“Una carrera contra el reloj”: A Qualitative Analysis of Barriers to Legal Abortion Access in Bogotá, Colombia

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Background

In many parts of the world, unsafe, clandestine abortion is a significant contributor to maternal morbidity and mortality. Maternal mortality from abortion ranges from 34 deaths per 100,000 live births in countries with restrictive abortion laws, to less than one death per 100,000 live births in countries with liberalized abortion policies (Grimes et al., 2006). In Latin America, unsafe abortions are responsible for 30 maternal deaths per 100,000 live births per year (Rao & Faúndes, 2006).

A plethora of studies conducted globally have shown that legal restrictions on abortion access result in barriers to safe abortion access (Berer, 2004; Grimes et al., 2006; Levels et al., 2014; Paine et al., 2014; Rao & Faúndes, 2006; Sedgh et al., 2012; Sedgh et al., 2015; Yam et al., 2006). Recent studies in Nepal, Australia, Mexico, the United States, Ghana, India, and Colombia have also found that educational, physical, financial, emotional, religious and social barriers acting singularly and in tandem result in delays in accessing abortion (Andersen et al., 2015; Banerjee et al., 2012; Doran & Hornibrook, 2014; Paine et al., 2014; Peterfy, 1995; Prada et al., 2013; Rominski et al., 2014).

In 2006, a landmark case in the Colombian Constitutional Court, C-355/2006, partially decriminalized abortion. This case provided three situations in which abortion is legally permitted: when the mother’s life or health is at risk, when there is a deformity to the fetus that will make it unviable, and/or when pregnancy is a result of rape, incest, or unwanted insemination (Amado et al., 2010). The ruling is one of few in Latin America that does not limit abortion by gestational age. Despite the liberalization of abortion in Colombia in 2006 and its subsequent legal availability, the incidence of illegal abortion had not declined by 2008. That year, an estimated rate of 39.2 abortions per 1,000 women ages 15-44 occurred, or 400,412 abortions, compared to only 322 recorded legal abortions (Prada et al., 2011a).

The reason for the high number of illegal abortions during the ten years post-C-355/2006 has been unclear. La Mesa por la Vida y la Salud de las Mujeres (La Mesa) - a reproductive rights activism organization based in Bogotá – published a report on barriers experienced by their clients in 2014, naming a lack of information, and legal, financial, and religious barriers as the most prominent (La Mesa, 2014). For the past ten years, implementation of the court’s ruling has been inconsistent and many women continue to be denied or delayed in accessing abortion services (Dalén, 2013; Baum et al., 2015; La Mesa, 2014).

There exist fundamental disagreements about abortion provision in Colombia. Key actors including hospital administrators and physicians utilize varying interpretations of ethical, legal, and medical requirements and obligations outlined by C-355/2006 (Amado et al., 2010). In an attempt to solve this issue and clarify the legal rights and responsibilities of health care providers as well as hospitals, the Colombian Constitutional Court issued a decision in 2008 that defined conscientious objection as a right of individual human beings to refuse to perform abortions, given that they do so out of established moral or religious convictions (Colombian Constitutional Court, 2008). This decision, known
as T-209/2008, made clear that institutions like hospitals do not have the right to adopt conscientious objection as institutional policy. Additionally, T-209 delineates that objecting physicians are obligated to refer, and institutions have a duty to ensure the availability of non-objecting physicians to whom patients can be referred (Cook et al., 2009). However despite the sentence, many health care institutions illegally adopt this policy as a whole, turning away all patients from abortion services (Roa, 2008; Ceaser 2006).

While legal abortion is available at public hospitals, non-governmental providers, and some clinics in Colombia, multiple access barriers lead to a continuing high incidence of illegal abortion (Ashford et al., 2012; Prada et al., 2011a). The dearth of research on the subject suggests that delays in abortion access are attributable to multiple barrier types, and this study aims to qualitatively identify existing barriers and explore the way their interrelated nature may result in delays in receipt of quality, legal abortion care for women in Bogotá.

**Methods**

The first author (Brack) created an in-depth interview (IDI) guide using the Three Delays Model, which outlines three major types of delay in access to obstetrical and pregnancy-related care: (1) delay the decision to seek care; (2) delay arrival at a health facility; and (3) delay the provision of adequate care (Thaddeus & Maine, 1994). The guide prompted participants to answer a series of questions about their experience in accessing abortion care, their knowledge of available services, barriers to accessing abortion care, and their attitudes surrounding abortion.

**Sample, Study Setting, & Data Collection**

This study was conducted in Bogotá, Colombia in June and July 2014. IDI’s were conducted with 17 women, ages 18 and over, who had accessed abortion services in Bogotá in the 12 months preceding the interview. Due to the nature of the research topic, interviewees were accessed via collaboration with local partners and the use of gatekeepers at clinic sites, including clinic directors, ethics committee representatives, psychologists, and lawyers from La Mesa. Women were approached by the first author using convenience and venue-based sampling. A similar, small number of interviewees were recruited from the five main abortion clinics in Bogotá in order to reach thematic saturation. Interviews were conducted in private consultation rooms and were uninterrupted. Interviews lasted between 30 minutes and 2 hours, depending on the interview, with a median interview length of 1 hour and 10 minutes.

**Data Analysis**

Interviews were analyzed using MaxQDA (VERBI Software, Berlin, Germany), a qualitative software package. Interview transcripts were coded, and analyzed using standard qualitative analysis techniques including memoing, and both a priori and inductive coding, to find patterns, parallels, and differences. A list of key themes was developed and later grouped into broader domains of barrier type as defined by study participants. A conceptual framework was then developed to illustrate the common patterns that emerged from the data.

**Ethical Considerations**

Because this study included human subjects and their personal health information, approval by the Emory University Institutional Review Board (IRB) was required. Protocol and research instruments were submitted to the Emory University IRB and expedited approval was granted on May 23, 2014 (IRB 00073234). Ethics Committee approval was also necessary from the research ethics committees at Universidad de los Andes (No. 352/2014), Fundación Oriéntame (No. 101/2014), and Profamilia (No. 001/2014). Approval was granted both verbally and in writing before research was conducted. Written informed consent was obtained from each study participant before beginning each interview. Participants were not compensated for their time.
TABLE 1. Selected demographic data for participants in in-depth interviews on barriers to abortion access (n=17), Bogotá, Colombia, June-July 2014

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>%</th>
</tr>
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<tbody>
<tr>
<td>Marital status</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>53</td>
</tr>
<tr>
<td>In a relationship</td>
<td>47</td>
</tr>
<tr>
<td>Religious preference</td>
<td></td>
</tr>
<tr>
<td>Catholic</td>
<td>94</td>
</tr>
<tr>
<td>Evangelical</td>
<td>6</td>
</tr>
<tr>
<td>Employment status</td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>30</td>
</tr>
<tr>
<td>Employed</td>
<td>40</td>
</tr>
<tr>
<td>Full-time student</td>
<td>30</td>
</tr>
<tr>
<td>Education level</td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>0</td>
</tr>
<tr>
<td>Secondary</td>
<td>82</td>
</tr>
<tr>
<td>University</td>
<td>18</td>
</tr>
<tr>
<td>Gestation at time of abortion</td>
<td></td>
</tr>
<tr>
<td>1st trimester</td>
<td>70</td>
</tr>
<tr>
<td>2nd trimester</td>
<td>30</td>
</tr>
</tbody>
</table>

Results

Throughout the seventeen transcripts, barriers to information and education about abortion services and legal rights to an abortion were coded 32 times, one of the highest code frequencies. The most universal theme across study participants was a lack of information and education about their right to an abortion. Only one study participant, a lawyer herself, knew about C-355/2006. The 16 participants who did not know about their legal right to an abortion expressed frustration about not knowing beforehand, and questioned why it had felt like a secret.

About 60% of study participants paid for their abortions out-of-pocket, the prices of the abortion varied by service type. Half of those who paid for abortion services in cash said that they had to sell items they owned including cell phones and clothing, asked for advancement on paychecks, borrowed money from family or friends, and all of them admitted to being dishonest with others about their reason for needing to borrow money. These participants also stated that the time it took to get the money together to pay for the abortion delayed their access to abortion, ultimately causing them to have an abortion later than they wanted. Of the women who paid for their abortion out-of-pocket, several described seeking the financial support of their health insurance company and being unlawfully denied.

This research uncovered several ways in which Colombian women’s legal rights to abortion have been obstructed. Regardless of age, income level, or experience with previous pregnancy, study participants experienced delays in access to safe, legal abortion care via delay in the decision to seek care, delay in arrival at a health facility, and/or delay in the provision of adequate care. Women described experiencing educational, physical, financial, emotional, religious, and social barriers to abortion access. Typically, the study population experienced several identified barriers which culminated in one or more of types of delay, making it difficult for them to exercise their right to safe, legal abortion.
TABLE 2. Select quotes from study participants describing significant barrier types

<table>
<thead>
<tr>
<th>Type</th>
<th>Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational</td>
<td>“I had it in perspective that if I wasn’t raped, I wouldn’t have a right to an abortion... Because, the fact that just because I’m not about to slit my wrists or about to jump off of a bridge, doesn’t mean that I’m not suffering psychologically, it manifests in various forms.” – Lucila¹</td>
</tr>
<tr>
<td>Physical</td>
<td>“…after [14] weeks, they can’t do the abortion because it’s too big, it’s not possible... so it’s a race against the clock, because if you’re eight weeks along, well one more week is going to make it riskier, if you wait a few weeks more then time will be up, and [the abortion] can’t be done.” – Tana¹</td>
</tr>
<tr>
<td>Religion/Social</td>
<td>“They referred me to the EPS, which completely denied me. They told me I was making a total mistake, and asked if I was aware that I was murdering a person. I told them ‘Right now it’s not a person, because it has not been born.’ They said it had a soul, that it already had many things. They just tortured me.” – Angelina¹</td>
</tr>
<tr>
<td>Stigma, turned</td>
<td></td>
</tr>
<tr>
<td>Financial</td>
<td></td>
</tr>
</tbody>
</table>

¹ Pseudonyms used in place of real names of participants

A common theme described by study participants was their interaction with health care providers, including hospital administrators, psychiatrists, physicians, and nurses. Thirty-five percent of study participants described the ways in which health care providers acted as barriers to access to abortion, and access to humane, compassionate, and comprehensive services. One participant said that while a physician performed a sonogram on her, he told her: “You can already hear the heartbeat, how are you going to kill it?” In the case of another participant, a psychiatrist brought a group of students into her hospital room who then began to perform an interview on her about her severely compromised mental state, causing her to break down in tears and nearly check herself out of the hospital.

Once women had been admitted to health care facilities and were in the midst of receiving abortion services, the quality of care by nurses acted as a barrier to comprehensive care. In the case of three participants, the fetus was presented to them after the abortion either in a plastic bag, or wrapped in gauze, and was either left at the foot of their bed or in a tub in the hospital room. One participant described how a nurse attempted to talk her out of having an abortion, and threatening that if she had one, the nurse would throw the baby in the trash. The participant recounted:

“The religious nurse came in... it’s a striking memory, because she picked it up, the fetus, she put it in a plastic bag and I didn’t want to see it, I covered my eyes. Then she came up close to me, my mom was in the other room and the other nurse was far away, and she whispered: ‘I told you that your baby is going to be thrown in the trash.’ And I stayed quiet, I just started to cry.” – Nayely¹

Not only were the women treated badly in their time of need, but the treatment constituted abuse that continued to psychologically affect several of them. The behavior of the nurses, who cannot legally object to participation in abortion services, appeared to be deeply rooted in their Catholic belief about when life begins and the meaning of abortion.

**Discussion**

The 17 women who participated in the in-depth interviews each had unique interactions with the Colombian health care system. However, many of the women experienced very similar discrimination, and barriers to access to abortion services. The majority of study participants described struggling to find ways to cope with negative emotions they experienced as a cause of both personal, internally experienced stigma, as well as pervasive, externally imposed social stigma both before and after obtaining an abortion. The confronting of barriers experienced by study participants culminated in delays in making the decision to have an abortion, delays in accessing abortion services, and delays in receiving timely, compassionate, ethical, and humane abortion care (Thaddeus & Maine, 1994).
This research is the first of its kind to qualitatively explore and identify the multitude of barriers experienced by Colombian women since the Colombian Constitutional Court passed C-355/2006 providing a legal right to safe abortion. In a recent quantitative study of barriers to legal abortion access in Colombia conducted by Fundación Oriéntame and Ibis, similar barriers were identified. The authors quantitatively identified similar barriers experienced by a cohort of 300 women surveyed in 2012. Women experienced delays in making the decision to terminate – an average of 10.6 days for first-trimester and 19.5 days for second-trimester patients, followed by an additional period of delay predominantly due to financial and logistical barriers averaging 13.4 days for first-trimester and 24.2 days for second-trimester patients (Baum et al., 2015).

This study revealed key findings to promote changes in current legislation and expansion of medical and nursing curriculum, and to facilitate the removal of barriers to access to legal abortion services. The wealth of misinformation and lack of accurate information about legal availability, and how to access safe abortion, interfere with Colombian women’s legal rights to safe abortion.

References


