s access to a full spectrum of appropriate, necessary, and safe reproductive health care, existing obstacles to care must be addressed at systemic, institutional, policy, and community levels. Women’s strategies for challenging inequalities in health care settings, and for working within systems to get their needs met, must be acknowledged and supported. Finally, women’s experiences in this historical moment of legal, publicly funded abortion in Catalunya reinforce the importance of ensuring real, meaningful access to needed health services, particularly in contexts of social inequality, economic crisis, structural barriers to care, and shifting political sands.
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Nosotras Decidimos

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Chapter One
Pg. 29, Afrodita’s quote about Rajoy:

¡[Interrupción] tiene que ser siempre gratuito! ¡Siempre! Con eso CatSalut no se puede jugar. ¿Como dice Rajoy [Spanish Prime Minister] que abortar un feto malformado no es motivo de aborto, que es eso, porque los dice, no? ¡Eso es algo, entonces si un feto no, no está bien, y eso no es motivo de aborto, que es motivo para aborto, porque madre mía, porque no sea él que tiene que quedar con los niños!? Como él no, como somos las mujeres que nos tenemos que estar con ellos, que bonito decir que un malformado no es ningún problema. Para ellos no, para las madres, sí. Porque yo, sepa, tengo tres amigas que han tenido niños con malformaciones o tal, y lo están, dedican a trabajar, pero han tenido que dejar de trabajar a sus hijos, no hay ayudas, no hay nada. ¿O sea, esa gente, para que la ven, y me digan a mí, que es algo de gracia? ¡Hombre, por favor! ¿Y quién me paga de esta, que alguien viene para la ayuda, quien lo va pagar? [De broma, digo a su hijita, “¡tu madre se convierte en feminista!”] ¡Un poco, un poco, pero es que, él me hace ser, lo hacen ser! ¡No me pone a favor de un hombre que me está diciendo que tengo que ser madre porque él me lo diga! ¡Por favor! Esto es increíble...

Pg. 30, Superwoman’s quote about having a child during the crisis:

Es que soy muy joven, que no estoy en la situación por nada apropiada, estoy en la universidad, trabajando por las mañanas, no es el momento, ni tengo economía para hacerlo... era problema económico mío, yo no tengo dinero por eso. Los dos de mis padres son médicos. Si tuvieras que llorarme a alguien para dinero, los llorare a ellos por el dinero, no es por eso. Pero influenciado por el tema de mis padres, si yo me pelea con mis padres, se acaba el dinero. Y que si peleará con mis padres era obvio, es muy obvio. Entonces, estos dos factores eran muy importantes para mí. El hecho de tener el niño solo no era un problema para mí, porque yo me considero una Superwoman, hablando de plata, me considero una mujer muy fuerte, he pasado por muchas historias, del aborto ha sido uno de los peores... pero también el problema encima de si lo tengo el niño, lo que me cuesta es de hacer comida para mí, como llevarle al cole, hacerle de comida, las pañales. Otra cosa que me hizo ver claramente no, es que al fondo no era un niño buscado. De lo que veo, si voy a aportar algo muy bonito en mi vida, lo haría. Pero yo, entrada en la situación que estará ahora, de falta de tiempo y de culo a todos lados, de todo, no era algo que yo esperaba, ni que hubiera bien-recibido. ¿Si hubiera sido, yo no hubiera sido llorando todo una semana, que hacer?

Appendix I - Original Castilian text of participants’ long quotes

32 All text of quotes in the dissertation were translated into English by me, from the original transcripts which I transcribed and then analyzed in Castilian.
Lo que si me pidieron [en el ASSIR] fue que tenía que tomarme tiempo para pensar si decidiera hacer lo de la interrupción... y [a este punto] es donde empiezo a ver unos fallos en términos de la información porque esto fue en la mañana. En la mañana me dijeron, “tienes que tomar 72 horas después de enterarte [del embarazo], para decidir cual es el paso que quieres tomar.” ¿Pero ya cuando me confirmó en el diagnóstico, de alguna manera ya había una decisión tomada, no? Y yo quería efectivamente hacer esto lo más pronto posible, porque además allí vino el siguiente fallo de información, y es que la persona que me hizo esta valoración me calculó que tenía en ese momento, que tenía seis semanas. Otro fallo de información, porque claro [yo mismo] me hice un cálculo, pero me dijo tienes seis semanas y esto es justo sobre el tiempo, porque es ideal [hacerlo] por la séptima semana [sic], así que me dijeron, “que tramites esto si lo quieres hacer, pronto.” Entonces luego el mismo día hablé con mi novio, dije que, “mira, tenemos que esperar 72 horas,” no sentía muy bien, decimos en la [misma] tarde, “vamos a intentar a ver si nos permiten solicitar la cita para la interrupción.” ¡Sale que me dicen una cosa en la mañana y otra cosa en la tarde, [en la tarde] me dijeron, “vale, le estaremos ahora mismo,” y me hicieron la derivación en el mismo lugar, solo en la tarde me dijeron otra cosa! Sabes, entonces si yo no hubiese intentado en la tarde, hubiese esperado tres días más para ir otra mañana! Además entonces esperamos unas tres horas [en el ASSIR], y luego, nos dio el médico la derivación, nos dio la información de la clínica, como comunicarnos, que ya es encargada de dar la intervención.

Digo que ‘asesinar’ es tener un hijo y darle mala vida, digo eso es peor. ¿Traer un ser humano al mundo, que sufre? Lo veo mal. Prefiero tener un hijo y tenerlo bien, que tener otro y que sufran. Con la época que ocurre ahora, tiene que ser [que la IVE continúa a ser legal], no se puede tener otro hijo durante La Crisis. Yo pienso así, eso sí. ¿Venga un niño, venga otro niño, y si después no los puedes mantener? Que pasen penurias. ¡En este aspecto [IVE] tiene que ser siempre [legal y] financiado!

He trabajado en el tema de salud reproductiva y el derecho a abortar desde antes de acabar la carrera, como cuarenta-y-pico de años este tema ya me preocupaba. La especialidad de ginecología, la hice porque me preocupaba este tema. Evidentemente, cuando empecé, no me preocupaba de la misma manera que me preocupa ahora. Me preocupaba porque cuando yo empecé a estudiar había una mortalidad femenina muy alta aquí. Entonces cuando, digamos, de mis años veinte estuve en ayudar a cambiar el mundo (se rie de el mismo). Y colaborar con lo que puedo. Bueno, antes de proveer servicios de aborto, lo que hicimos fue buscar la solución, es decir, para empezar a mandar gente fuera de España, cuando era prohibido, yo fui uno de los descubridores [de otros proveedores en Europa], si quieres decir, ni sabíamos a donde íbamos. No, es que claro en que España había una dictadura social-católica, una fascista-católica, bueno, no teníamos ninguna información. Empezamos a buscar soluciones por el proceso. Era una situación complicada, y difícil, y además, tuviera que ser
atrevido, porque se jugaba hasta del cárcel. Éramos cuatro, las cuatro [que empezamos a hacer abortos], no lo decía a nadie más, tenía mucha participación en ayudando a montarlos, sea, el montaje de los primeros centros de planificación familiar [en Catalunya en los años 70, 80], hicieron unos diez en Barcelona. Me convertí en responsable, no solamente para las mujeres que eran pacientes mías. Me llamaban para servicios. He llevado a conocer a gente que se dedicaba aquí de contracepción, de la asociación de planificación familiar. Soy un personaje histórico (lo dice de medio-broma) en este, porque estaba. Es que formo parte de esto.

Chapter Two

Pg. 51, Afroditá’s quote about CatSalut:

Me fui al médico, me hice un test, y salió positivo... en el centro de ginecología [de CatSalut]. Y nada, y allí ya me dieron la derivación. Pasaban dos semanas entre irme a hacer el test, y tener las citas.

Pg. 62, Carla’s quote about the number of abortions CatSalut will pay for:

No, no yo pensé que en principio que si a lo mejor había que pagar, pero no, que está financiado por la seguridad social. Que ocurrirá que no pasa mucho... porque se ve que hasta, el mínimo de tres veces, luego a partir de tres veces que hay que pagar.

Pg. 65, “Superwoman’s” quote about CatSalut:

Por el económico, cuando lo miré no sabía que era gratuita tampoco, pensé que había algún tipo de coste... De todas formas, me enteré que hubo gratis, por la cual ese problema no estaba.

Pg. 68, Yolanda’s quotes about making her case to CatSalut:

El segundo día fuimos directamente al hospital a hablar con la co-madrona, donde esté mi ginecólogo, me atendió otra ginecóloga, luego ella [la co-madrona] bueno, pues, me dijo, ¿que quería hacer? Yo lo comente que, bueno, que en esta situación de vida, que me habían fallado también los parches, a ver, tenernos ese problema, de verdad, no veía ninguna posibilidad de dar por adelante tener un niño, además porque tengo poco tiempo con mi pareja, no vivo junto con el, estoy en paro, todas cosas negativas por la cual decidimos los dos que no, que realmente, que ahora no era el momento. Entonces, bueno, ella al explicarle también el tema de lo que me hubiese pasado con los anticonceptivos, me dijo que, y por mi caso que también estaba en el paro, me comento ella de una clínica que trabajan solo con ellos, que puede ser que a lo mejor no tuviese que pagar que es todo el dinero del aborto que es un €450 o algo así.

and
Me hizo los papeles para no tener que pagar la cantidad del aborto. Ahora lo veo muy mejor, que al contar tu situación, el porqué, y entonces que pagar esa cantidad de dinero en el momento dado, depende de cada situación, como por ejemplo, que este en el paro, no cobrar ese dinero, y estoy en case de madre, claro... aver, ¿imposible no? ¿Por qué se paga, pero, luego y a ver qué hago todo el més?

Pg. 70 Ariadna’s quote about variations in CatSalut policies about vouchers:

Hay algunos ambulatorios que tienen un, como te diré yo, un tope por la manera. Dicen que hasta mas mejor hasta 15, y a lo mejor la paciente esta de 18, entonces esto si es un problema.

Pg. 70 Alba’s quote about CatSalut:

Hay veces que depende del ambulatorio que les toque, le soluciona el problema rápido, y depende la persona que encuentran allí, como a veces me dicen, “pues es que no me dicen nada, que voy la semana que viene,” porque la persona que le lleva les da un poco de misinformación. En los puntos del CatSalut, el persona que este allí en este momento no le sabe que decir, se inventa cualquier cosa para ir perdiendo un poco al usuario.

Pg. 79, Mari’s quote about CatSalut delays forcing her to have a surgical rather than medication abortion:

Cuando fui con la co-madrona ya me dijo, “¿Por qué no lo hice mucho más rápido?” Porque ella me dijo, para no haber llegado a ese punto de hacerme la intervención, lo que hubiera tomado fue las pastillas.

Pg. 81, Sofia’s quote about CatSalut:

La rapidez, la rapidez del CAP [en hacer la derivación]. Realmente, el CAP, fue brutal, yo antes de ir, tenía esa duda de, que, que es lo que me van a decir, o que pegas me pueden poner? Diciendo que es lo que yo quiero hacer, como el tema está al equipo del CAP ya cumple la sistema sanitaria, y que si pongan pegas? Pero realmente, con la doctora, mi doctora de cabecera, súper bien. Yo fui a mi médico, o sea, primero aquí sí, primero me conté a la cabecera, mi hizo la derivación, pero a menos de cinco minutos y sin esperar. No me hicieron ver a una co-madrona.

Chapter Three

Pg. 90, Frida’s quote about obstacles:

Primero... estas muy confundida, pasando por un etapa que no es sencilla, y la verdad que lo que menos quieres es que te digan cosas contradictorias, porque no ayuda, es
un obstáculo importante. Creo que hay un obstáculo muy grande y es en pensar que la mujer es simplemente, como decirlo, un recipiente que contiene a un bebé... y ya, como un objeto. Si, y el hecho de no que te hagan hacer el proceso en un solo lugar, que es lo que requiere una armonización entre las dos entidades [CatSalut y la clínica], que va cada uno por su propia línea, entonces esa información es contradictoria. La información, hasta la manera de calcular las semanas, los pasos de seguir que te indiquen cuando volver y donde ir, a cuando tiempo te has corrido, que no sea simplemente, ni en una particita. Pero todo, necesita coordinarse un poco mejor, que hasta el final, hasta el último día. Pero no, hay mucha segmentación mal coordinada.

Pg. 97, “Superwoman’s” quote about friend’s lack of support:

Un día hablé con una amiga, y ella me dijo, ¡aborta, por todo! Después de como diez minutos o veinte minutos hablando por teléfono, así un poco con la indirecta, un poco así, me insinuó que no era mi momento apropiado y tal, bueno. Es una de mis mejores amigas, en el momento no dije nada, pero realmente sentí fatal, llegué a mi casa llorando. No sé, como que quería que todo el mundo me dijera, si, tenlo, ¡yo te ayudare si hace falta! ¿No hace falta que abortes, un poco así, no?

Pg. 97, Leyre’s quote about partner support:

Me apoya en todo. Pues sí... cuando te pasan cosas de estas valoran más lo que tienes a tu lado... [pero] me sentí muy sola, la verdad que sentí muy sola allí adentro.

Pg. 107 Mari’s quote about appointment scheduling, childcare, travel

Para llegar a la clínica, eso sí fue difícil, porque vivo lejos. Me dijeron, “tienes que llegar a las 8:30am.” – para mí fue imposible. Tengo mi niña, a las 8:30 la dejo al ‘cole. Me dijeron, “Si no llegas a las 9:30am. Como máximo, no puedes hacerlo.”

Pg. 110, Jorge’s quote about how women decide:

Mujeres miran un embarazo y evalúan lo que tienen en sus vidas, de lo que son capaces. Para que estén preparadas, y deciden basado en si se sienten preparadas según sus valores acerca de la maternidad, y qué tipo de madre se sienten preparadas para ser. Deseado o no deseado no es la palabra correcta, es preparada o no preparada. Hay que tener en equilibrio todo para que la mujer está preparada, no de lo que quiere su pareja, su familia d, no de lo que piensa la vecina, ni cualquier otro, se debe tener en cuenta el equilibrio suya. Punto.

Pg. 111, Mari’s quote about CatSalut paying for care:

¡Pues, antes había necesidad de pagar... fue un alivio conocer, al llamar a la [Today Clinic] que iba ser gratis con el papel [de CatSalut]! Hubiera sido bueno si alguien me hubiera explicado que con la derivación sería gratis.
Pg. 112, Ariadna’s quote about the permanent CatSalut card:

*Es en el ambulatorio que no les expliquen, les dan los papeles y nos cuesta que nosotros tenemos que decirles que estos papeles les sirven para cobertura de CatSalut, pero no para la interrupción. Cuando es una tarjeta provisional, no podemos aceptarlo, tiene que ser la tarjeta de CatSalut.*

Pg. 119, Alina’s quote about lack of social support:

*Si nadie quiere ir conmigo, me iré sola... No tengo amigas, no tengo a nadie, aquí. Que si tenía alguien, estaría bien. Una hermana, una prima, algo [sic]. Como estoy solo, no quiere ayudarme nadie. Y en mi país, mis padres son viejos, no tienen [como ayudarme]...*

Pg. 125, MariDos’ quote about teens:

*¿Aquí tenemos chicas muy jóvenes, su obstáculo más importante es la incomprensión de la familia, vale? Porque una vez que le dices que no pase nada, que al nivel legal se puede hacer, que no va haber ningún problema, su preocupación es la reacción de los padres, básicamente. [Dicen], “mi padre me mata!” Es su preocupación principal, que mis padres me maten... sí, hay algunas para quienes realmente [es un peligro].*

Pg. 128, “Superwoman’s” quote about dealing with things alone:

*Yo misma di cuenta que no podía influir en mis opiniones de unas terceras personas por algo tan importante en mi vida. Entonces decidí encerrarme en mi misma. Yo me considero una Superwoman. Yo cuando tengo problemas, me los como yo.*

*Chapter Four – ¿I Ara Que?*

Pg. 130, Greta-Maria’s quote about obstacles:

*Cuando una mujer quiere aceder al aborto, aquí en Catalunya después del cambio del ley de 2010, ha mejorado muchas cosas es cierto, pero también es verdad que hemos creado un protocolo, un camino, una carrera de obstáculos como más larga para las mujeres que, bueno, ¿que en cierta manera les puede dificultar este acceso, no?*
Appendix II, Data analysis techniques

I used several strategies to analyze the data generated in this study. For the surveys I calculated descriptive statistics to establish a demographic picture of the participant population, and to contextualize interview findings. I also consulted with a trained statistician (Erika Phillips, University of Connecticut), and together we used SPSS to calculate relevant correlations, as appropriate, to examine associations between several factors to explore apparent trends or patterns that emerged in the qualitative data, and see if these were borne out in the quantitative data. I was especially interested in identifying which factors appeared to be associated with later gestations (as these suggest delays) and factors associated with longer wait times or more visits to obtain necessary vouchers for care.

I analyzed interview transcripts and fieldnotes through an iterative qualitative process known as modified Grounded Theory (Charmaz 2010), in which I repeatedly closely read and reviewed an initial set of three interview transcripts to identify recurring themes and patterns (e.g. bureaucratic delays, problems with paperwork required to obtain a health card, confusion about where to go, logistical issues, etc.), and then coded key concepts to identify salient and recurring factors in women’s experiences. With an initial set of factors identified, I coded all subsequent interview transcripts and all fieldnotes. As needed, I added additional factors that emerged repeatedly in later transcripts to the list of factors, and re-coded earlier transcripts. My coding process involves using many differently colored pens or highlighters, and index cards on which I write each emerging theme or factor, and assign it a color. In this way, I can visually scan a transcript to see which topics are discussed most often, while bearing in mind that some issues that are barely mentioned, or mentioned only once after much other discussion, carry as much or more weight.

Once I manually coded all transcripts, I engaged in a further stage of modified Grounded Theory analysis in which I used the index cards, and then PowerPoint, to visually map the most significant themes emerging from participants’ narratives into diagrams that I used to formulate theoretical constructs explaining the relationships I perceived between the various forces and factors, and their impacts on women’s overall process of seeking care, and then to explore the roles of systems-challenging and systems-correcting praxis in women’s experiences (Schemas below). In addition, I created tracking sheets to tally the frequency with which various obstacles were mentioned, and by which participants. My tracking sheets included columns for all factors that I coded, such as health system obstacles, logistical obstacles, social support or lack thereof, a sense of needing to handle everything alone (aka the “Superwoman complex,” discussed at length in Chapter 3), stigma, and the decision, as well as factors like immigration status, time in Catalunya, age, occupation, family size, and then, in a later stage of analysis when I realized the extent to which La Crisis and threats to the abortion laws formed an important backdrop, mentions of La Crisis as a factor in the decision to seek abortion, mentions of the abortion laws changing, and related topics. For coding clinic and NGO staff interview transcripts, I used additional factors not relevant to women seeking care.
modified Grounded Theory schema/concept map 1

Used in my qualitative analysis to explore relationships between structural forces and multi-layered factors affecting women’s experiences accessing publicly funded abortion care in Catalunya

**Political-economic Context**
- 2010 abortion law reforms
- La Crisis/Austerity
- Anti-abortion government
  - Catalan Independentism

**Public Health System**
- CatSalut
  - Health Centers
  - Contracted clinics

**Logistical Obstacles**
- Travel, childcare, time off

**Lack of Support**
- Partner, family

**Delays and Problems**
- Getting referrals

**“Superwoman Complex”**

**Women accessing publicly funded abortion care in Catalunya**
- Immigrants, women from outside of Barcelona, teen women, second-trimester need
modified Grounded Theory schema/concept map 2

Showing the roles of Systems-challenging and Systems-correcting Praxis in the structural forces and multi-layered factors that my data analysis revealed affected women’s experiences accessing publicly funded abortion care in Catalunya

**Political-economic Context**
- 2010 abortion law reforms
- La Crisis/Austerity
- Anti-abortion government
- Catalan Independentism

**Public Health System**
- CatSalut
- Health Centers
- Contracted clinics

**Logistical Obstacles**
(travel, childcare, time off)

**Lack of Support**
(partner, family)

**Delays and Problems**
getting referrals

**“Superwoman Complex”**

**Women accessing publicly funded abortion care in Catalunya**
- Immigrants, women from outside of Barcelona, teen women, second-trimester need
Finally, in an attempt to triangulate data I obtained from the Today Clinic and the Family Planning Organization, I contacted a local government-funded office charged with helping (and funding) low-income, immigrant, and other marginalized women seeking reproductive health care (primarily abortion). In 2012 and 2013 I repeatedly requested information on their understandings of what women must do to access legal abortion services through the public health system, and in particular, what they specifically require of the women they assist financially, as rumors about this office requiring mandatory IUD placements following the granting of abortion funding to immigrants who did not want to, or seemingly could not, obtain health system coverage, were rampant at the clinic and NGO. In a pilot interview I conducted with the director of this office in 2010 to assess the feasibility of the proposed study, he reported they collect anonymous data on the demographic backgrounds (age, income, ethnicity, immigration status) of all women they assist, going back several decades. At that time, he offered to share with me the anonymous demographic data they collect, at the time of my (then) future doctoral research.

Based on this potential opportunity to compare the original data I was collecting with existing local data on the demographic profiles of women seeking assistance with finding (and funding) abortion care, I made several formal requests for access to the information, and also requested permission to attend a meeting to explain my study and recruit interview participants from among the staff. Despite offering evidence of my IRB approval for both requests, and his earlier offer to share de-identified data, the director of the funding program was unwilling to meet with me or show me any of the organization’s data in 2012-2013, without further reassurance from the University of Connecticut, that I was ultimately unable to succeed in obtaining from administrators at the university. I suspect his reluctance to cooperate with my study once I was established in the field, despite earlier offers to do so, stemmed from a history of strained relations between the funding office and both the Today Clinic and Family Planning Organization, both of which have periodically refused to work with the funding office because of its reputation for coercing immigrant women into accepting permanent or long-term contraception methods as a condition of receiving abortion funding or other assistance. I only learned of these conflicts after I had been in the field for several months, but I believe that when the director of the funding office saw that I had been working with the Today Clinic and Family Planning Organization, he changed his mind about cooperating with my study.
Appendix III, Response from the *Campanya pel Dret a l’Avortament Lliure i Gratuit*, to the announcement that the abortion laws would be overturned (December 21st, 2013. Translation from Catalan mine):

“We will not take one step backward!

Since the Partit Popular [PP] began to govern they have threatened to overturn the Sexual and Reproductive Health and Voluntary Interruption of Pregnancy law approved in 2010.

This threat has been concretized [enacted], disgracefully, today, December 20th of 2013, in what they have named “The Organic Law of Protection of the Life of the Conceived and of the Rights of Pregnant Women.” All a declaration of intentions.

We return to being the tail-end [bottom] of Europe in the recognition of Sexual and Reproductive Rights with a project going forward that assumes that women do not have the right to decide about our own bodies and that we are always victims to be told [what to do], and not the subjects of our own lives. We return to a situation more restrictive than what was gained with the partial de-penalization of 1985:

- Abortion will return to being clandestine and not it nor even emergency contraception can be advertised by clinics.
- In Catalunya [getting an] abortion will become a pilgrimage from doctor to doctor, but in reality it will not be possible to abort neither in public centers nor private, as you can now. All in all, the clinics and the doctors and can even refuse to give us information.

But the practices of women, the initiatives of the feminist movement, the work of these and of professionals, will not become the tail-end of Europe. Women do and will continue to abort, as we have done always, around the world.

And we will launch initiatives to do it in the best possible condition, here or abroad. We count on international networks of feminist support. We count on the involvement of professionals who believe in and implicate themselves in what they do. We count on all and each of us.

We will not remain passive in front of this new attack on our right to decide about our bodies and our lives.

We continue and will continue, practicing, reinforcing, and promoting:

- The right to decide about our own body, without assumptions, without directions, without supervision
- Egalitarian, free, and safe sexual and emotional education
- Free contraceptives without side effects and available to all
- Support between women and professionals

We recall that on September 27th, 2013, the Parliament of Catalunya approved, with votes in favor from CDC, ERC, PSC, ICV-EUiA i CUP [all of the leftist and socialist parties], the following resolution (fragment):
3) The Parliament of Catalonia agrees to initiate the process for the preparation and development of its own law of sexual and reproductive health rights.

4) The Parliament of Catalonia urges the [Catalan] Government to:

a. Deploy [enforce] in its entirety, with maximum efficiency and effectiveness, the current law guaranteeing the implementation of legislation in terms of sex education, including contraception and abortion. Provide the necessary resources for public health, to ensure equal access to and exercise of, sexual and reproductive rights.

b. Fully guarantee that the current law provide for the right to protect the confidentiality and security of women and professionals who [seek/perform] a voluntary interruption of pregnancy [abortion], limiting any attempt by the [Spanish] government to retreat in this matter.