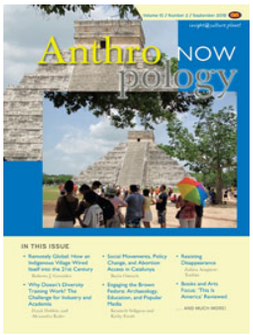

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# Social Movements, Policy Change, and Abortion Access in Catalunya

*Bayla Ostrach*

## Introduction

In mid-2010, residents of Spain and Catalunya gained greater access to publicly funded abortion as a result of the Socialist government then in power liberalizing abortion laws.[1] This followed years of grassroots organizing by feminist and reproductive health coalitions. Under popular pressure, elected officials changed legislation that previously allowed abortion only under a set of qualifying circumstances, or for pregnancies resulting from rape and incest. Years of popular efforts expanded the legal grounds under which an abortion could be obtained — for any reason in the first trimester and under a set of qualifying reasons in the second trimester.[2] While international press coverage described the 2010 changes as a "legalization" of abortion, providers and activists among whom I conducted fieldwork in 2012–2013 described it as "liberalization" of a 1985 law that allowed abortion under circumstances now applied to second-trimester abortion — though rarely with public funding.

The reforms and resulting inclusion of publicly funded abortion in health system services were extended to autonomous regions such as Catalunya, long considered by the Spanish government part of Spain. Yet for many people I met, and increasingly among residents of Catalunya, the legal, economic and political relationship between Spain and Catalunya is — to put it mildly —a contested one. In Catalunya, the movement for full separation from Spain intensified rapidly during my fieldwork there. It has grown even stronger since, and more so now, under a coup, as Spain has indicted and even jailed many democratically elected Catalan parliamentary leaders and the Catalan President following an October 2017 referendum on full separation.[3] During the research described here, the complicated nature of these geopolitical relationships shaped local responses to social movements, public policy and abortion access.

Such shifts in the region emerged and evolved against the backdrop of an ongoing economic crisis in Europe and globally — the effects of which the Spanish government disproportionately imposed on Catalunya. Downstream effects had severe local impacts through austerity measures that affected the health system, dramatically so for those seeking abortion. Initially ordered to cut off health care for immigrants under a eurozone austerity deal imposed on Spain and relayed to Catalunya, the Catalan government resisted. Rather than cutting off health care for the most vulnerable, even centrists defended health care for new arrivals.

**In Catalunya, the movement for full separation from Spain intensified rapidly during my fieldwork there.**



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[redacted] *Photo by Bayla Ostrach.*

caption: "We are the most powerful weapon with which to change the world."

Instead of imposing a three-month residency requirement before immigrants could obtain health cards, the Catalan government announced the waiting period would not apply to pregnant women, children or those with disabilities. This policy intertwined with other effects of the crisis, an evident lack of training and accountability, and other factors to constrain access to abortion. Providers and clinic staff, many of whom identified as supporters of Catalan independentism, referenced the insistence on preserving health care for immigrants as an example of a broader Catalan commitment to justice and public health care for all. They rhetorically contrasted it with the Spanish government cuts to health care they recognized as widespread under the crisis.

I arrived in Barcelona in August 2012 to begin fieldwork exploring how immigrants and others seeking publicly funded abortion navigated the Catalan public health system, following reforms and ensuing policy changes, and to examine whether they encountered obstacles. A week later, the local government announced Spain's imposition of new austerity measures, including pressure to cut off immigrant health care. Using surveys, open-ended interviews and participant observation in a clinic contracted with the health system to provide abortion, I investigated how people experienced and overcame obstacles to obtaining and providing abortion.

Austerity, crisis, social movements and policy changes shaped women's experiences navigating the health system to access publicly funded abortion, as I learned while collecting surveys and conducting interviews and conducting participant observation in a clinic contracted with the public health system and with a regional women's health NGO. During participant observation, I first observed and eventually began to assist in various areas of the clinic, primarily in the medical social work office. During most of the research period, the clinic where I carried out fieldwork was the only abortion clinic contracted to accept referral vouchers in the Catalan public health system, for both first- and second-trimester abortion. Patients attending thus represented a wide cross section of women obtaining publicly funded services during that time. The average income reported by those arriving at the clinic fell just slightly above the poverty threshold for Catalunya. At least 25 percent of women seeking publicly funded abortion reported zero income. Nearly half (46 percent) traveled from outside Barcelona. Two clinics in large towns an hour or more away, accessible by commuter rail, were home to

abortion clinics not then contracted with the health system.

As described in my recent ethnography,[4] an early conversation the day I arrived in the field foreshadowed the contexts in which I would examine threatened cuts to public health coverage for immigrants. Coming from the airport into town to begin fieldwork, I answered a friendly Catalan cabdriver's question about my plans in his city by explaining I'd arrived to undertake doctoral research about the public health system. He hastened to tell me *La Crisis* (what locals called the ongoing recession) would cause problems for public health. He informed me Spain wanted Catalunya to cut back health care spending, and immigrants would likely be the first to lose services. Within days, headlines confirmed it.

That proved to be only the first of many such conversations in which a self-proclaimed Catalan pride in caring for immigrants and defending social services loomed large. "I am Catalan," the taxi driver had boomed from the front seat, "and the Catalan health system covers everyone." The driver framed such coverage as necessary for public health, social stability, justice. He described it as inherently Catalan, as many others I interviewed would. This was, of course, not an uncomplicated framing or a simple, uncontested claim to make. When the Spanish government demanded the cessation of public health coverage for immigrants in the region without labor contracts, the Catalan government in fact refused, instead instituting "only" a three-month residency requirement, which was unprecedented.

Policy makers, health system workers and providers implemented reforms within the existing public health system. This happened as the effects of the wider eurozone and Spanish austerity climate became visible in increasing delays and difficulties many experienced while seeking vouchers required for publicly funded abortion. In addition to my fieldwork being informed by the global economic crisis, austerity measures and social movements against austerity and in favor of Catalan independentism, participants also discussed looming threats to the legal status of abortion.

Responses on the surveys, in interviews and in interactions in the clinic revealed persistent delays experienced in obtaining required referral vouchers from neighborhood health system offices. Under existing policy, vouchers should have been given at the first visit to health system offices, when requested and without an appointment. The abortion could not be performed until three days after the date on the referral voucher. This was according to a widely imposed "reflection period" that does not appear in the language of the 2010 law.[5] However, the health system, officially, must give the referral voucher without delay. Then it is the clinic's responsibility to ensure the abortion is not initiated until three days pass. My research revealed that women also reported challenges related to travel, time off and child care needs, and a mix of social support perceptions.

## Health System Delays, Obstacles and Social Support

Reinforcing what survey data and clinic observations revealed about delays and difficulties with health system coverage, women

seeking publicly funded abortion and clinic and NGO staff reported delays, misinformation, and problems getting the required referral vouchers from health system staff, as well as structural constraints, and, in some cases, a lack of social support that could exacerbate the challenges of overcoming other obstacles.

Take for example Frida.[5] She was 27 years old, had recently immigrated to Barcelona from Colombia and was both a doctoral student and janitor. Frida described experiencing a runaround at her neighborhood health center and being given inaccurate information at several turns. Not only did health system representatives tell Frida that she had to go away and think about her decision, they forced her to return three times over two days. She interacted with different health system workers each time. Only then did she succeed in securing the referral voucher necessary to get a publicly funded abortion. All of this was in violation of existing policy.

Under the 2010 abortion law, as implemented in the Catalan health system at the time, she should only have had to go in once and should have received a voucher the same day. As she described it, it was Frida's boyfriend's supportive presence that facilitated her persistence in going back repeatedly to insist on ultimately getting the voucher to which she was fully entitled under both Spanish law and Catalan public health policy. Several participants who did not receive enough social support indicated that this made it harder to face other aspects of the process of seeking publicly funded abortion.

Alina, a 25 year old Rumanian sex worker who had been in Barcelona for six years, struggled to complete her abortion procedure for a variety of reasons. These included the apparent health system–perpetuated stigma toward sex workers that resulted in her being referred for unnecessary and ultimately irrelevant blood tests for hepatitis C; repeated delays in issuing a new referral voucher, which delayed her from the first to the second trimester while awaiting the results; and difficulty finding someone to accompany her. The clinic would not perform Alina's second-trimester abortion unless she had someone present to accompany her afterward, and she expressed fatalism in our interview about her chances of finding an accompanier. She described her elderly parents living back in her home country, her lack of close friends in Barcelona and her challenging financial straits.

Alina first sought a voucher for publicly funded abortion care in the Catalan health system early in the first trimester of her pregnancy. Through a combination of logistical, health system and social support challenges Alina reached 15 weeks' gestation by the time she obtained an abortion. All of these difficulties were compounded by stigma about her nationality, occupation and social status, as evidenced by her treatment by the public health system and contracted clinic workers. In terse, hopeless sentences shared with me while we sat in the tiny plywood-partitioned room she rented a few blocks off the *Ramblas*, the emblematic tourist avenues in central Barcelona, Alina linked her difficult economic situation and her need for a public health system abortion to the Crisis and resulting diminishing demand sex work services. "Things are very bad … they [local men] can't even afford to come to me

now. They must be content to sleep with their wives!"

In such stark descriptions, Alina described a dramatic reduction in numbers of local clients coming to see her, and fluctuation in tourist demand for her labor since the global economic crisis and its intensified effects, as felt through increased austerity enacted on Catalunya in the second half of 2012. Despite her dire economic circumstances, and a likely eviction from even her tiny makeshift room the same week as her abortion, Alina told me the hardest aspect of it all was the lack of support. Social support can be key to overcoming obstacles to abortion. Whether this is even more true in settings of crisis and austerity merits further research.

Duran, a 35 year old Andalusian who had been in Catalunya for four years, perceived adequate support from her partner and his family during the process of seeking an abortion. However, in her case, she had wanted to carry the pregnancy to term. At her home in a small town an hour outside Barcelona, Duran told me that due to the economic crisis and her husband's precarious employment, they realized they could not afford a third child. As for many participants, staff at her local health system center did not tell her, in any of the multiple visits she made to ultimately get the required voucher, that her abortion would be paid for under the recently liberalized abortion law.

Duran had earlier sought a pharmacologic abortion at the health system office closest to her home but was not given a timely appointment for the first vists. When she arrived for the appointment she was given, she was already too far along for a medication abortion. They referred her to Barcelona for an instrumental procedure — an unnecessary trip had they scheduled her initial appointment sooner, based on a simple question about her last period. The local office eventually sent Duran to Barcelona with a voucher, though they apparently did not tell her (as was true for fully 51 percent of participants) it would cover her costs.

By the time the voucher was ready for Duran's trip, she had already taken time to ask her husband's family for money, assuming she would need to pay cash for care obtained beyond the neighborhood center. She resorted to fundraising, for an abortion she did not really want to have, while jumping through hoops and facing scheduling delays, because local health staff had evidently not been effectively trained, or had not bothered, to tell her the abortion for which they made her wait would be covered. By the time she reached Barcelona, Duran was near the end of the first trimester — after seeking an abortion many weeks earlier. Staff where I collected data mentioned health system centers outside of

**She resorted to fundraising, for an abortion she did not really want to have, while jumping through hoops and scheduling delays, because local health staff had evidently not been effectively trained, or had not bothered, to tell her the abortion for which they made her wait would be covered.**

Barcelona were less likely to be fully staffed and may not have providers trained to complete referral vouchers on-site everyday — especially in the wake of austerity cuts.

## Austerity and Health Policy

Some women, particularly Catalans and immigrants who had lived in Catalunya for a long time or grown up there, discussed not wanting to seek support or logistical help from friends, family members or partners. They preferred to be "superwomen" who faced it all alone and found strength in this. Some mentioned that asking for help could mean a sister or husband would risk losing an already precarious job in the context of rampant unemployment and readily available labor supply to take a day off and accompany them. Several participants talked explicitly about links they perceived between *La Crisis* and austerity — and, often, a reluctance to ask or allow anyone to help them overcome health system and other obstacles to obtaining publicly funded abortion.

Carla was a 36 year old Catalan janitor with one child. Her employer illegally fined her €150 for using her government-guaranteed paid medical leave to take a day off to go to her abortion procedure. She expressed particular concern about her husband risking his job if he also took the day off to go with her. Instead, she chose to forgo twilight sedation, which involves IV narcotics and sedatives that would have allowed her to be asleep through her instrumental abortion. Instead she requested only a local anesthetic to numb the cervix, so she could go to the clinic alone. Crisis and austerity directly impacted not only access to the publicly funded procedure Carla sought and the sedative she chose, but her motivation for the abortion, as well. She described deciding how many children to have based on the "penury" a child would suffer if the family already has a child, and then has another, during crisis/austerity. Consequently, she chose not to continue her pregnancy. She framed this as a reason abortion must always be publicly funded.

Months before I interviewed Carla on a park bench near her metro station in a working-class suburb of Barcelona, another Catalan mother of a toddler, Afrodita, used very similar language to describe her own reasons for navigating the health system to seek an abortion. Younger than Carla, at 25 years old, she stated the economy did not permit her to have a second child, though she would have liked to. She echoed Carla's distinction between what can be provided to one child, versus two, and was adamant that she would rather care well for one child than have two go hungry.

In fact, Afrodita had a veritable outburst during the interview that took place in her small but comfortable flat in another working-class suburb. Despite professing to be personally opposed to abortion, she burst out with an impassioned defense of publicly funded abortion in the context of austerity. Proclaiming, like Carla, that "abortion must always be free!" she spoke about the challenges of parenting when social services are rapidly being defunded, under austerity, and specifically mentioned the reduction in subsidies for child care and nursery school and the lack of public funds for mothers caring

for children with disabilities. Multiple participants, not only Carla, echoed Afrodita's comment about "preferring to care for one child well than have two that go hungry," nearly verbatim.

Another Catalan woman who linked the crisis to her decision to have an abortion and who, like Carla, preferred to face the process alone, chose as her pseudonym "Superwoman." She was 24 years old, working in a research lab, waitressing and going to school. Despite having physician parents and a sister she thought would be supportive if she carried to term, this self-assured young woman nevertheless worried about how she could provide for a child without being financially reliant on family members with whom she often had conflict. Superwoman worried about times getting harder for her generation, under the crisis: "We've always fought for this health system, that now they are taking away [through austerity] … I don't know what we will do."

What emerged most powerfully from the data were excessive wait times for referral vouchers from the public health system staff. These resulted in notable delays in obtaining care and other perceived obstacles. These themes dovetailed with compelling survey data on excessive numbers of visits to obtain vouchers, excessive wait times for visits and a lack of information provided to women about the coverage vouchers would provide.

The biggest obstacles to accessing publicly funded, legal abortion, reported by participants and observed in the clinic, included delays in getting the required referral vouchers in a timely manner, having to make multiple visits to get vouchers, lack of accurate and complete information provided by the health system, and a lack of social support or some women's sense of needing to do everything on their own, which often compounded other obstacles. At the time of the increasing budget cuts implemented in the Catalan health system, as a result of austerity, it appeared that lack of training and accountability for health system staff related to information and referrals for publicly funded abortion intensified.

Thus, austerity measures implemented on and within the Catalan health system had immediate negative implications for abortion access — and disproportionately so for already marginalized populations. In-depth interviews with abortion providers, clinic staff and reproductive health advocates in the region who worked for many years to establish and implement abortion law reforms echoed and confirmed women's experiences, concerns and frustrations with and about delays and misinformation encountered while navigating the crisis-affected public health system to obtain referral vouchers. In addition, many providers and advocates talked in detail about the multilayered political-economic context, as it shaped the broader context of health policy and abortion access and the care they could provide.

Intensive participant observation and observations in the regional women's health NGO offices and at the youth sexual-reproductive health center the NGO runs contextualized and enriched the formal data collection. In particular, during clinic days, my (then) thirteen years of experience working as a bilingual advocate and medical assistant in abortion care allowed me to support clinic staff in various areas. I therefore directly ob-

served women routinely arriving at the clinic, after multiple visits to their neighborhood public health system centers, with referral vouchers filled out incorrectly. Mistakes included listing the wrong gestation, citing the incorrect article of the law, having the wrong date, or dates left off, missing a signature, or being otherwise invalid.

Each time, we had no choice but to send patients back to their health center to start the process over, requesting a corrected voucher and hoping the clock would not run out on their legal right to publicly funded abortion before they could get one. Hundreds of interactions and observations with women who navigated the same process of requesting and eventually obtaining a referral voucher only underscored patients' and providers' reported pattern of health system constraints, delays and misinformation. This also revealed the acceleration in problems apparent after health system quota reductions, attributed to internalized austerity measures, that took effect in early 2013.

## Working within the System/ Challenging the System

Despite such hurdles, women seeking publicly funded abortion in Catalunya, and providers working to offer it through contracted facilities, worked within the existing health system to get women's needs met. They simultaneously challenged power inequalities inherent in microlevel relationships between women and health system representatives, and in the macrolevel of austerity policies. I analyzed women's and providers' responses to obstacles and delays as, on the one hand, systems-correcting praxis. I saw this in women's persistence in returning to their neighborhood health centers repeatedly until given a valid referral voucher. But, on the other hand, there was also systems-challenging praxis. Here even self-avowed anti-abortion women loudly proclaimed the need for legal and publicly funded abortion.

**I therefore directly observed women routinely arriving at the clinic, after multiple visits to their neighborhood public health system centers, with referral vouchers filled out incorrectly.**

Many women in my study (45 percent) criticized threats to the abortion reform laws, and most mobilized social support to face logistical and health system challenges. The combination revealed a core lesson of critical medical anthropology. When health inequalities become "unmasked and demystified," people seeking care, providers, advocates and researchers can all see more clearly the power relationships and structural forces undergirding and maintaining them.[6] Opportunities to undo and resist obstacles to care also emerge. By doing whatever they had to in order to provide and obtain publicly funded abortion care, women and providers in this study challenged political threats to the abortion law reforms, structural inequality disproportionately affecting immigrants, and the day to day seeming inevitability of the effects of the crisis and austerity.

Austerity measures alone do not explain all the delays and difficulties women experienced with the health system. Clear disconnects between policy and practice likely resulted also from a lack of training, enforcement and accountability within bureaucratic layers above the health system workers who individually filled out referral vouchers for publicly funded abortion. However, as the news about waiting periods for immigrants' health system coverage broke in the late summer and fall of 2012, I talked with clinic staff about the likelihood that some immigrant women who had never applied for a health system card prior to an ill-timed pregnancy might not realize the new restrictions did not apply to them. A clinic receptionist, Ariadna, explained that any request for health system coverage produced first a provisional card that can only be used at the neighborhood health centers. A permanent card that must be taken to the contracted abortion clinic along with the signed referral voucher arrives in the mail a month or more later. This was something I saw firsthand after going through the lengthy process of applying for my own daughter's health card, as immigrants to the region ourselves.

Though this built-in one-month delay in obtaining a publicly funded abortion would apply to any woman applying for health system coverage for the first time due to a pregnancy she wished to terminate, there was a much greater likelihood that someone born in Catalunya (or who had grown up there) would already have a health card, as compared with immigrants known to use public health systems at lower rates and to face greater difficulties doing so, even before the crisis. Any additional delays produced within the health system as the result of internalized austerity measures pressuring health system representatives to slow down the pace of approvals for, or reimburse fewer, referral vouchers for contracted abortion care only further exacerbated an existing structural health inequality.

In the wake of the policy changes in 2012 affecting immigrants' access to the public health system, the health system also restructured its existing quota system for reimbursable abortion procedures performed by contracted clinics. Ostensibly expanding access to care for patients, the Catalan Health Department opened contracts to more abortion clinics, regionally and in Barcelona. This did not allocate a greater number of publicly funded abortions that could be reimbursed overall among the proportionately greater number of providers. Rather, the health system reallocated the existing number of total approved procedures per year away from the two clinics that previously shared it, and evenly divided it among a greater number of clinics. Decision makers failed to account for capacity, staffing, demand or the services and gestational limits for which a given clinic offered care.

Prior to the abrupt policy change in early 2013, the health system divided reimbursable abortion procedures semiproportionally between the clinic where I conducted fieldwork (then the only contracted provider of second-trimester abortion in Catalunya) and one other small clinic that often exhausted its quota before the end of the year. Health system representatives framed this as an attempt to give women more options of where to go for care. In effect, however, this simultaneously reduced the number of public health

system vouchers that the only clinic then offering publicly funded second-trimester care could accept in a given year. This was during precisely a time period when many women, especially immigrants, were delayed into the second trimester of a pregnancy while seeking referral vouchers.

This all transpired in a health system affected by crisis and austerity. In addition, clinic staff speculated that internalized austerity measures in the ensuing years motivated the continual reduction in the number of reimbursable procedures allocated to the clinic where I collected data for this study. In fact, their contract continued to diminish each year after I left the field, and clinic activities are now suspended. Instead, according to clinic staff, health system representatives encourage many women who initially request a referral voucher for instrumental abortion to initiate a medication abortion at the neighborhood health center. There is no follow-up care available at this center for the statistically higher proportion of such procedures that fail, despite it being an option available during a much smaller gestational window.

During the height of the news coverage of the Spanish ruling conservative party's threats to overturn the abortion reforms, some participants, especially abortion providers and reproductive health advocates and activists who organized for decades to win the abortion reforms, framed the burgeoning movement for a fully independent Catalunya as a potential way to preserve legal, free abortion in Catalunya. More broadly, key informants described Catalan independentism as a response to *La Crisis*, insofar as it symbolized, among other things, an attempt to preserve social services for all — including immigrants.[7] Symbolic of this commitment, within days of a typical Gallardon announcement of a plan to make abortion completely illegal again in Spain (and by extension, the autonomous regions it claims and partially controls), the Catalan Parliament in September 2013 passed a resolution guaranteeing continued public funding and availability of abortion, for all, in Catalunya — even if or when it might become illegal in Spain.

**Abortion-seeking occurs within shifting political-economic landscapes, to which healthcare seekers and providers actively respond.**

Abortion seeking occurs within shifting political-economic landscapes, to which health care seekers and providers actively respond. In the wake of policy changes, the Catalan health system implemented reforms intended to improve access to abortion. Yet disconnects between policy and practice reproduced structural inequality, constraining care. In this setting, women (45 percent) and providers (63 percent) linked *La Crisis* and austerity measures to the need for public funding of legal abortion. Multiple providers and regional health advocates discussed the movement for full Catalan independence as a response to austerity and a potential way to preserve legal, publicly funded abortion and health care for immigrants. Ethnographic fieldwork research on locally specific and regionally linked responses to the global eco-

nomic crisis and austerity measures — and the effects of these on access to health care — offers contextualized lessons for protecting existing social services and identifying those most in need of more, better and more just care.

## Notes

1. This article summarizes fieldwork of which the findings are fully published in *Health Policy in a Time of Crisis: Abortion, Austerity, and Access* (Routledge Press, 2017).

2. The first trimester is defined in the 2010 law as up to 14 weeks from the first day of the last period. The second trimester is 14–22 weeks from the first day of the last period.

3. Bayla Ostrach and Ron Lare, "Catalan President Puigdemont's Arrest in Germany and Potential Extradition to Spain Evokes History of Shared Fascist Collaboration; Sparks Renewed Catalan Resistance," *Solidarity Webzine*, April 7, 2018, https://solidarity-us.org/p5288/.

4. But it is in the Health Department policy documents throughout Spain and Catalunya and was explained by a key informant who helped advise the Ministries of Health and Justice on crafting the law as a period of time not for the patient to reflect on the decision to abort but rather to review information the state is required to provide about the medical options and rights under the law. How the three days are explained to patients, however, seems to vary widely.

5. A pseudonym chosen by the participant, as were all pseudonyms.

6. Robert A. Hahn, *Sickness and Healing: An Anthropological Perspective* (New Haven, CT: Yale University Press, 1996).

7. In more recent fieldwork with Catalans involved in anti-austerity and anti-gentrification movements, and active in neighborhood-level collectives and solidarity efforts, I interpret Catalan independentism as a form of inclusive nationalism (Ostrach 2017; Kammerer 2017) that encompasses protection of and support for immigrants and refugees as a core tenet.

B. Ostrach, "Building Castles, Building Community - Castellers, Catalunya, Camaraderie," American Anthropological Association meeting. Washington DC, 2017.

N. Kammerer, "Popular Culture Matters, but to Whom, How, and Why in Contemporary Catalonia?" American Anthropological Association meeting. Washington DC, 2017.

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