



Barriers in access to legal abortion in the public health system in two Argentine jurisdictions: Rosario and Autonomous City of Buenos Aires, 2019-2020

Barreras de acceso al aborto legal en el sistema público de salud de dos jurisdicciones de Argentina: Rosario y Ciudad Autónoma de Buenos Aires, 2019-2020

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ABSTRACT In recent decades, decisive events shaping the political and social context surrounding abortion in Argentina culminated in the passing of the Voluntary Termination of Pregnancy (IVE in Spanish) Law in December 2020. The objective of this article is to explore the main barriers to accessing legal abortions in the public health system faced by women during 2019 and 2020 in two Argentine jurisdictions: Rosario and the Autonomous City of Buenos Aires. Based on an adaptation of the “three phases of delay” framework, surveys and semi-structured interviews with 117 women were conducted. Study participants reported difficulties in accessing information about the places and people to turn to for abortions, and most stated that pregnant individuals lack information regarding their legality. Although the majority of interviewees reported positive experiences with health services, they also identified some administrative and institutional barriers.

KEY WORDS Abortion; Health Services Accessibility; Argentina.

RESUMEN En las últimas décadas, en la Argentina sucedieron hechos determinantes en el contexto político y social con respecto al aborto, que culminaron con la aprobación de la Ley de Interrupción Voluntaria del Embarazo (IVE) en diciembre de 2020. El objetivo de este artículo es explorar las principales barreras que enfrentaron las mujeres en el acceso al aborto legal en el sistema público de salud de dos jurisdicciones de Argentina: Rosario y Ciudad Autónoma de Buenos Aires, en los años 2019 y 2020. A partir de una adaptación del modelo de las tres demoras, se realizaron encuestas y entrevistas semiestructuradas a 117 mujeres. Las participantes reportaron dificultades para acceder a información sobre lugares y personas donde recurrir para acceder un aborto. La mayoría de las participantes respondió que las personas gestantes no cuentan con información sobre la legalidad del aborto. Si bien la mayoría reportó haber tenido una buena experiencia con los servicios de salud, también identificaron algunas barreras administrativas e institucionales.

PALABRAS CLAVES Aborto; Accesibilidad a los Servicios de Salud; Argentina.

INTRODUCTION

Over the last decades, Argentina saw a process of gradual visibilization and legitimization concerning the right to abortion, and a process of an increasing demand for access to abortion on certain grounds under the statutory framework in force since 1921. These advances are evidenced in successive documents and technical guidelines elaborated by Argentina's National Ministry of Health since 2007,^(1,2,3) as well as the rules adopted in various jurisdictions to establish the conditions required to have access to abortion, under the provisions contained in the Penal Code, the rulings by the Supreme Court of Justice, and the technical guidelines issued by the World Health Organization (WHO) for safe abortion care.⁽⁴⁾

In this context, which was referred to as a "procedural turn,"⁽⁵⁾ no prior court authorizations were required to have access to a legal termination of pregnancy (hereinafter, 'ILE') [*Interrupción Legal del Embarazo*], and progress was made toward access to legal abortion on statutory grounds, but with unequal realities for each province.

Despite this greater openness, there were still obstacles and resistances to guarantee access to legal termination of pregnancy within the health system. These barriers included, for example, court actions against national and provincial protocols, or imposing limits to abortion provision according to arbitrary criteria and intentions of health authorities and/or health care workers.⁽⁶⁾

Other processes converged to enable a progressively broader access to abortion. On the one hand, experiences of health care approaches in different jurisdictions⁽⁷⁾; dissemination of self-managed abortion encouraged by women groups like Lesbians and Feminists for Abortion Decriminalization [*Lesbianas y Feministas por la Descriminalización del Aborto*]⁽⁸⁾ and *Socorrismo*⁽⁹⁾; creation of professional networks within the public sector committed to guaranteeing the right to legal abortion, like Access to Safe Abortion Network (REDAAS) [*Red de Acceso al Aborto Seguro*] and Professionals for the Right to

Choose Network [*Red de Profesionales por el Derecho a Decidir*]; and commercial availability of misoprostol for induction of labor as authorized by the Federal Department of Health, which can be sold upon prescription filed with pharmacies following a special filing mechanism and can be used in public health services – Resolution No. 6726/2018 adopted by the National Administration of Drugs, Foods, and Medical Devices (ANMAT) [*Administración Nacional de Medicamentos, Alimentos y Tecnología Médica*] –, as well as the production of 200 micrograms misoprostol by a state-owned laboratory.

As part of this process, in the year 2018, a fundamental change in the political and social context took place, which was marked by the first debate on decriminalization and legalization of abortion held in Argentina's Congress. That debate promoted the circulation of information and arguments coming from the legal, social, and health research spheres to the whole society.⁽¹⁰⁾ Moreover, the feminist and women movement was established as a key actor in the political scenario and public debate, being in the spotlight even in spheres where the topic had not been addressed within the media and the public opinion. In addition, social mobilization called large sectors of society in favor of a legal change and increased the bases of support, engaging the youth and new allies in the ordinary political world. This whole experience led to a counterattack by the conservative sectors, articulated around new health, legal, and ethical arguments, as well as new strategies of incidence and social mobilization, with a visible level of organization.⁽¹¹⁾

The confluence of these changes, together with the continuous demand for women movements, resulted in the passage of Act No. 27610 on access to Voluntary Termination of Pregnancy (hereinafter, 'IVE') [*Interrupción Voluntaria del Embarazo*] in December 2020.

The new scenario after such an enactment required new strategies and arguments that consider the obstacles to access abortion that had been observed in the scenario existing before this new piece of legislation.

Bearing this in mind, the aim of this article is to identify the barriers faced by pregnant individuals to have access to legal and safe abortion in the public health system in two Argentine jurisdictions: Rosario and the Autonomous City of Buenos Aires, during 2019 and 2020. These jurisdictions were chosen because they both have a long trajectory in public policies regarding access to legal termination of pregnancy before the passage of the above-mentioned act.^(12,13,14,15)

Considering the political process in Argentina over the last years, and particularly the outcome that was the legalization of abortion at the end of 2020, the results of this study are intended to offer a situation diagnosis prior to the passage of the act, as a baseline for the barriers in access to abortion. In this way, our goal is to contribute to the follow-up of the implementation of the public policy flowing from Act No. 27610 and provide empirical research that can be used in upcoming studies on the impact of the new piece of legislation.

CONCEPTUAL FRAMEWORK

Based on the barriers identified in literature dealing with abortion,^(16,17,18,19) we adapted the “three phases of delay”⁽²⁰⁾ framework to discuss from an analytical perspective the obstacles encountered by women to access legal abortion services. According to this model, the factors hindering access to health care services can be chronologically identified in the following way based on the stages to access and use health services:

- *Delay in decision to seek care:* It depends on women’s opportunities, capacities, and their environment to recognize that they need medical attention (this can be an emergency, understood in this case as the potential termination of a pregnancy using unsafe methods or the continuation of an unwanted high-risk pregnancy or a pregnancy resulting from abuse), and on available information about where to go.

- *Delay in identifying and accessing health care services:* It depends on symbolic and material resources to overcome the distance from health services, the availability and efficiency of means of transport, and travel costs.
- *Delay in receiving adequate and timely treatment:* It depends on the availability of qualified and trained staff at the institution women go to, the availability of drugs and supplies (technology), and of the infrastructure of the health care facility.

According to this model, it is understood that the search and provision of health care does not depend only on the lack of financial or human resources of the person seeking medical attention, but on multiple cross-linked factors.⁽²⁰⁾ If we consider that not having access to legal and safe abortion in a timely manner exposes women to potential complications of pregnancy or of abortion in risky conditions, the possibility of tackling barriers/delays can be key.

Among these delays, account was taken of the obstacles and barriers faced by women seeking legal abortion. Barriers can be classified into five groups:

- 1) Personal and interpersonal factors: Lack of information on legal abortion grounds, about how to access services where abortion services are delivered, and on the legal framework; late recognition of pregnancy; lack of support from family/friends or partner; emotional aspects.
- 2) Logistic factors: Distance, mobility, and accessibility; difficulties in abandoning household and formal job tasks.
- 3) Social factors: Abortion-related stigma; social pressure from family/friends.
- 4) Health care system factors: Access limits due to gestational age and lack of services; gestational age restrictions established by laws and regulations; scarce or deficient referral processes; scarce availability of services (in general, but particularly during the second trimester); limited clinical options; mistreatment from health workers.
- 5) Structural factors: Normative limits and restrictions – gestational age, waiting periods

requirements –; costs of abortion procedure; travel costs to reach facilities; lack of health insurance.

In addition, several studies that analyze the reasons that lead people to seek abortion services outside of the formal health system (in the community-based health care system) also report the existence of institutional barriers.^(21,22) These barriers include such situations as delays in accessing abortion services (waiting long weeks), a bad past experience, criticism from health care providers,⁽²¹⁾ and delays caused by medical prescription of several tests,⁽²²⁾ among others.

It should be noted that although the conceptual framework on barriers considers lack of information to be a *personal barrier*, this does not imply that the lack of information should be seen as an individual responsibility. On the contrary, we want to emphasize that public health policy officials are primarily responsible for guaranteeing access to information on sexual and reproductive health.

METHODOLOGY

Design and sampling

This is an exploratory research study aimed at identifying the barriers faced by pregnant individuals seeking legal abortion in two Argentine jurisdictions: the Autonomous City of Buenos Aires and the city of Rosario. Data was collected through surveys and semi-structured interviews.

We used a non-probability sampling with people capable of becoming pregnant that had access to grounds-based legal abortion, between July 1, 2019 and the March 31, 2020, in five health care facilities: *Hospital Álvarez* and *Centro de Salud Y Acción Comunitario No. 34* (CESAC 34) [Health Care and Community-based Centre No. 34] located in the Autonomous City of Buenos Aires; *Centro de Especialidades Médicas Ambulatorias de Rosario* (CEMAR) [Center of Outpatient Medical Specialties of Rosario], *Maternidad Martin* [Martin Maternity Hospital], and Hospital

Roque Sáenz Peña in the city of Rosario. Individuals were invited to take part in the study by the health care professionals of the institutions participating in the research while preserving professional secrecy and confidentiality. If the person agreed to participate, they were contacted by an interviewer or surveyor from the team, who applied the process of informed consent to take part in the study. After obtaining consent, the next step was to conduct the survey or the semi-structured interview.

We started with an initial sample of 191 women that expressed their intention to participate in the study. Right after being contacted by a member of the research team, 117 women (61%) did agree to take part in the study. The main reasons to change their minds between the first and the second contact stage had to do with lack of privacy, difficulties in finding time to complete the interview, overload of household and caregiver tasks, and the emotions evoked from telling their abortion experiences (see Figure 1). Regarding group assignment purposes, for the interviews, priority was given to gestational age (13 weeks or more) in order to have enough participants in this group. Once this

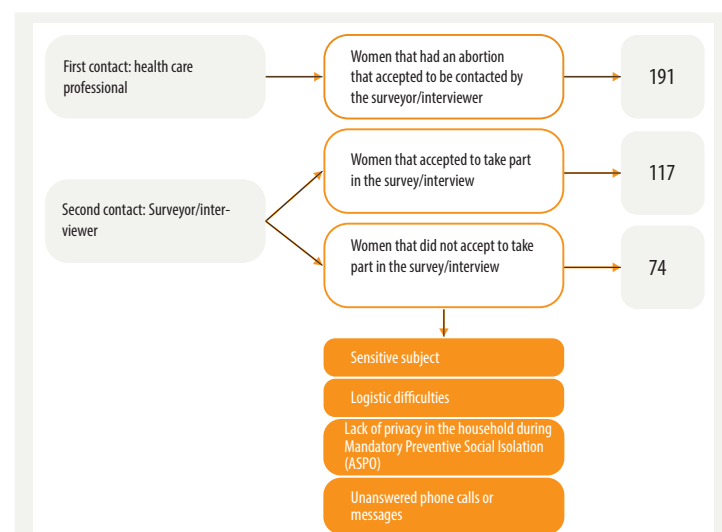


Figure 1. Organization of contacts and sampling, Rosario and Autonomous City of Buenos Aires, 2019-2020

Source: Own elaboration.

requirement was satisfied, we started to conduct interviews with a group, and surveys with the other group, until the list of available contacts was fully checked up.

Interviews and surveys were conducted by telephone given mobility restrictions imposed by the Mandatory Preventive Social Isolation (ASPO) [*Aislamiento Social Preventivo Obligatorio*] due to COVID 19 pandemic. This context likely contributed to the reduced number of individuals willing to take part in the study.

With respect to phone interviews, some women may feel more comfortable in this type of interview than during in-person interviews, mainly when it comes to sensitive topics like abortion. This statement is based on previous experiences of the team.⁽²³⁾

DATA COLLECTION TOOLS

The tools were organized around dimensions related to the barriers to accessing legal abortion services, based on an adaptation of the “three phases of delay” framework⁽²⁰⁾ explained in more detail in the conceptual framework section.

Data collection tools included surveys and semi-structured interviews. For the survey, 92 questions were prepared, 83 with a pre-established list of answers and nine with open-ended answers, organized in eight blocks: 1) sociodemographic data, 2) information on the last pregnancy that led to abortion, 3) the process followed to terminate pregnancy, 4) the first consultation, the experience in the 5) public or 6) community-based health care system, and one last block on 7) women’s opinion and 8) perception regarding the barriers existing in society to access abortion services. Some of the blocks were mutually exclusive depending on the participant’s trajectory (first consultation in the public, private, or community-based health care system).

Regarding the semi-structured interview, it was chosen because it is a type of guided but flexible interview in which the interviewer leads

the conversation with questions and cross-questions, and the interviewee gives answers by expanding and using their own words.⁽²⁴⁾ For the interview, a list of open-ended questions, cross-examination, and probes was prepared for collecting qualitative information related to the same dimensions described for the survey. Both tools had been previously tested.

Data analysis

The surveys were paper-based to avoid inconsistencies. Then we entered the information on an Excel database for later statistical processing. The audio semi-structured interviews were transcribed. Information was reduced according to theme blocks and dimensions of the tool used. We used an Excel spreadsheet in which the *verbatim transcription* of the information provided by the interviewees for each dimension was entered. The dimensions and themes used to analyze the information, as well as the inductively created categories, were discussed by the research group in order to agree on the operating definition and the way of using them when analyzing the data.

The material gathered was saved electronically with limited access by the research team. Paper-based versions were kept in a safe place that could be accessed only by the research team.

Study limitations

As to study limitations, it should be noted that, although the sample was selected before the legalization of abortion (December 2020), the interviewed and surveyed individuals were exposed to a social and political environment where the subject of abortion gained relevance on the public agenda, particularly, after the first legislative debate in 2018. This context could have affected the perception of the interviewees in this research in respect to barriers to accessing abortion services, and also of their right to access abortion. Therefore, the results presented

here should be read taking into account the social and political scenario of those years, which was completely immersed in the public debate over abortion.

Another limitation to consider is that the sample is made of women that managed to access legal termination of pregnancy (*ILE*). Therefore, there could be barriers for women that did not access a legal termination of pregnancy that could not be identified in this study. The same can be said regarding women that did not agree to take part in the survey or the interview, who could give account of various experiences and barriers not included in the present study.

Ethical aspects

All women participating in this study accepted the terms of the informed consent. The study was approved by the Ethics Committee of the Center of Perinatal Studies in Rosario [*Centro Rosarino de Estudios Perinatales*], by the Ethics Committee in Research under the Secretary's Office of Public Health of the Municipality of Rosario, and by the Teaching Committees of the health care facilities taking part in the study.

In order to protect the identity of women that took part in this investigation, fictional names are used.

RESULTS

To report the results, we used the term *women* and not *pregnant individuals* because the interviewed individuals identified themselves as cisgender women. Therefore, our intention is not to exclude trans or non-binary pregnant individuals; the manner to refer to the group of individuals who completed the interviews and the surveys has to do with the characteristics of the sample.

The number of women that took part in the study was 117 (23 interviews and 94 surveys). Out of the total of the interviewed women, 14 resided in Rosario and nine in the

Autonomous City of Buenos Aires, and 13 were women that a second-trimester abortion. Table 1 shows the profile of both samples.

Differences can be observed in the profile of the interviewed and surveyed women (interviewed women have a higher educational level and most of them do not have children). These differences cannot be explained by the type of service chosen, since both interviews and surveys were conducted in all the institutions participating in the study. Non-probability sampling and self-selection to take part in the study could explain some of the identified differences.

First delay

Subjective and social aspects directly linked to the person, but also to institutional factors, are involved in women's pathways to seek abortion services. Taking into account both personal resources as well as the resources provided by the health care system itself is fundamental to understand the obstacles – and, consequently, the *delays* – faced by abortion seekers. At the beginning of the process, the delays in recognizing the pregnancy due to irregular menstrual periods, denial of pregnancy, or absence of an adequate diagnosis of pregnancy made by health care professionals were some of the factors that generated delays and put off seeking medical attention. Once pregnancy was confirmed, six out of ten surveyed and interviewed women reported emotional aspects like anguish, fear, and uncertainty about what to do as factors present at this stage of the process:

The day I learned I was pregnant... it was the end of the world to me. (Julia, 41 years, Rosario)

Almost half of the surveyed women (48.7%) reported that they did not know where they could go or to whom they could turn to have an abortion. The interviewed women did not know where to go to seek abortion services, and in many cases, they lacked information on legal termination of pregnancy:

Table 1. Profile of women participating in the study, Rosario and Autonomous City of Buenos Aires, Argentina (2019-2020).

Characteristics	Interviewed women (n=23)		Surveyed women (n=94)	
	n	%	n	%
Education Level				
Complete/incomplete primary education	2	8.7	3	3.2
Complete/incomplete secondary education	5	21.7	48	51.1
Complete/incomplete tertiary education	2	8.7	17	18.1
Complete/incomplete university education	13	56.5	26	27.7
Don't know/No answer	1	4.3	0	0.0
Condition				
Single/no partner	15	65.2	50	53.2
Non-marital partner/married	5	21.7	42	44.7
Separated/divorced	2	8.7	2	2.1
Don't know/No answer	1	4.3	0	0.0
Employment status				
Performing a job for which women receive payment and they are the primary income earners	18	78.3	73	77.7
Jobless	5	21.7	21	22.3
Social Assistance Plan				
No social assistance plan granted (to women or to their cohabiting group)	19	82.6	67	71.3
Yes, Universal Child Allowance	4	17.4	17	18.1
Yes, other plans	0	0.0	10	10.6
Number of children				
No children	13	56.5	37	39.4
One child	3	13.0	33	35.1
Two children	4	17.4	16	17.0
Three to six children	3	13.0	8	8.5

Source: Own elaboration.

At that time when I went to have... to find out about this, I had no idea that there was something like 'ILE' [Legal Termination of Pregnancy]. I had to start... then I began to search, to surf the Internet and that's how I saw that 'ILE' was an option, because I had no idea it existed. (Bárbara, 32 years, Autonomous City of Buenos Aires)

These testimonies match the opinion of the surveyed women: 60% stated that almost none of them know when an abortion is legal.

Friends were the main source of information on where to go to have an abortion (four out of ten surveyed women), followed by health care institutions (three out of ten women). Internet (one out of ten) and relatives (one out of ten) were less common sources.

Despite not being significant delays – the average gestational term of weeks at the time of choosing to have an abortion was 7 weeks –, five out of ten surveyed women reported that the decision to have an abortion was difficult to make. The testimonies of the interviewees coincided with this view:

I think it's not an easy decision or something that we want to go through, nobody wants to experience that. (María, 21 years, Rosario)

These difficulties link up with women's perceptions of their opportunities to access abortion: seven out of ten commented that, once the decision was made, access to abortion was going to be a little or very difficult:

Honestly, I thought it would cost me a fortune, that I couldn't do it. (Julieta, 20 years, Rosario)

The interviewees linked this difficulty with lack of information on legal abortion and on the facilities that they could resort to, but also with *social barriers*. These included lack of supportive family environment, gender-based violence situations, and persistence of abortion stigma:

It still is a taboo subject, actually [...] I can't imagine having to tell my parents. (Florence, 31 years, Rosario)

Despite these difficulties, nine out of ten surveyed women could talk about abortion with somebody and eight out of ten received support in their decision-making. Most of the surveyed women did not talk about the subject with their parents, but they did with their partners and/or friends. The testimonies of the interviewees show that the people with whom they shared the decision were close and trusted people:

Well, I have a super feminist friend and she backs all this up, she's a psychologist, and I knew that she would... so I called her, I was told on Saturday and I called her on Sunday, and she was the one that accompanied me along this journey that we made, because the truth is that we made it together. (Julia, 41 years, Rosario)

In addition to the personal, subjective, and social aspects noted above, our intent is to focus on the barriers encountered within the

health system. Some of the obstacles identified by women are labeled as *institutional barriers*: women commented that when it came to having a medical test or ultrasound scanning to confirm pregnancy and determine gestational age, they had to go through situations of symbolic violence exerted by health care workers, as well as delays in attention due to scarce availability of appointments. These situations have an impact on women's emotionality and entail delays in access to abortion in a timely manner. Some interviewees stated:

That was the only obstacle I had when the gynecologist sort of insisting too much that I had to think about it over and over again. (Julieta, 20 years, Rosario)

Let's say, when my ultrasound scan was completed, I had a really bad time because the "sonographer" wasn't a very good professional [...] She starts looking and tells me: "There is no IUD here." She told me this in a rude manner, actually. And she's sort of turning the screen toward me and tells me: "You're quite likely pregnant, it is attached to the right-sided ovule." A lot of data that were irrelevant to me because I wasn't in the mood of having a child, but rather I wanted to know what had happened to my IUD. You see? And, well, when I was leaving, she told me: "Good luck with your pregnancy." (Silvia, 25 years, Autonomous City of Buenos Aires)

Second delay

After women learned about their pregnancy and decided to seek medical attention within the health system, they encountered several barriers that fall within the *second delay*. At this stage of the process, just like in the first, there are subjective and institutional factors.

Personal barriers identified in the first delay persisted: anxiety, panic, and fear linked at this stage with not knowing if they would access health care services to have the

abortion procedure performed. At the same time, lack of information on the legal status of abortion determined the way that some people related with the institutions that they attended to request abortion services:

When I went, I felt a bit embarrassed about saying the word [...] because, in fact, I had been told to find out about 'ILE' [acronym in Spanish for 'Legal Termination of Pregnancy'], and I didn't know what the acronym stood for. I didn't know what it meant, and I learned the meaning later. (Guadalupe, 27 years, Autonomous City of Buenos Aires)

The interaction between women and health care services was also determined by the fear of finding professionals against abortion or by fears deriving from past experiences – whether their own or someone else's – of mistreatment in private or public health care services. It should be noted that, nevertheless, some women attended the public health care services to have a first consultation precisely after having been well treated in previous experiences or because of the recommendation of friends and/or information available on the Internet about facilities where the procedure is performed.

Surveyed women, in turn, stated to have had, in general, a good experience with health services during their first consultation: 71.3% said that it proved easy or very easy for them to find a place to have an abortion while 77.1% highlighted that they were attended during the first consultation. Most of them had high-quality abortion care: eight out of ten women stated that they were given information about abortion as a right, seven out of ten said they received information on abortion methods, eight out of ten received the information that they expected or better, and eight out of ten said the staff manners were as expected or better.

The information from the interviews was useful to explore more in depth women's experience in the public health care services and to identify the problems that they had to face. Their narratives suggest that, despite

having good experiences, they also encountered *administrative and institutional barriers* that hindered both the identification and access to a health care facility.

Administrative barriers include deficient and inadequate referral systems, failures in notices and offered information, non-compliance with the patient's confidentiality, and lack of specific places for consultations and access to legal termination of abortion ('ILE'), as described by some of the interviewees:

We went to a public hospital downtown in Rosario and of course not... they told us that we couldn't have it there, well, we went, I don't know, then they sent me to some place dealing with sexuality issues, I can't remember exactly where, and they told us that it wasn't the right place, that it had to be in another district, I mean, they started to go round and round, and me, after estimating the periods I had missed, I realized I couldn't wait any longer, they were a lot, I needed to sort it out right away. (María, 21 years, Rosario)

The infirmary has plenty of units, and we couldn't find where to go, there was a long queue and the like. (Paula, 27 years, Rosario)

And they told me: "If I give you an appointment from this date to date when we have an available bed, your pregnancy will be at a very advanced stage already," and that's why they told me: "Try in the Autonomous City of Buenos Aires or go directly to this hospital, and surely you'll have no trouble," they didn't say 'surely,' but: "Perhaps you get an appointment." (Bárbara, 32 years, Autonomous City of Buenos Aires)

...When I went to get the appointment for the ultrasound scan that is indeed an ultrasound scan [...] you're standing in the queue with lots of people, pregnant women with such a terribly big belly, and they tell you "Well, this way for 'ILE' [legal termination of abortion],"

and you... that's no good... I didn't like it. (Roxana, 39 years, Rosario)

Administrative barriers, at this stage, are linked with lack of availability and organization of services (resources and appointments); however, the interviewees' experiences with state-owned institutions show that they also encountered *institutional obstacles* related to episodes of mistreatment by health care workers and/or administrative workers, an assumption about the desire to have children and/or having no respect for their autonomy:

...Instead of asking questions to me, because I was the person, the pregnant individual, I was the one that was feeling everything, they started to ask things to my partner [...] so at that moment I interrupted him and said, "Sorry but he's not pregnant... He's my partner [...] basically I feel that I have a tumor inside my body and that you're not listening to me as a health care professional, you're not examining me, and I am the patient. (Perla, 31 years, Rosario)

Finally, when interacting with health care services, they also identified *logistic barriers*, related with the geographic distance to get to facilities providing abortion services and with difficulties in reconciling work schedules and household care with available appointments. Out of the surveyed women, 44.7% said that they had to quit important household tasks or that they had to leave work outside of their homes to make it for the consultation and, within this group, 42.9% indicated that it proved difficult or very difficult to do so. The narratives of the interviewees focus on the same issue:

My schedule, I take my son from one place to another... I live halfway, in Baigorria, I take my son to his school in Bermúdez, from there I set off to the southwest part of Rosario, and also a lot of kilometers to get to my job and everything, it was like travelling... not real kilometers, I mean, it's all the distance

you have to travel [...] I had begun to adapt my calendar all the same, for example, the day that I had the MVA, I asked for a contingency leave, and that's it. (Roxana, 39 years, Rosario)

The experiences of the interviewed women also demonstrate their difficulties to reach health care services to access abortion:

...I live much more close to the hospital in Escobar, me... From my house to Hospital Álvarez I have to travel about one hour and fifty minutes, and here from my house to Escobar's hospital it's only twenty-five minutes, and I have thirty-five minutes to Pacheco's hospital, by Uber or private care, so to me it was much more... If it was performed here it would've been more reachable, everything, but again no. (Rufina, 39 years, Autonomous City of Buenos Aires)

Third delay

The third stage refers to *delay in obtaining adequate and timely treatment*, that is to say, in accessing legal termination of pregnancy with quality standards as indicated by the norms that regulate this service in Argentina.⁽³⁾ As noted above, the present investigation is based on the so-called *three phases of delay approach*; however, it should be recalled that said approach has been adapted in order to describe a phenomenon that does not follow the ordinary care pattern. In the case of abortion, the third delay includes, many times, having to pay several visits to health care facilities, for example, to access ultrasound scanning prior to performing an abortion, to obtain a prescription or tablets in the case of abortion with medication or to have post-abortion tests.

In this sense, the overwhelming majority of the surveyed women had medication abortion at home, after receiving tablets at a hospital or a health care facility (72.3%) and 30.9% had an abortion performed at hospital, most of them using Manual Vacuum Aspiration (MVA).

A factor that is observed throughout the whole process, since the woman suspects that she is pregnant until the abortion is performed, are feelings of fear, nervousness, and anxiety, that in the third delay are related to potential negative consequences for their health, both before and during the procedure. This continuity is summarized by one of the interviewees:

From the very beginning until the last day, I was always sort of nervous, the truth is it was the only thing I had in my mind, I couldn't think about anything else. (Guadalupe, 27 years, Autonomous City of Buenos Aires)

Again, *personal barriers* had an impact on the way that women interacted with health services. Despite their feelings and fears, the interviewees highlighted the importance of feeling reassured as they were supervised and accompanied by health care professionals, in particular where abortion required hospitalization:

Yes, of course I was overwhelmed by the situation, but well, I knew that it was the pathway that I had to take, the right way, that I was in good hands, that I was going to be supervised, that I was going to be controlled, that they were professionals, that they would take care of me, that they would give priority to my life above all. [...] And it was like a relief. (Julia, 41 years, Rosario)

This same trust in health care professionals was also described by those who performed abortion at home although, in these situations, the fact of not receiving support from family and close friends during the procedure was identified as a difficulty.

The narratives of women give account of situations related to *social barriers* like taboo and silence on abortion, as well as fearing judgment:

It's not well regarded and it's a hidden topic, and what is hidden is not well seen, it is like... it's not very helpful to

move on, it's not very helpful to talk about it, feel it or share it in a healthy way. (Micaela, 42 years, Autonomous City of Buenos Aires)

It is a very, very ugly situation, I felt that people looked at me and judged me, although I was very confident about what I was doing; you feel that the others are judging you, looking at you and judging you because they know what you did. (Wilma, 19 years, Rosario)

Women also mentioned such *institutional barriers* as situations of mistreatment and misogynistic comments from health care professionals:

Quite softly, with a very chauvinist, degrading answer, which made me feel awkward, because... he was the person that had to help me [...] He said, "she's almost 39 years old and she didn't know how to avoid pregnancy, and she already has six children," so... this thing sort of also making me feel embarrassed. (Rufina, 39 years, Autonomous City of Buenos Aires)

In addition, lack of adequate facilities for performing abortions (for instance, places where abortion seekers did not have to share the space with pregnant women or women in labor) and *administrative barriers* like scarce availability of services were also highlighted.

As with the two previous stages, in the third delay *logistic barriers* are also identified and linked with difficulties in abandoning caregiver duties related to children or aging adults, in being absent from work out of the home or in reconciling health care service schedules with formal work, as well as distances from hospitals or health care facilities:

Yes, because until now they could put me in, [at hospital], that day because in those days I wasn't with my children. (Julia, 41, Rosary)

I couldn't have more absences from work [due to a post-abortion follow-up]

because I had already lost my work attendance bonus, paid workdays, I mean, I couldn't have more money deducted from my wages. (Candelaria, 26 years, Autonomous City of Buenos Aires)

DISCUSSION

This article aimed at describing the barriers faced by women seeking abortion in the public sector health services within two jurisdictions of Argentina – Rosario and the Autonomous City of Buenos Aires – in the year prior to the passage of Act No. 27610. To achieve this, we used an adaptation of “three phases of delay” framework, which presents both advantages and challenges. One of the potentialities of the approach, which has been largely used in literature on maternal mortality,^(25,26,27,28) is that it incorporates the time dimension into the analysis of obstacles to access health care services, facilitating the identification of critical moments during the process. However, some challenges are faced when adapting this model to the particular features of the decision-making process and abortion care. Some obstacles can be “overlapped” among delays or can be difficult to classify. For example, barriers to access ultrasound scanning could fall within the first delay (need to confirm pregnancy to make a decision) or the third delay (confirmation of gestational age to offer the adequate procedure).

The obstacles identified in the results of this investigation can be interpreted in line with other local, regional, and international studies addressing this topic. In this sense, a previous study conducted by this research team,⁽²⁹⁾ in which the same data-collection tool was used but with a different sample, was useful to create evidence to provide information to the debate held in Argentina's National Congress in 2020 and in the media, and was relevant to describe the barriers in access to abortion even in specific situations permitted by law and to define the horizon of necessary improvements to ensure access to abortion in a timely and appropriate manner.⁽²⁹⁾

Taking this background into account, the present study shows results that highlight the diversity of women's experiences in health care facilities where they could access abortion services. The participants reported obstacles with respect to the service delivered at health care facilities; however, most of them claim to have had a positive experience, a situation that matches the research studies carried out in Brazil, Argentina, and Mexico.^(30,31,32) In line with this general positive evaluation, during the interviews, women highlighted the accompaniment by health care professionals in the process and affirmed that they felt “safer” having the procedure performed in a health care facility. A study conducted in Argentina on medical abortion had already highlighted that women praise the safety of facility-based abortions.⁽³¹⁾ In the present study, most of the surveyed participants stated that they had a good experience with the public health system when it comes to finding services, the quality of attention, and the information received. These data suggest willingness from health care professionals to offer adequate information, which is an aspect that contributes significantly to the reduction of unsafe abortion practices.⁽³³⁾ It should be made clear that these data can also be the result of the fact that, unlike other regions, the jurisdictions chosen for this study have long trajectories in public policies dealing with access to legal abortion.^(12,13,14,15)

Apart from these positive points, participants also reported obstacles related to health care services. These can be split into two types, following the classification used by the “Group for Women's Life and Health” [*La mesa por la Vida y la Salud de las Mujeres*] in Colombia⁽¹⁶⁾: obstacles related to the attitude of health care professionals and obstacles that have to do with the administrative level. Among the first group, some participants reported mistreatment from health care professionals and lack of specific facilities for legal termination of pregnancy (*‘ILE’*) and voluntary termination of pregnancy (*‘IVE’*) procedures. Mistreatment and comments about maternity, as well as the provision of abortions in spaces shared with other

practices (for example, maternity rooms), affect women in a negative way and contribute to arousing such feelings as guilt, repentance, and discomfort. These results largely coincide with the literature developed in our region. In Colombia, attitudes of health care professionals have been analyzed, which are intended to prevent access to legal abortions⁽¹⁷⁾ or to create barriers and substantial delays.⁽¹⁸⁾ Another aspect that was identified was the abuse suffered by women from health care workers aimed at making women change their minds with respect to their abortion decision,⁽¹⁶⁾ the discomfort generated by careless health workers in abortion facilities,⁽³⁰⁾ and the need to count on a more understanding health care staff.⁽³²⁾ In Uruguay, research studies have revealed the need for a comprehensive training of health care professionals delivering abortion services, since training in technical aspects does not in itself guarantee a respectful attention when it comes to abortion.^(34,35)

As regards administrative obstacles, some women reported a deficit in the information provided, lack of available appointments, and inadequate referral mechanisms among institutions, among others. These results are aligned with the findings of research studies in other Latin American countries that highlight the existence of unexcused delays in rendering services and failures in the referral system,^(16,18) as well as the need reported by women for receiving comprehensive information about the abortion procedure from health care staff.⁽³²⁾

One of the results that needs highlighting was the lack of information on the legal framework, a barrier reported as much in the surveys as in the interviews. This obstacle is reported in literature as a factor that has an impact on access to abortion.^(16,19,36) However, existing evidence in the region is still scarce. Having evidence about the information and the knowledge that women have on the legal framework is key to better understand their attitude and willingness to seek health care services, and to overcome obstacles to access abortion. Similarly, knowledge on these factors could contribute to designing and strengthening plans and communication strategies offering information adequate to the

context to make it easy to access abortion and to demand high-quality medical attention.

Logistic obstacles, in particular the time required to travel to reach a health care facility or the impossibility of quitting work or caregiver duties, were also reported as barriers. This coincides with the evidenced described in other research studies carried out in the region^(37,38) that place special emphasis on the restrictions of socioeconomic conditions as access determinants. This adds to women's difficulties to be absent from work and reconcile appointment schedules with caregiver duties for their children or aging adults – an aspect that was revealed in other research studies.⁽¹⁸⁾

The importance of friends (in the first place) and of health care facilities (in the second place) as sources of information in respect of where to go to have an abortion was reported both in the surveys and the interviews. This does not amount to an exclusive finding of this study; friends have already been identified in literature as the main source of information.^(39,40) However, it is interesting to observe that the information shared among friends and the trust that some of them had in the health system, as well as the demand for and greater knowledge of their rights in the presence of health care professionals reported by the participants could be demonstrating some aspects of this phenomenon that is necessary to keep on investigating. Although the subject of abortion continues to be considerably sensitive for women, since stigma or silence remains,⁽⁴¹⁾ as also highlighted by the participants of this study, the greatest social visibility of the topic could constitute a window of opportunity to lay out strategies with a view to the implementation of Act No. 27610 on Access to Voluntary Termination of Pregnancy ('IVE') [*Interrupción Voluntaria del Embarazo*], thus contributing to tumbling down social barriers and the persistent stigma in connection with abortion.

Account should be taken of the limitations of this study. First, the sample only includes women that actually managed to access a legal termination of pregnancy ('ILE') within the health system. In this sense, other barriers could exist and still not be identified

due to the characteristics of the sample. Secondly, among those women who accessed the health care system, but finally decided not to take part in the study, there could also be experiences and different barriers that could not be identified.

One of the strengths of this study is that it provides empirical and systematized information on the barriers in access to legal abortion in two jurisdictions of Argentina, explored in a context of significant social, political, and legal changes. Although at present Argentina has a piece of legislation that ensures access to voluntary termination of pregnancy, barriers in access to abortion possibly exist, some of which can be similar to the barriers reported in this study.

CONCLUSION

Before the new scenario that emerged after the passage of Act No. 27610 and the ensuing cessation of mobilizations of various sectors within civil society and of the public debate held in previous years, the barriers identified in the present study become more relevant when it comes to strengthening the process of access to abortion in Argentina. It is important, in turn, to interpret the findings in the light of the local context. The jurisdictions chosen for this study have a long trajectory in public policies on access to

legal termination of pregnancy (*'ILE*), prior to the passage of the above-mentioned statute. This could explain, at least in part, the fact that most of the participants in the study reported that they had a good experience with health services. In addition, account should be taken of the fact that some of the most significant barriers were identified in the first delay, before women got to health care facilities. Among these obstacles, feelings of anguish and fear, lack of information on places where to turn to, and lack of knowledge on legal abortion were reported.

Women lacking information in relation to legal abortion, even in jurisdictions with public policies on legal termination of pregnancy, could be due to the absence of communication campaigns launched by governmental agencies. In this sense, one should wonder whether mass or focused communication strategies could correct this situation and facilitate access to voluntary termination of pregnancy (*'IVE*) or legal termination of pregnancy (*'ILE*).

Thus, to continue producing data and evidence on the barriers in access to abortion proves indispensable in order to disclose information about the implementation of the public policy flowing from Act No. 27610, taking into account not only the difficulties encountered by women within the health services, but also at previous stages of the process, in such a way to introduce corrections when and where detected.

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CONFLICT OF INTEREST

The authors declare that they have no links or commitments that may influence the statements disclosed in the text and that may be understood as a conflict of interests.

AUTHOR CONTRIBUTION

All the authors contributed to conceptualization, methodological development, organization of the research project, writing of the original draft, and formal analysis. Mariana Romero, Silvina Ramos, and Edgardo Abalos took part mainly in obtaining funding for the study, in the supervision of the research, conceptualization, and editing and proofreading of the final manuscript. Mercedes Vila Ortiz and María Victoria Tiseyra took part at all the stages of the research and provided writing, editing, and proofreading of the final manuscript. The five authors had complete access to the data and accepted the final manuscript and the responsibility for sending it for publication.

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