

The dilemma of a practice: experiences of abortion in a public maternity hospital in the city of Salvador, Bahia

Cecilia McCallum

Professora, Departamento de Antropologia/Faculdade de Filosofia e Ciências Humanas (FFCH)/Universidade Federal da Bahia (UFBA); honorary research fellow, University of Manchester.
Rua Aristides Novis, 197
40210-909 – Salvador – BA – Brasil
cecilia.mccallum@uol.com.br

Greice Menezes

Pesquisadora, Instituto de Saúde Coletiva (ISC)/UFBA.
Av. Adhemar de Barros, s.n., Campus Universitário de Ondina
40170-110 – Salvador – BA – Brasil
greice@ufba.br

Ana Paula dos Reis

Doutoranda, Programa de Pós-graduação em Ciências Sociais/FFCH/UFBA; pesquisadora, ISC/UFBA; honorary research fellow, University of Manchester.
Av. Adhemar de Barros, s.n., Campus Universitário de Ondina
40170-110 – Salvador – BA – Brasil
reis.ap07@gmail.com

Received for publication in November 2014.

Approved for publication in April 2015.

Translated by Derrick Guy Phillips.

<http://dx.doi.org/10.1590/S0104-59702016000100004>

MCCALLUM, Cecilia; MENEZES, Greice; REIS, Ana Paula dos. The dilemma of a practice: experiences of abortion in a public maternity hospital in the city of Salvador, Bahia. *História, Ciências, Saúde – Manguinhos*, Rio de Janeiro, v.23, n.1, jan.-mar. 2016. Available at: <http://www.scielo.br/hcsm>.

Abstract

The article discusses abortion and miscarriage from the perspective of women admitted to a public maternity hospital in Salvador (BA), Brazil. Based on qualitative and quantitative research, it draws on participant observation of everyday hospital life. Taking an ethnographic approach, it addresses the hospital experiences of women who had miscarriages or induced abortions, also presenting the views of health professionals. It argues that the way the institution structures care for abortion and miscarriage involves symbolic processes that profoundly affect women's experiences. The discrimination against women who have had abortions/miscarriages is an integral part of the structure, organization and culture of these institutions, and does not derive solely from the individual actions of healthcare personnel.

Keywords: abortion; hospital ethnography; maternity; symbolic processes; obstetric violence.

This article seeks to understand the care given in cases where the termination of pregnancy takes place in public maternity hospitals in Brazil, by means of a study conducted in a hospital in the city of Salvador (BA), investigating the concepts and practices related to the procedure, participants and the institution concerned. The experience of abortion is addressed from the standpoint of women who underwent miscarriages and induced abortions, from the time that their pregnancy was first confirmed until the moment that it was terminated. Our main area of interest, however, is the hospital experience itself, which forms part of the termination of pregnancy process that women experience. In order to enhance our understanding of these experiences, we analyzed the findings of an ethnographic investigation, which included a study of the views and practices of healthcare personnel who interacted with these women, as well as the way that care is structured by the institution when pregnancies are terminated.

Our aim is to show that the symbolization processes that are part of hospital care provided to women have a marked impact on the experiences they undergo. Far from an analysis that treats people as autonomous individuals, whose intentional actions determine or explain the type of care given, or the way that this is experienced, we seek rather to understand the system that has been ethnographically analyzed as a socio-cultural complex created in a greater specific dynamic, formed by the meeting and/or clash of various cultural and structural forces. For a woman, terminating a pregnancy in hospital involves having to suddenly immerse herself in an environment that has a deeply-rooted institutional culture, expressed through everyday procedures and dynamics and involving the work routine and care provided. In this distinctive space, different discourses and a variety of attitudes and forms of behavior flourish side by side, leading to contradictions and paradoxes.

Our analysis shows that, in general, a moralizing viewpoint reinforces professional practices and underlies the institutional structure, leading to displays of intolerance or hostility towards women suspected of provoking an abortion, despite the ubiquitous presence of a “pro-humanization” institutional discourse. We argue that discrimination against women who terminate their pregnancies does not only come from this or that individual health professional, but is an integral part of the structure, organization and “culture” of these institutions, making it difficult, if not impossible, to provide a “humanized” form of treatment.¹

Central to the questions discussed here is a practice peculiar to Brazil: Here maternity hospitals also provide care for women whose pregnancies have been lost or terminated. It is ironic that in these shrines to motherhood, care is also given to those whose pregnancies have been interrupted. The institutional culture itself is both a reflection and a producer of processes of wider significance, both local and national, that relate to race, class, gender, generation, among other markers of differences and hierarchies. To become a mother or to abort a child in Brazil means occupying the same symbolically dense and complex space, linked to a hegemonic morality, that is constantly being constructed and which acquires different forms in distinct periods and places. The first section of this article summarizes the dimension and context of the problem.

Abortion in Brazil

Abortion is widely practiced in Brazil, in spite of restrictive laws presently in force. Women still face serious obstacles as regards having access to safe and reversible contraception within the public health service in the country today, even though the prevalence of feminine sterilization is widespread (Dalsgaard, 2004; Perpétuo, Wong, 2009).

The number of abortions in the country is estimated to be high. The only survey conducted on a national level, involving women who were literate and lived in urban areas, showed that, by the time they reached the age of forty, one in every five women said they had terminated a pregnancy (Diniz, Medeiros, 2010). A recent study, which analyzed the records of the Ministry of Health's Hospital Information System relating to the hospitalization of female patients in Brazil in cases of the termination of pregnancy, for the period between 1996 and 2012, estimated that there have been 994.465 abortions per year, with an average coefficient of 17 unsafe abortions/1.000 women of a fertile age and a ratio of 33.2 unsafe abortions/100 live births (Martins-Melo et al., 2014).

Abortion is among the four main causes of maternal death in the country, with unacceptably high rates, according to international standards. Data related to hospitalization via the Unified Health System (Sistema Único de Saúde, SUS) show that post-abortion curettage is one of the most-practiced obstetric procedures. The high number of hospitalizations implies elevated costs to treat post-abortion complications, affecting a sector that lacks resources (Brasil, 2005).

The criminalization of abortion reinforces powerful social inequalities to which Brazilian women are exposed. When an unforeseen pregnancy occurs, only a small number of women can cover the costs for an intervention in a private clinic (Silveira, 2014);² the remainder, undoubtedly representing the majority of the female population, seeks a series of unsafe and sometimes deadly procedures.

The introduction of Cytotec,³ to the Brazilian pharmaceutical market during the mid-1990s, made it easier to induce abortions (Barbosa, Arilha, 1993). Although it was later banned, the product continued to be sold, at highly inflated prices. Despite suspicion regarding the authenticity of the drug, its use has given women relative freedom to be able to terminate a pregnancy. Even though it is difficult, poorly informed women from lower income backgrounds are able to induce an abortion, or begin to do so, for many will subsequently need to seek the health services in order to terminate the process. They also go to hospital to treat any complications arising from abortion, such as infections and hemorrhaging. Thus, the relative freedom that women have is tempered by a subsequent dependence on professionals in the public healthcare sector, with whom they interact within public health units, principally in maternity hospitals.

Research into abortion in Brazil rarely describes the relationship between the women and health professionals who care for them (Brasil, 2009). The studies that do involve these individuals are mainly concerned with the opinions of the health professionals as regards the conditions that may lead women to terminate their pregnancies and their knowledge of current legislation in the country, rather than comparing the views and practices of these health professionals with those of the women concerned (Menezes, Aquino, 2009; Cacique, Passini Jr., Osis, 2013).

On a political level, women's movements constantly denounce problems faced by healthcare users, including difficulty of access to a vacancy in a health unit, as well as cases of discrimination suffered during hospitalization, and including delays in responding to a woman's requests or the indifference shown to the complaints they make (Soares, Galli, Viana, 2010). With regards to scientific research, authors have documented these problematic issues (Menezes, Aquino, 2009). They show that the standards of abortion care provided by health professionals are far from those set out in national and international guidelines (Aquino et al., 2012).

Thus, the aim of this article is to help reach a greater understanding about the relationship that exists between women hospital users and professional healthcare workers as regards abortion and miscarriage. Based on an anthropological approach, we focus on the problem of "obstetric violence," an expression that has heretofore been adopted above all in studies that analyze experiences of childbirth. Our analysis will show the need to understand the ways in which day-to-day relationship dynamics – including institutional obstetric violence – are intrinsically part of the social and symbolic contexts that encompass them.

This work is part of a wider study, of an anthropological nature, which involved participant observation, during a period of one year – between 2002 and 2003 – at the "Maternity Hospital of Bahia" (fictitious name), or MHB, a leading public maternity and teaching hospital in the city of Salvador (BA). The study combined qualitative and quantitative methods to investigate the relationships between young users aged between 15 and 24 years and the hospital institution. At the time of research, the MHB had approximately eighty beds and took nearly eight thousand hospital admissions per year, of which around 20% were for post-abortion curettages. Approximately 90% of these procedures involved women between the ages of 15 and 29, of which nearly 20% were under the age of 19.

This article examines the experiences of young women admitted to the MHB with miscarriages or abortions. The material analyzed in this text has not been treated in other publications. Of the 39 interviews conducted, 11 involved women who had been admitted because of spontaneous or induced interruptions to their pregnancies. This number was pre-selected when the project was first elaborated and was based on the total percentage of curettages carried out in the institution surveyed. These women were contacted during the period they were hospitalized, after their curettages had been performed, and the interviews took place after they left hospital, in locations suggested by the interviewees themselves. At the time of the interviews, all the women had regained their physical health and had no difficulty in speaking to the interviewers.

In addition, a census was carried out with the health professionals directly involved in their care at the MHB. In all, 113 professionals – including doctors, nurses and nursing assistants/technicians, a psychologist, social assistant and a nutritionist –, of a total of 127 possible candidates, replied to a questionnaire. The questionnaire, which was structured but contained some "open" questions, covered issues related to abortion. It was applied to healthcare workers by a team of interviewers and covered all the work shifts. In addition, semi-structured interviews with 19 health care professionals were conducted inside the MHB (Table 1). This research was approved by a Research Ethics Committee subject to the National Commission for Research Ethics (Comitê de Ética em Pesquisa/Comissão Nacional de Ética em Pesquisa, CEP/Conep).

Table 1: Healthcare professionals interviewed

Professional category	N	Gender		Color/race	
		F	M	White	Black/Brown
Obstetrician	5	1	4	4	1
Anesthetist	1	-	1	1	-
Nurse	5	4	1	3	2
Nursing assistant/technician	6	6	-	2	4
Social assistant	1	1	-	-	1
Nutritionist	1	1	-	1	-
Total	19	13	6	11	8

Source: Elaborated by the authors.

Profile of the young females interviewed and of the MHB health care professionals

In general, the socio-economic characteristics of the women interviewed are typical of MHB hospital's clientele. Most are young (aged between 15 and 24 years old), were born in Salvador, live in "low income" neighborhoods and were not employed at the time of the interview. None of them had a formal work contract. Their parents formed part of the low-skilled workforce, and their family income varied from less than one to nearly six minimum salaries. Ten of the interviewees classified themselves as being dark-skinned or black, and one, as brown; only one classified herself as being white. She also belonged to a middle class family, with an income of over ten minimum salaries. This young woman lived in an upmarket neighborhood and was a university student. Of the other ten interviewees, five had not completed primary education, one was illiterate and two had completed their secondary education (Chart 1).

Four of the women interviewed who had provoked abortion were already mothers, and none of them studied or worked for a living. Only one was married at the time of the interview. Two were single mothers and, at the time, their partners had refused to "bear responsibility" for their pregnancies which resulted in a child. All these mothers had induced an abortion during their last pregnancy.

Among the women without children, one was living in a stable relationship, and the others were single and lived in the home of their parents or relatives. However, all except one (who became pregnant by an ex-boyfriend) explained that they had become pregnant with a steady partner, rather than casual boyfriends. Most of these women stated they had continued to date the same partner after terminating their pregnancies. One sixteen-year-old separated from her partner when he said he was against her decision to have an abortion, and another twenty-two-year-old mother of three children, who had no schooling and was unemployed, left her husband when she found out he had made another woman pregnant.

The interviewees mentioned having few partners during their affective-sexual lives (between one and five partners). The youngest among them stated that they had become pregnant when they first began their sexual activities.

With regards to their experiences of pregnancy loss, three of those interviewed said that they had had miscarriages, while the remaining eight stated that they had induced an abortion

with the use of Cytotec. None of these women considered they had had a planned pregnancy but, when they became pregnant, they mentioned subjective conflicts, which included a series of negotiations within the family environment, before they had decided to terminate their pregnancy. Even so, only the university student, who miscarried just before the end of the first trimester, mentioned wanting to maintain her pregnancy. The others two interviewees with lost pregnancies said they felt relieved when they had miscarried.

This brief portrait of the women and their social, economic and reproductive conditions does not do justice to the differences that exist between them. Even though, at first sight, only one in the 11 women interviewed appears different to the rest, due to her social origins, being from the middle class and white, there are significant differences between the others, both as regards socio-cultural aspects as well as in relation to their educational and professional

Chart 1: Women interviewed

Name	Age	Children	Marital status	Self-definition of color	Employment status	Level of education	If studying	Family income (R\$)
Alzira	19	None	Single	Dark brown/Black	Secretary	Complete elementary school	No	400,00
Deborah	16	None	Single	Black	Unemployed	Incomplete secondary school	Yes	Does not know
Dolores	22	Three	Single	Dark brown	Unemployed	Incomplete elementary school	No	Does not know
Karine	19	One	Single	Black /Brown	Unemployed	Incomplete secondary school	No	Does not know
Lia	21	None	Single	Black	Nanny	Incomplete secondary school	No	600,00
Lúcia	20	None	Single	White	Unemployed	Incomplete higher Education	Yes	3.500,00
Luíza	16	None	Union	Light brown	No information	Incomplete elementary school	No	Does not know
Magaly	22	Two	Married	Black	Unemployed	Incomplete elementary school	No	400,00
Marta	25	None	Single	Black	Unemployed	Complete secondary school	Yes	1.200,00
Olívia	20	None	Single	Brown	Unemployed	Complete secondary school	Yes	800,00
Virginia	21	One	Single	Dark brown	Unemployed	Incomplete elementary school	Yes	400,00

Source: Elaborated by the authors.

ambitions. Two of these young women had completed secondary school. Of these, one was taking a university entrance prep course and simultaneously training to become a nursing technician, and the other was starting a technical course to become a beautician. The others, including the young mothers, expressed no interest in continuing their studies.

These 11 interviewees form an image of the social, cultural and discursive diversity that exists among the population that uses public hospitals in Salvador, who share similar backgrounds with the majority of MHB healthcare professionals, most of whom are nursing technicians and assistants. They are women from the same social class as their “patients,” who like them are mainly black and brown-skinned, and live in low-income districts. However, unlike their “patients,” they have achieved a higher level of education, earn their own income (many are the main family breadwinners) and are older: Their average age is over 40. The nursing assistants compose the main hospital healthcare workforce, but it is the doctors and, to a lesser degree, the nurses, who are in charge of healthcare and who retain power in the institution. Reflecting the racial and social hierarchy in Salvador, most of the doctors and, to a lesser degree, the nurses, considered themselves to be “white” (Chart 1).

Care given to women who have aborted

When they arrive at the MHB reception, the women are required to identify themselves to the receptionist – usually a man – and inform the reason they are seeking assistance.⁴ The receptionist will authorize their admittance to the hospital, before directing them to the filing service, “Same,”⁵ located in a small area inside the hospital and close to reception, to open their “medical records.” After depositing their belongings, users are directed to the next sector. As they wait to be seen, whether in labor or aborting (or in any other condition) the women share a concrete bench located besides the screening room where they will be examined by a doctor, assisted by nurses. Once the need for hospitalization has been decided and as soon as a space is available, a nursing technician will give them hospital gowns. Now formally admitted to the hospital, they will be taken to the Obstetrics Centre (OC), where they will occupy a bed in one of the labor wards or will be put on a trolley, in the internal circulation area.

According to information proved by various health professionals working at this institution, the MHB does not discriminate against its “patients” in any way. As a result, those in the process of miscarrying or abortion should occupy the same physical space as other women in childbirth, not being separated in the OC, or in the wards, even though this is not a formal part of institutional protocols or rulings. Even so, in practice, after curettage, many women are taken to a ward known as the one used for “the infected,” located in a less visible area in a wing of this same sector. There is also an operating theater within the OC called the “curettage room,” also located in a less visible area. In fact, two curettages can be performed simultaneously there, using the services of a single anesthetist. Although screens are available, these are not used, so that it is quite common for a patient, before she is anesthetized, to have a partial view of the procedures being carried out in the adjoining space.

Also as part of the organization of care in MHB, curettages are generally carried out by resident doctors or on duty physicians towards the end of the afternoon, after the caesarians and normal deliveries have taken place, since the latter are given priority. Only in cases of

imminent danger of death, such as intense hemorrhaging, for instance, will professionals first attend to a woman who is miscarrying or has had an abortion before assisting the women in childbirth.

In the case of uterine evacuation, curettage is the method of choice in practically all cases, rather than manual vacuum aspiration (MVA), considered as being a more adequate procedure, since it is less invasive, enabling patients to recover more quickly and with fewer side-effects.⁶ An MVA does not require general anesthesia, as is the case of a curettage,⁷ only a local anesthetic. Although some professionals at the MHB, mainly residents, have received training in MVA, they have not adopted this procedure. Some of our informants attributed their resistance to doing to the fact that this technique requires more effort than performing a curettage.

In order to be submitted to a curettage, the women usually walk to the OC. They lie down on operating tables in the room where the procedure is to take place, and their legs are raised and secured in stirrups. Once they are in this position, they are anaesthetized and the curettage is performed. When they awake, they are taken to a bed in one of the wards, where they will wait to be discharged from hospital, usually on the afternoon of following day, provided no clinical complications have occurred.

During the period of this research, none of the women were offered any help related to post-abortion contraception, such as information or availability of contraceptives, even in the case of adolescents. Few of the interviewees mentioned having received any guidance in this matter. They only remembered informal suggestions made by some professionals to the effect that once discharged from hospital, they should visit a family planning clinic. However, MHB's social workers organized talks and invited the women to watch films related to human reproduction, though lamented the fact that most of the women showed little interest in these. According to our interviewees, however, these talks were designed only for mothers, and not for women like them who had suffered a miscarriage or abortion. They also said that the hospital did not offer any activities related to contraception and about post-curettage care, an issue that the doctors did not mention either, when they discharged patients from hospital.

The perspectives and practices of healthcare personnel

The majority of the MHB healthcare personnel, irrespective of their occupational category, considered it inadequate for a young woman to become a mother before the age of 25. Although they stated that adolescent pregnancy is a social problem that has negative repercussions in the lives of these girls, they did not see induced abortion as an appropriate solution. Of those interviewed in the census, 62.2% stated, for example, that this practice should not be decriminalized, and there was no major support for the legalization of abortion in any one of the professional categories investigated. It is worth noting, however, that unlike the gynecologist-obstetricians and nursing technicians, nurses tended to show greater support for decriminalization. Another point that stands out is that 9% of the professionals declared that they do not know how to respond to this question. Most of those who responded thus have university degrees.

The interviewees made their opinions very clear about the law in force in 2002, with only 15 of these saying this was right. For the others, the law was problematic, though for different reasons: 28 professionals thought the law was limited, since they understood that abortion should be a decision taken only by women; 61 argued that the law should include cases of mal-formed fetus; 19 professionals, however, declared themselves to be against abortion under any circumstance. However, most (76) said they would agree to be part of a professional team which performed legal abortions, since, in spite of their moral and/or religious convictions, the circumstances surrounding a pregnancy would justify their participation.

When contextualizing these “data,” taking into consideration the practices observed in the institution and the comments expressed in the semi-structured interviews, a more complex portrait of the attitudes of the healthcare professionals with regards to the question of abortion emerges. Important here are their views about the users, whose behavior, in particular that of adolescents, engendered both ambiguities and harsh criticisms. Some understood that the young women are victims of social circumstances, but, even so, they are judged as being irresponsible as regards the precocious practice of their sexuality, as well as being selfish, with respect to the consequences of having sex, such as a pregnancy (McCallum, 2008).

Health professionals usually do not use a person’s name when they speak to their “patients.” Pregnant women are addressed as “mother,” which is a term that can also be used for women in a situation of abortion or miscarriage. The use of the term “mother” in these situations is common in the public health system more generally, especially in the Northeastern region of Brazil. Another term of address used at the MHB is “daughter.” In some situations, for example during an ultrasound examination, it is quite possible that no term at all is used, since the doctors, in general, only communicate among themselves, or with medical students, or direct their conversation towards the equipment, restricting themselves to giving a few simple instructions to the patients, such as: “Come in!,” “lie down,” “you can go now” (Macedo 2005). The most common term used by professionals to refer to women who have terminated their pregnancies is a “curette,” the name of the instrument used in a curettage, calling them by a name that refers to the technology to which they are/will be submitted. There is a strong tendency to relegate users to a condition of being a non-person, denying them their individuality, by consigning them to anonymity (McCallum, 2007).

Although the replies that the healthcare professionals gave in the survey relate to their wider views about the reproductive rights of women, it is important to note that, when trying to understand practices at the MHB, there is no way of separating general perceptions about women and those that specifically refer to the users they have treated. Analyzing the set of data produced in this research, McCallum and Reis (2008) concluded that the professionals share the understanding that the users of the maternity hospital have a low level of “culture.” Adding this to their perception that these women supposedly live in precarious conditions of hygiene, they tend to negatively distinguish them from clients treated in the private sector. This explains why several suggested to us that the bodies of patients at the MHB, and in other public health units, require special attention as regards hygiene.

Of all the users, adolescents are the ones most criticized, which is also the case with respect to abortion and miscarriage. Even so, a complex relationship exists between the views of

professionals on this issue and the attitudes they take as regards their “patients.” Someone who is against abortion does not necessarily make an unconditional moral judgment against a patient, nor adopt a discriminatory attitude towards them. Vitória, a nursing assistant, 58 years old, condemns abortion under any circumstance. She states that adolescents abort indiscriminately, usually to “satisfy their egos.” Even so, according to her, youngsters become pregnant due to their lack of experience, thereby justifying why pregnancy should not be seen as their sole responsibility. Vitória softens her criticism against inexperienced adolescents and says there is little to be gained by trying to rebuke them: “It is far better to treat them well, offer them help and explain methods to avoid a future pregnancy.”

However, in the view of other professionals, these adolescents are simply immature, egotistical and lacking in education. The behavior of these young women in hospital is described as proof of this. A nursing assistant, Cíntia, for example, considers these adolescents to be “lazy and ignorant.” According to this healthcare worker, although adolescents are aware of contraceptive methods, most of them do not use them. In addition, they are not interested in acquiring new knowledge and, because of this, do not ask healthcare workers any questions, nor do they turn up for their pre-natal appointments.⁸ According to Cíntia, these young women also behave inappropriately when they are at the MHB, walking about without clothes, touching their bodies and, then immediately afterwards, touching the healthcare workers.

Perceptions such as these are potentially transformed into attitudes that lead to mistreatment. Although some professionals say that the institution attempts to combat such attitudes, we observed moralizing comments and attitudes of reprimand being used towards all young women, including new mothers (McCallum, Reis, 2005, 2006). Some healthcare workers, like Vitória, mentioned cases where women who had aborted or miscarried were mistreated, adults and adolescents alike.

Teresa, who is also a nursing assistant, observed that patients who had suffered a miscarriage ran the risk of being mistreated by the professionals, who accused them of having induced an abortion. Indeed, the interviewees confirmed this observation and three of them, who claimed they had miscarried, said that they had to convince healthcare workers that they had not induced the pregnancy loss themselves. Contrary to these discriminatory attitudes, Teresa stated that a policy of humanized care was needed for all users at the MHB, one that guarantees dialogue with health personnel and offers them help. An obstetrician called Luís highlighted the fact that, at the MHB, providing humanized care was a constant concern. However, when he was questioned about cases where women who had aborted were not well treated in public hospitals, in comparison to the way new mothers are treated, he replied:

This happens. We always try to make sure this does not happen, but it does, coming from the nursing assistants, the assistants and professional healthcare personnel themselves. A doctor can feel very strongly about a patient who has had an abortion, and so on. This has nothing to do with us, we have to try and treat and care for the patient in the best way possible. If she has provoked an abortion, that is her business, and it has nothing to do with us. We only have to take care of her and provide her with medical assistance.

There are differences of opinion as regards the way that patients who had aborted were treated at the MHB. In this survey, most of the healthcare personnel (69%) agreed that

“women who have aborted/miscarried⁹ usually suffer from some sort of prejudice on the part of health professional.” With regards the same type of discrimination, but in this case practiced by MHB personnel, 43% deny that this occurs at the hospital. They therefore tend to believe that the care provided at the MHB is more humanized than at other institutions.

Mara, 62 years old, nursing assistant, states that all the women receive equal treatment at the MHB. She complains about the “patients,” saying that they like to assume they are being badly treated: “This is not true. They like to put silly ideas into their heads!” Mara claims she always talks to the adolescents, warning them about the effects that multiple abortions have on their health, “which leave women sick, ugly or can even cause death.” According to her, she frequently encourages users to seek family planning services once they have been discharged from hospital.

Like Vitória, mentioned above, Cristina, who is also a nursing assistant, confirms that the way the organization treats patients who have lost or terminated their pregnancies, is discriminatory, and as an example she mentions the curettages, which are performed at the end of the day’s shift, as if “the patients were just ‘leftovers’” – using *restos* the same term used for the embryonic debris removed from the uterus. In short, there is no agreement among healthcare personnel about the treatment given to women who have aborted or miscarried, especially as regards the care given within the hospital. Some see signs of discrimination; others deny it exists.

The perspectives and experiences of users

That which precedes and surrounds a hospital experience is fundamental to understanding it. Abortion is influenced by questions related to the specific situation of a woman and the particular factors involved – her use of contraceptive methods, the type of relationship she has with her partner, the ease or difficulty she encounters when seeking to terminate a pregnancy (Menezes, 2006; Heilborn et al., 2012). Three narratives illustrate the complexities involved in the act of abortion.

Marta, Deborah and Lúcia

Reports of physical and emotional suffering – before admission to hospital, continuing after hospitalization – are prominent in the stories interviewees told. Yet the circumstances of each pregnancy, what they went through after conception and how they made the decision to have an abortion, are all different, as are their views of the treatment they received at the MHB.

Marta and Deborah are black and live in “low income” districts. Lúcia is white and lives in a middle-class neighborhood. Marta is 25 years old and has completed her secondary education; Deborah, who is 16 years old, attends secondary school. Lúcia, who is 20, is a university student at a private college and lives with her mother and sister. Marta lives with an aunt and has more financial resources than Deborah, who lives with her parents and one sister.

Marta became pregnant as a result of a casual affair with an ex-boyfriend, who removed his condom before ejaculating. She “panicked” and argued with her partner. She did not know about emergency contraceptive. She had already used contraceptives, unlike Deborah, who became pregnant during her first sexual relationship with her boyfriend, a relationship

that began two years before this happened. Deborah said she had wanted to “take some medicine” – an injectable contraceptive, using a prescription issued to a girlfriend – but that the injection was “very expensive,” and she did not see the need to use a condom with her boyfriend, because she had “known him for a long time.” Lúcia had her first sexual relationship when she was 15, with her boyfriend. When she was 20, she “swapped the pill for an injection” and became pregnant, which was unplanned. She really wanted this child and rejected the possibility of an abortion, claiming this was because of her religious beliefs and the support received from both families concerned (her own and her partner’s). When she was four months pregnant, she suffered a miscarriage.

Marta bought contraceptive pills after an unprotected sexual relationship and used them for fifteen days, until she suspected she was pregnant. This was confirmed by an ultrasound test performed at a private clinic. Like her ex-boyfriend, her reaction to this was one of “dread.” They both decided on an abortion, but, at the same time, said they were thinking of getting married and taking responsibility for the pregnancy. Although supported at times by her friend/ex-boyfriend, Marta was unable to organize an abortion and she felt very much alone as the pregnancy progressed. She began to feel angry at her ex-boyfriend, who had since travelled. As she was unable to buy Cytotec, she took a tea made of Rue leaves (*Ruta graveolens*) and a menstrual regulator, Regulador Xavier 2.¹⁰ She later used an injection, for which she paid R\$30.00, at a local pharmacy. Since this did not work, Marta became very worried and looked for a clandestine abortion clinic, but abandoned this idea when the pharmacist told her he had managed to obtain Cytotec. She inserted two pills in her vagina and had a second injection, which she couldn’t name. She had completed one month’s pregnancy at this time. Finally, Marta began to bleed in the form of a hemorrhage, but refused to seek admittance to a hospital, since she was “afraid” of hospitals and of not being well-treated. Her ex-boyfriend supplied a medication to stop the bleeding. When he delivered this, Marta gave him a “present:” when he opened the package tied up with a ribbon, the young man found a huge blood clot, which he believed to be the fetus.

Marta continued to feel nausea and her stomach remained distended. After performing a second ultrasound examination, the doctor confirmed that she had suffered a partial abortion and, as a matter of urgency, sent her to the MHB. Feeling cold chills, Marta thought she had an infection, but, frightened that her aunt might discover what happened, she returned home and told everyone she was going to spend the following night at a friend’s home. The next day she went with her ex-boyfriend to the MHB. She entered alone and afraid: “I was very frightened, because I did not know what would happen there, I only knew I would be humiliated because they do not treat people like me well, they attach little importance to people who have induced an abortion.”

The experiences that Deborah went through until she reached the MHB, were also torturous. Her boyfriend was against an abortion. Deborah told her older cousin about her sexual initiation, her pregnancy and desire to abort. She was advised to take an abortive tea, and she did this but without success. Her mother discovered she was pregnant and urged her not to induce an abortion. Deborah sought out her cousin, who purchased three Cytotec pills, which she took and also inserted in her vagina. Her boyfriend was against this and asked her to give up trying to induce an abortion, even though fearing for the future of the

baby. After 15 days, Deborah had an ultrasound examination, paid for by her cousin, and the doctor told her that the “fetus had suffered a hematoma.”

After that the cousin told her mother, who authorized and paid for the purchase of more Cytotec pills. Once again, Deborah took two pills and inserted another two. In addition, she took a tea of abortive herbs. She went back home but only after another 15 days returned for a second examination, which showed evidence of the gestational sac in her uterus. The doctor referred Deborah for a curettage. According to her, the procedure would “clean the uterus and provide space so that menstruation could occur.” The day after she had this examination, Deborah went to the MHB, accompanied by her mother.

Lúcia said she was alone when she began to bleed and have signs of a miscarriage. It was ten o’clock at night, and she called her boyfriend, who accompanied her to a private hospital. The parents of both were away and Lúcia’s private health insurance did not cover hospital expenses. Required to leave a deposit at the hospital, as a guarantee, she was unable to do so, as neither Lúcia nor her boyfriend had bank accounts. In view of this, the doctor suggested she should be transferred to the MHB. She arrived during the early morning and had to wait two hours to be seen. Once she was admitted to hospital, she was indignant to find that her boyfriend could not accompany her. She tried to rise from her hospital trolley to find him, but, as her bleeding intensified, she had to remain lying down. The doctor told her she would need a curettage, which could only be performed after eight o’clock in the morning. Lúcia recalled:

These people don’t treat us well – when people arrive there, when you have lost a child, they always think you have induced an abortion. I was very upset at the time; I couldn’t talk to anyone, to tell them that I really wanted to have this baby. The doctor arrived, removed the blood, which was already coagulated inside me and showed me this blood, as a kind of torture, implying: ‘Oh, see what you have done to your child, everything is putrid inside,’ just like that!

Lúcia’s experience at the MHB was in large measure negative. She spent the night in a labour ward, where she was unable to rest, because a woman who was giving birth moaned continuously. Her mother, who is a journalist, claimed to know the director of the hospital and managed to get into the OC. It was only her mother’s arrival that the healthcare professionals finally believed that Lúcia had not induced an abortion. She said she became the target of prejudice on the part of other users: “You took something. You are very young. You provoked this abortion.”

Marta also had to wait to be seen. She arrived in the morning to be admitted to the MHB. Very nervous, she spent the afternoon observing the women as they arrived and were admitted, while she continued to wait. She says she believes that the time she had to wait to be admitted was “normal,” since “all the rooms were full and pregnant women were waiting there as well, so I don’t think I was made to wait on purpose.” But she felt she was being discriminated against, since even pregnant women who did not need urgent hospitalization were seen before she was. “I couldn’t say anything, because I already thought that this is how it would be, that they would give preference to pregnant women rather than to those who had gone there to terminate their pregnancies.”

No professional offered her reassurance while she waited. When she was being examined, the doctor told her off for having eaten that morning and because she was not accompanied, which made her feel “humiliated.” After admittance, she had to wait again, since there were no spare beds in the OC. After another half an hour and now medicated, Marta is taken, walking, to the curettage room. There, she considers that, unlike the doctors, she was well treated by the nurse and an intern, in contrast to the treatment dispensed by the doctors: the anesthetist, who shouted at her not to move during the procedure, and the person who had processed her hospital admission. On waking from the curettage, Marta found she was alone in one of the OC rooms. Still feeling groggy, from the effects of the anesthetic, she called out for help, but people continued to circulate in the area and did not approach. Finally, the nurse who had been kind to her came into the room and Marta pleaded: “For the love of God, get me out of here!”

In the ward, Marta encountered several mothers with their newborn children. She felt that it was “embarrassing” to be with new mothers, since the people visiting them usually asked: “Where is your baby?” When she arrived in the ward, she tried not to look at the other women: “They were happy,” she recalled, “chatting about things that mothers do, how to give their baby a bath or to feed them.” Marta stated that she would have preferred the company of other women who, like her, had had abortions.

Deborah cried when she was admitted to the MHB. Her mother was not allowed to accompany her, even though this is a right guaranteed by law. She arrived at the hospital at nine o’clock and “went up” to the OC at 9:45. She was put on an intravenous drip in the early afternoon. Deborah said that, on seeing how nervous she was, they brought forward the curettage. Crying, she was transferred to the room where the procedure would take place. When she awoke, she started crying again, since she felt responsible for her abortion: “I killed my child, I killed my child.” She said her feelings were presumably due to the effects of the anesthetic: “I was not myself, I was affected by the drugs,” but said she would never forget that she had “killed her child” and that one day she would talk about this experience with the daughter she hoped to have in the future. However, she again declared that she was “too young to have a child” and that she had, therefore, made the right choice.

For Marta and Deborah, the process that preceded hospitalization and led up to their abortions was long, drawn-out, full of suffering and lonely. In this Lúcia, who could rely on the support of her partner, had a different experience. Both Marta and Deborah went through moments when they imagined having their child, but said that this was just a “fantasy.” In Marta’s case, the reaction of her partner made it clear that he would not accept the role of father and spouse, which led her to take the decision to abort. In Deborah’s case, she faced opposition, from her partner and even from her own mother, with regards her decision to abort her child. Even so, another relative’s emotional and logistical support was crucial in order to obtain the means to abort. Marta and Deborah lived this process alone: they experienced what seemed insurmountable difficulties in overcoming conflicts in relationships, financial and legal obstacles, and in obtaining abortifacients – especially Cytotec. For both, it was necessary to keep their pregnancy a secret, not only from society in general, but from some of their relatives (Deborah’s father, Marta’s aunt).

The need for secrecy marks the process of abortion from beginning to end, something that healthcare personnel did understand; thus, they noted that the young women do not usually like to spend much time at the institution, as the hospital's system required.

Interviewees who induced abortions had similar experiences in this respect. Once pregnancy was confirmed, the relationships they had suffered pressures and changes. The women in question considered the possibility of completing the full-term of their pregnancy, until the moment they understood that they could not have the child, for a variety of reasons, particularly those involving financial and relationship issues. Knowing that she is pregnant, a woman goes through an imaginary process where she experiences the sense that her pregnancy is a relationship with a potential child, and imagines how her relationship with the baby will be in the future, while also experiencing a relationship in the present. Thus, several interviewees used the phrase, "my child," to refer not only to the aborted fetus, but also to the feelings she had experienced when thinking about her pregnancy, before inducing an abortion.

The decision to abort is never taken alone and it is an experience that is not easy to face, as other studies in Brazil have shown (Costa et al., 1995; Ramirez-Galvez, 1999; Menezes, 2006; Heilborn et al., 2012; Silveira, 2014). When a woman reaches the conclusion that an abortion is "the only way out," she has already considered a variety of negative issues, such as: the fact that abortion is a crime; the difficulties involved in trying to find the means to provoke an abortion; the opposition from partners, relatives, and others; information that the procedures adopted can cause some sort of damage to one's health.¹¹

Relationships between these women and the healthcare institutions become part of this negative scenario. This relationship is riddled with distrust and marked by the fear that they will suffer mistreatment at the hands of doctors and other healthcare personnel. As a result, the women delay going to hospital. Among other harmful effects, this also means that, once hospitalized, they are in a state of tension and insecurity, until such a time as any caring attitudes shown by the health team alter this feeling.¹²

Anti-mothers and mothers: symbolic processes and hospital care

When a mother arrives at a public maternity hospital with an induced abortion, she has already gone through a series of experiences that test her socially and emotionally. At this particular moment, she is psychologically vulnerable and often suffering symptoms that indicate ill-health, such as fever and hemorrhaging. Although women who have miscarried have similar experiences, the fact that they have not induced an abortion gives them a certain moral superiority compared to those who have. The way both are treated at the hospital, however, tends to be the same, since all are seen as having induced an abortion: "guilty" until able to prove their "innocence."

Like women in labour, women who are miscarrying or have sought to terminate their pregnancies have to face a "via dolorosa," for they must go from hospital to hospital until they find one that has an available bed and can admit them. Alzira, four months pregnant, went to four hospitals for treatment until finally being admitted to MHB. Like most of the other interviewees, when her admission to MHB was finally confirmed, she felt that an end

to her suffering was finally in sight. Irrespective of the time they arrived at the maternity hospital, most of the women said they had to wait until early evening for a curettage. In general, they consider this to be quite “natural,” since expectant mothers represent “cases” that are of greater importance and urgency.

However, few of them understood the procedures to which they were to be submitted. Most relate that they were very frightened and that the healthcare personnel did not explain to them what would happen, except for a few details just before the curettage took place. Lia recalls that, although she was terrified at the prospect of having a curettage, which she thought would be extremely painful, she sought to comfort two other adolescents, telling them, even without knowing this herself, that the procedure would be painless. It was only when she was transferred to the operating room where the procedure would take place, that Lia was informed that she would have a general anesthetic and that she would therefore feel no pain.

It is perhaps this lack of advance information, especially within the hospital environment where the curettage will be performed, that explains why the interviewees thought that a curettage involves removing the uterus from within the abdomen to the “outside,” to be emptied of “remains” and “unclean waste,” before being replaced in the “stomach.” This understanding, which was frequently expressed by the women involved in this research study, articulates the idea that doctors are the ones responsible for sanitizing the body and, especially, the uterus, making it possible to renew feminine fertility. Some of the MHB users shared the theory that “cleaning the uterus” by means of a procedure of curettage increases the capacity of a woman to become pregnant again.

Although pain and suffering define women’s experiences during the process of abortion, we found that most of those interviewed, even those who made critical comments,¹³ gave a positive evaluation of the treatment they received at the MHB. Dolores, Virginia, Karine and Deborah, who induced their abortions, and Alzira, who had a miscarriage, stated that they had received good treatment at the hospital, making comments such as: “I loved the MHB,” “I felt protected,” “I liked it,” “they treated me super well.” Magaly also said she liked the way she was treated, although she expressed less enthusiasm than the above-mentioned interviewees. Like Bruna, Magaly said that she “had not felt discriminated.” However, Olívia, Marta and Lia criticized the treatment they had received, especially as regards the time they had to wait to be seen. However, Lúcia, gave the most negative rating as regards the care she received at the MHB. “Shocked” at what she had witnessed, she claimed she had been the victim of mistreatment and discrimination. Lúcia already had a negative image of the public health system (SUS). Together with her actual experiences at MHB, this gave rise to her criticisms of the treatment she received. One should not forget that this was the first time that Lúcia, a middle class girl used to her private health insurance, had sought the services of a public healthcare center.

The interviewees expressed very different opinions vis-à-vis the health professionals. Analyzing the same body of data as that discussed here, Santana (2003, p.18) comments: “The women who have abortions or miscarry undergo a range of experiences at the institution. They have no guarantee that they will be well-treated, since there is a lack of constancy in the attitudes of health professionals. The type of attention they receive varies according to the personal views or ‘humor’ of the professionals concerned.”

Indeed, the accounts the 11 interviewees provided do support this observation. When analyzing the way the health professionals treated them, the young women remember individual attitudes, describing whether the person was abrupt, cold, and rude or, on the contrary, showed affection and respect. For example, Deborah described a friendly conversation she had with a young doctor and what she learned about the effects of Cytotec in the uterus: “He told me that it was like throwing acid at someone.”

Some of the interviewees, even those who gave a positive evaluation of their treatment, described hearing aggressive comments and witnessing cruel or even shocking scenes.¹⁴ For instance, Olívia said that while she was being examined at admissions, a doctor had asked her: “Who wants to see a dead fetus?” However, she emphasized that another doctor who was attending her “looked into his face with an expression of disapproval.” Later, when she was already in the OC, Olívia saw an adolescent of 16 expelling a dead baby: “She shouted and shouted, but no one came to help her, because all the doctors were busy delivering babies.”

How can one explain the reasons, from the perspective of the interviewees who had miscarried or had abortions, why someone would give a positive evaluation of the treatment they had received? At first sight, it seems strange to give an evaluation of this kind, bearing in mind the suffering experienced by all those interviewed, as described in their statements. Although the experiences of such women are similar in some aspects to those of women giving birth,¹⁵ our data shows clear evidence of discrimination in a variety of forms against women who had abortions or miscarried at the hospital investigated.

Actions taken at MHB to humanize the care given to these women encouraged some health professionals to think about their attitudes and actions and to try and change them. However, these measures did not change the stance or behavior of others. At MHB – as is the case of other public services in Brazil – no special attention is given to this problem. As a result, any institutional concerns about combatting discrimination and improving services for certain categories of users (especially those who have the right to a legal abortion) tend to become diluted in the course of the daily services they provide. More than this, a negative attitude exists, insofar as the institution pays no attention to the specific characteristics of women who are aborting or miscarrying.

This is related to an important factor that encourages discriminatory practices: health professionals and users perceive MHB as a place that is dedicated above all to childbirth. Thus, the demand for abortion/miscarriage care is at odds with the institution’s main objective; it is seen as being less legitimate than care in childbirth.

The assumption that MHB is a “maternity” hospital – a place where women become mothers – is ingrained into institutional practice. We merely have to remember that curettages are performed at the end of the afternoon, after the caesarians and normal childbirths have taken place, precisely because childbirth is seen as a priority. The way that physical space is structured and the organization of hospital practices also reflect this assumption: the room where curettages are performed is located in a less visible area of the OC; the ward of “those infected,” occupied by most of the women who have terminated their pregnancies, is also in a less visible part of the wing where the wards are found. This division of space perhaps results from institutional strategies to conceal an illegal practice that negates motherhood.

The way professionals address and refer to users, described above, also reinforces our analysis. When a health professional calls a user “mother,” it is evident that, as an integral part of the healthcare services provided, she is also conferring an identity on the woman. The way that care for “curettes” is organized marginalizes such women in space and time, making it clear that the hospital is mainly concerned with taking care of mothers, and not those who have miscarried or terminated their pregnancies.

These women therefore end up in the position of “anti-mothers,” a connotation contained in the terms of reference themselves: “curette” and “infected.” This symbolic message, which is part of the way care is structured, permeates the actual care given, being repeated during the whole period that the women stay at the hospital.

Final considerations

Failings in the care given at MHB to women who have lost or terminated their pregnancies is not simply the result of the “prejudiced” attitudes that we identified when focusing on the behavior of health professionals there; other factors are also involved. While it is evident that some of the professionals working at the institution showed overt prejudice and treated all users, whether adolescents or not, in an inhuman way, we should be clear that their actions are shaped by the broader context. More importantly, the underlying meanings giving form to the institution’s *raison d’être* – to help women become mothers – negatively interfere in the care given to women who have had abortions or miscarried. The obstetric violence shown towards these women takes shape, therefore, through symbolic process, gaining contours in the negative meanings that find their expression in the way care is structured and practiced in the institution.

This signifying process, which underlies hospital practices, has as its ally the hospital users themselves. This is also true of women who have had abortions, when they accept their categorization as “anti-mothers.” One way of interpreting this is to say that their experience of care at the MHB is conditioned by the moral attitude in relation to self-induced abortion that many women share, even before they arrive at the doors of the hospital. Thus, those who induce abortion tend to accept the treatment given without any sense of anger. They arrive at hospital already expecting to be criticized, not only by healthcare personnel, but also by others. On the other hand, those who have not induced an abortion react to any mistreatment by saying that the accusations are not fair: after all, they are not to blame, since they want to be mothers – even though they do not approve when they see that other women are not treated well. The experience of a miscarriage is therefore, affected by a whole array of meanings and practices that revolve around an induced abortion.

The knowledge that “abortion is wrong” therefore gives women the feeling that they deserve less than optimal treatment. As indicated in other studies on the subject (Pedrosa, Garcia, 2000; Carneiro, Iriart, Menezes, 2013), our interviewees mentioned feeling a sense of guilt and anguish during their stay at the hospital. There is something more than just the idea that they do not deserve to be as well treated as mothers-to-be, when they judge their care in a positive way, or when they do not criticize what could be interpreted as mistreatment. In the first place, it is common for low-income users not to react in other situations requiring

medical care, since they know they run the risk that those that care for them turn against them and deny them what they need at a particular moment. Secondly, not all these women made explicit feelings of guilt. Rather, what emerges clearly is the sense of ambiguity that surrounds guilt as such. Although they say they did something “wrong,” these women insist that this was something that needed to be done at that particular moment. This is the same evaluation given by obstetricians and gynecologists who have themselves experienced abortion, as noted by Faúndes et al. (2004). For some, there is, indeed, a sense of relief knowing they are no longer pregnant, helped by the ending of symptoms of pregnancy and/or abortion and the return to a state of physical normality.

Finally, the long and painful process that women have to undergo before they even reach a hospital is fundamental to understanding how they evaluate what happens to them during the period of care. They see the hospital institution as a place where their suffering will come to an end and their physical problems solved. For them these problems, although fundamental, are just one aspect of a wider and more complex dilemma. There, in user’s understanding, the process of terminating or losing a pregnancy, which generally began days or weeks beforehand, is brought to an end. It is where they regain their physical health and become fit enough to return to their daily lives. And it is precisely for this reason that, together with the sadness of having caused “the death of a child,” as they describe their feelings after an abortion, our interviewees state that they felt, above all, a great sense of relief. Ironically, it is this sense of relief from suffering that maternity hospitals offer that helps perpetuate a cruel and inefficient care structure, since neither the users, nor others involved, do anything to change the treatment given to women who have induced an abortion or suffered a miscarriage.

ACKNOWLEDGEMENTS

We would like to thank the World Health Organization, who provided funding for this Project, through the Special Program of Research, Development and Research Training in Human Reproduction; and the Research Support Foundation of the State of Bahia (Fundação de Amparo à Pesquisa do Estado da Bahia, Fapesb), who awarded a visiting professor fellowship to Cecilia McCallum, during 2004-2005, making it possible to complete this case study analysis and to promote its findings. We would also like to thank Estela Aquino and other colleagues at Musa – the Integrated Gender and Health Studies Program, at ISC, for their comments and support. We are particularly grateful to the professors at the Institution highlighted in this study and to the young women we interviewed. A preliminary version of this article was presented at the following forums: ST05 Youth: Sexuality, Gender and Reproduction, 30th Annual Meeting of the National Association of Graduate Studies and Research in Social Sciences (Anpocs – Associação Nacional de Pós-graduação e Pesquisa em Ciências Sociais), in 2006; Making Gender (Fazendo gênero), Florianópolis, 2007; RAM 2005.

NOTES

¹ In Brazil, the notion of “humanization” applied to hospital care and especially in cases of childbirth involves a series of meanings. See Diniz (2001); Tornquist (2002, 2003, 2004).

² Silveira (2014) states that, although abortions performed in private clinics can sometimes make it easier to have access to faster methods, that are safe and without involving apparent health risks, women pay exorbitant prices for this, do not have their reproductive rights guaranteed and are exposed to obstetric violence.

³ The commercial name of Misoprostol, a type of prostaglandin used to treat gastro-duodenal ulcers, which has been widely used by women to promote uterine muscular contractions.

⁴ Following the convention of anthropological terminology, we decided to use the present tense, known as “ethnographic present.”

⁵ Medical Statistics Archive service, which is where the Hospital’s medical records and medical care service files are stored.

⁶ The MVA is a procedure recommended by the WHO and by the International Federation of Gynecology and Obstetrics, until the twelfth week of pregnancy (OMS, 2013; Brasil, 2005). Since 2000, the use of this in public hospitals has been regulated by Decree No.569.

⁷ For descriptions of these procedures, see Brasil (2005).

⁸ As we shall see, young users have a rather different explanation for the difficulties they had in communicating with healthcare professionals.

⁹ The term *aborto* in Portuguese refers to both abortion and miscarriage.

¹⁰ Medication with herbal and painkilling substances, indicated to regulate excessive menstrual flow and to relieve cramps and discomfort caused by menstruation.

¹¹ Several informants mentioned, for instance, that Cytotec “corrodes the fetus and uterus.”

¹² Dalsgaard (2004) describes a similar relationship between women and maternity hospitals.

¹³ In the feminist discussions about care for those who have had abortions, there is a tendency to assume that the evaluation given by the users will always be negative. See Menezes, Aquino (2009). Our own analysis shows that the reaction is far more complex.

¹⁴ In connection with this, see Macedo (2005).

¹⁵ To read about the experiences of new mothers, see McCallum, Reis (2005).

REFERENCES

- AQUINO, Estela Maria Leão et al. Qualidade da atenção ao aborto no Sistema Único de Saúde do Nordeste brasileiro: o que dizem as mulheres? *Ciência e Saúde Coletiva*, v.17, n.7, p.1765-1776. 2012.
- BARBOSA, Regina Maria; ARILHA, Margareth. A experiência brasileira com o Cytotec. *Revista Estudos Feministas*, v.1, n.2, p.408-417. 1993.
- BRASIL. Ministério da Saúde. Secretaria de Ciência, Tecnologia e Insumos Estratégicos. *Aborto e saúde pública no Brasil: 20 anos*. Brasília: Ministério da Saúde. 2009.
- BRASIL. Ministério da Saúde. Secretaria de Atenção à Saúde. *Atenção humanizada ao abortamento inseguro: norma técnica*. Brasília: Ministério de Saúde. 2005.
- CACIQUE, Denis Barbosa; PASSINI JR., Renato; OSIS, Maria José Martins Duarte. Opiniões, conhecimento e atitudes de profissionais da saúde sobre o aborto induzido: uma revisão das pesquisas brasileiras publicadas entre 2001 e 2011. *Saúde e Sociedade*, v.22, n.3, p.916-936. 2013.
- CARNEIRO, Monique França; IRIART, Jorge Alberto Bernstein; MENEZES, Greice Maria de Souza. “Largada sozinha, mas tudo bem”: paradoxos da experiência de mulheres na hospitalização por abortamento provocado em Salvador, Bahia, Brasil. *Interface – Comunicação, Saúde, Educação*, n.17, v.45, p.405-418. 2013.
- COSTA, Roseli G. et al. A decisão de abortar: processo e sentimentos envolvidos. *Cadernos de Saúde Pública*, v.11, n.1, p.97-105. 1995.
- DALSGAARD, Anne Line. *Matters of life and longing: female sterilization in Northeast Brazil*. Copenhagen: Museum Tusculanum Press. 2004.
- DINIZ, Carmen Simone Grilo. *Entre a técnica e os direitos humanos: possibilidades e limites da humanização da assistência ao parto*. Tese (Doutorado em Medicina Preventiva) – Universidade de São Paulo, São Paulo. 2001.
- DINIZ, Débora; MEDEIROS, Marcelo. Aborto no Brasil: uma pesquisa domiciliar com técnica de urna. *Ciência & Saúde Coletiva*, v.5, supl.1, p.959-966. 2010.
- FAÚNDES, Aníbal et al. The closer you are, the better you understand: the reaction of Brazilian obstetrician-gynaecologists to unwanted pregnancy. *Reproductive Health Matters*, v.12, n.24, suppl., p.47-56. 2004.

- HEILBORN, Maria Luiza et al.
Gravidez imprevista e aborto no Rio de Janeiro, Brasil: gênero e geração nos processos decisórios. *Sexualidad, Salud y Sociedad*, n.12, p.224-257. 2012.
- MACEDO, Ulla.
“Útero em cena”: implicações e desdobramentos do uso da ultrassonografia obstétrica. Monografia (Conclusão de Bacharelado em Ciências Sociais) – Universidade Federal da Bahia, Salvador. 2005.
- MARTINS-MELO, Francisco Rogerlândio et al.
Tendência temporal e distribuição espacial do aborto inseguro no Brasil, 1996-2012. *Revista de Saúde Pública*, v.48, n.3, p.508-520. 2014.
- MCCALLUM, Cecilia Anne.
Vítimas egoístas: perspectivas sobre la sexualidad, raza, clase y adolescencia desde un hospital de maternidad en Salvador, Brasil. In: Wade, Peter et al. *Raza, etnicidad y sexualidades: ciudadanías y multiculturalismos en América Latina*. Bogotá: CES. p.137-166. 2008.
- MCCALLUM, Cecilia Anne.
Sem nome: pessoa como processo na dinâmica racial e de gênero brasileira. In: Pina-Cabral, João de; Viegas, Susana de Matos (Org.). *Nomes: gênero, etnicidade e família*. Coimbra: Almedina. p.265-289. 2007.
- MCCALLUM, Cecilia Anne; REIS, Ana Paula dos.
Users “and carers” perspectives on technological procedures for “normal” childbirth in a public maternity hospital in Salvador, Brazil. *Salud Pública de México*, v.50, n.1, p.40-48. 2008.
- MCCALLUM, Cecilia Anne; REIS, Ana Paula dos.
Ressignificando a dor e superando a solidão: experiências do parto entre adolescentes de classes populares atendidas em uma maternidade pública de Salvador-Bahia. *Cadernos de Saúde Pública*, v.22, n.7, p.1483-1492. 2006.
- MCCALLUM, Cecilia Anne; REIS, Ana Paula dos.
Childbirth as ritual in Brazil: young mother’s experiences. *Ethnos*, v.70, n.3, p.335-360. 2005.
- MENEZES, Greice Maria de Souza.
Aborto e juventude: um estudo em três capitais brasileiras. Tese (Doutorado em Saúde Pública) – Universidade Federal da Bahia, Salvador. 2006.
- MENEZES, Greice Maria de Souza; AQUINO, Estela Maria Leão.
Pesquisa sobre o aborto no Brasil: avanços e desafios para o campo da saúde coletiva. *Cadernos de Saúde Pública*, v.25, n.2, supl., p.193-204. 2009.
- OMS.
Organização Mundial da Saúde.
Abortamento seguro: orientação técnica e de políticas para sistemas da saúde. 2013.
Disponível em: http://apps.who.int/iris/bitstream/10665/70914/7/9789248548437_por.pdf. Acesso em: 8 nov. 2014. 2013.
- PEDROSA, Ivanilda Lacerda; GARCIA, Telma Ribeiro.
“I’ll never forget it!”: women’s experience with induced abortion. *Revista Latino-Americana de Enfermagem*, v.8, n.6, p.50-58. 2000.
- PERPÉTUO, Ignez Helena Oliva; WONG, Laura Rodriguez.
Desigualdade socioeconômica na utilização de métodos anticoncepcionais no Brasil: uma análise comparativa com base nas PNDS 1996 e 2006. (Dimensões do processo reprodutivo e da saúde da criança. Pesquisa Nacional de Demografia e Saúde da Criança e da Mulher: PNDS 2006). Brasília: Cebrap; Ministério da Saúde. 2009.
- RAMIREZ-GALVEZ, Marta Célia.
Os impasses do corpo: ausências e preeminências de homens e mulheres no caso do aborto voluntário. Dissertação (Mestrado em Antropologia Social) – Universidade Estadual de Campinas, Campinas. 1999.
- SANTANA, Fábila S.
Trajetórias em saúde reprodutiva: narrativas de mulheres jovens sobre o aborto, atendidas em uma maternidade pública de Salvador. (Relatório). Salvador: Universidade Federal da Bahia. 2003.
- SILVEIRA, Paloma.
Experiências de abortos provocados de mulheres e homens de estratos sociais médios no Nordeste brasileiro. Tese (Doutorado em Saúde Coletiva) – Universidade Federal da Bahia, Salvador. 2014.
- SOARES, Gilberta Santos; GALLI, Maria Beatriz; VIANA, Ana Paula.
Advocacy para o acesso ao aborto legal e seguro: semelhanças no impacto da ilegalidade na saúde das mulheres e nos serviços de saúde em Pernambuco, Bahia, Paraíba, Mato Grosso do Sul e Rio de Janeiro. Dossiê. Recife: Grupo Curumim. 2010.
- TORNQUIST, Carmen Susana.
Parto e poder: o movimento pela humanização do parto no Brasil. Tese (Doutorado em Antropologia) – Universidade Federal de Santa Catarina, Florianópolis. 2004.
- TORNQUIST, Carmen Susana.
Paradoxos da humanização em uma maternidade no Brasil. *Cadernos de Saúde Pública*, v.19, n.2, supl., p.419-427. 2003.
- TORNQUIST, Carmen Susana.
Armadilhas da Nova Era: natureza e maternidade no ideário da humanização do parto. *Revista Estudos Feministas*, v.10, n.2, p.483-492. 2002.