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Date

A Qualitative Analysis of Barriers to Legal Abortion Access  
Experienced by Colombian Women

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A Qualitative Analysis of Barriers to Legal Abortion Access  
Experienced by Colombian Women

By

Chelsey Brack

B.A., Kinesiology, Spanish Literary & Cultural Studies  
Occidental College  
2010

Thesis Committee Chair: Dr. Roger Rochat, M.D.

An abstract of  
a thesis submitted to the Faculty of the  
Rollins School of Public Health of Emory University  
in partial fulfillment of the requirements for the degree of  
Master of Public Health  
in Global Health  
2015

# **Abstract**

## **A Qualitative Analysis of Barriers to Legal Abortion Access Experienced by Colombian Women**

By Chelsey Brack

### ***Context***

In 2006, a landmark case in the Colombian Constitutional Court, C-355/2006, partially decriminalized abortion. However, the incidence of illegal abortion has not declined despite the availability of legal abortion. In 2008, an estimated rate of 39.2 abortions per 1,000 women ages 15-44 occurred, or 400,412 abortions, compared to only 322 reported legal abortions (Prada et al., 2011a). This study aims to qualitatively identify existing barriers to safe, legal abortion access for women in Bogotá, Colombia, and also to elucidate the ways in which these barriers impact their decision-making process with respect to access to care.

### ***Methods***

This study was conducted in Bogotá, Colombia between June and August 2014. In-depth interviews were conducted with 17 women, ages 18 and over, who had accessed abortion services in Bogotá in the 12 months preceding the interview.

### ***Results***

Educational, physical, financial, legal, emotional, and religious barriers, which led to social barriers in the form of both internalized stigma and pervasive external social stigma culminated in delays in accessing comprehensive abortion services. Social stigma appeared to be driven by religion, which manifested most powerfully in the behavior and actions of health insurance companies, hospital administrators, and health care providers. Of particular note was the way in which nurses attempted to dissuade women from having an abortion, and subsequently abused women while in the process of obtaining an abortion.

### ***Conclusions***

This research 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 how and where to access safe, legal abortion interfere with Colombian women's legal rights to safe abortion.

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First and foremost, I thank the 17 incredible women who shared their stories of anguish, courage, and triumph. I will forever be thankful for their bravery, and inspired by their desire to be a vessel of information and guidance for other women.

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I thank my EGHI Multidisciplinary Team members, Kalie Elizabeth Richardson, Kaitlyn Stanhope, and Lauren Fink for their friendship and professional support while we worked together to conduct research that informs a multidisciplinary analysis of barriers to access of legal abortion in Bogotá.

A very special thank you to Roger Rochat for your inspiration, guidance, support, and friendship, and your lifelong commitment to the global elimination of maternal mortality from abortion. My commitment has only succeeded through your support, and I will be forever grateful for your enthusiasm for my success.

Finally, I would not be where I am today without my family and loved ones. My mother, father, and sisters have always provided unconditional love and guidance. I am blessed with such a supportive family. I would also like to thank all of my friends, who have laughed and cried with me, and have kept me sane. And to my boyfriend, Ian Hennessee. I have more reasons to thank you than there are stars in the sky, but for now I principally thank you for your unwavering love and encouragement.

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## **Chapter I: Introduction**

### **1.1 Rationale**

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/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). Access to abortion is a legal, social and cultural issue. Colombia is a predominantly Catholic country (Conscience, 2013), and, while the court decision was lauded by some, it was criticized or ignored by many (Ceaser, 2006). Attempts to regulate the provision of abortion services have been met with resistance by providers, judges, and lawmakers. While legal abortion is available at public hospitals, clinics, and non-governmental providers, there is still a high incidence of illegal abortion due to multiple access barriers (Ashford et al., 2012; Prada et al., 2011a). One of these burdens is thought to be due to the high use of conscientious objection, the idea that an individual provider can, due to religious beliefs, refuse to deliver abortion service. However, many health care institutions adopt this policy as a whole, turning away all patients from abortion services (Roa, 2008).

### **1.2 Problem statement**

It is unclear what barriers currently affect a woman's experience and decision to access abortion services. Despite nine years of legal access to abortion in Colombia, many Colombian women continue to access abortion through illegal and unsafe avenues, due to a variety of barriers to safe, legal abortion, such as stigma, as well as physical, social, religious,



financial and legal barriers. These barriers to access result in a high incidence of abortion-related maternal morbidity (Ashford et al., 2012; Prada et al., 2011b). Currently no published research qualitatively explores the barriers that Colombian women face when seeking legal access of abortion services in Colombia since the partial decriminalization of abortion in 2006.

### **1.3 Purpose statement**

The aims of this research are to identify existing barriers to safe, legal abortion access for women in Bogotá, Colombia, and also to elucidate the ways in which these barriers impact their decision-making process with respect to access of care.

### **1.4 Research question**

What physical, financial, legal, social, or cultural barriers exist with respect to access of legal abortion services for Colombian women in the country's capital, Bogotá?

### **1.5 Significance statement**

Globally, liberalized abortion policies are associated with lower rates of maternal mortality and morbidity due to abortion. However, in Colombia, the incidence of illegal abortion has not declined since the liberalization of abortion in 2006, despite the availability of legal abortion. In 2008, an estimated rate of 39.2 abortions per 1,000 women ages 15-44 occurred, or 400,412 abortions, compared to only 322 reported legal abortions (Prada et al., 2011a). This difference is egregious, as illegal abortions are often unsafe, and the reason for the high number of illegal abortions is unclear. Increased legal access to abortion is

associated with lower incidence of unsafe abortion (Berer, 2004), yet where the law is applied unevenly, it is likely that vulnerable populations will most suffer from decreased access. There are many barriers to legal abortion access in Bogotá, Colombia that have yet to be explored and understood. The findings of this qualitative research will add to the dearth of information that exists about barriers to access of legal abortion in Bogotá, Colombia.

### **1.6 Definition of terms**

Merriam-Webster defines 'abortion' as: "the termination of a pregnancy after, accompanied by, resulting in, or closely followed by the death of the embryo or fetus: as a) a spontaneous expulsion of a human fetus during the first 12 weeks of gestation, or b) induced expulsion of a human fetus" (Merriam-Webster, n.d.). According to the World Health Organization (WHO), the term 'abortion' covers "a variety of conditions arising during early pregnancy, from ectopic pregnancy and hydatidiform mole, through to spontaneous and induced abortion." (Abouzahr & Ahman, 1998) This research explored the experiences of women seeking induced abortion in Bogotá, Colombia. For the purposes of this thesis, induced abortion will be referred to as abortion throughout.

The WHO defines unsafe abortion as "a procedure for terminating a pregnancy performed by persons lacking the necessary skills or in an environment not in conformity with minimal medical standards, or both." (WHO, 2015) This thesis refers to unsafe abortion using the WHO's definition.

## **Chapter II: Comprehensive Review of the Literature**

### **2.1 Global Unsafe Abortion**

The WHO recommends that “to the full extent of the law, safe abortion services should be readily available and affordable to all women” (WHO, 2012). Several ecological studies have shown that broad access to abortion is associated with lower incidence of unsafe abortion and lower mortality from abortion (Berer, 2004). According to the United Nations, a focus on eliminating morbidity and mortality from unsafe abortion is essential to achieving the United Nation’s Millennium Development Goal 5: Improvement of Maternal Health. Access to safe abortion services and post-abortion care is a vital element in achieving the targets of reducing maternal mortality globally by three quarters and ensuring universal access to reproductive health by 2015 (United Nations, 2013).

In many parts of the world, unsafe, clandestine abortion is a significant contributor to maternal mortality and morbidity. 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). Complications from unsafe abortion include hemorrhage, sepsis and trauma, any of which can lead to death, depending on severity (Grimes et al., 2006). In the United States, 2% of women ages 15-44 have an abortion each year and less than 0.05% end in major complications and, if performed before 8 weeks gestational age (of the fetus), only one in a million end in death (Guttmacher, 2014).

According to Thaddeus and Maine, a majority of maternal deaths and maternal morbidity can be prevented with timely medical treatment. In 1994, the researchers developed a model that is currently applied globally, known as the Three Delays Model. The

model articulates the three phases of delay as: delay in deciding to seek care (on the part of the individual, family, or both), delay in reaching an adequate health facility, and delay in receiving adequate care at a facility (Thaddeus & Maine, 1994).

Recent studies in Nepal, Australia, Colombia, Mexico, the United States, Ghana, and India 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). 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). In Latin America, unsafe abortion causes a higher proportion of total maternal deaths than any other region worldwide, in part due to the very restrictive abortion laws in most countries (Singh, 2006; Yam et al., 2006).

Legal abortion access with comprehensive services may further impact women's health through the extension of contraceptive services. Since the 2007 decriminalization of abortion in Mexico City, state-run abortion clinics have achieved 85% use of post-abortion contraception among the 50,000 patients served and have extremely low rates of repeated abortions (0.9% in 2010) (Mondragon et al., 2011). Such statistics demonstrate that decriminalization of abortion services in Mexico City has both decreased the number of unsafe abortions and the unmet need for contraception.

## **2.2 Abortion in Colombia**

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/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 first two cases must be documented by a physician and the third must be reported to the appropriate authorities, but the woman's report will be taken as true (Amado et al., 2010). Additionally, the decision also removed the limitation that abortion is always illegal when performed on someone age 14 or younger (Roa, 2007). The court found that age is not the sole determining factor of maturity and that all women deserve equal access to health care, regardless of age.

### *Conscientious Objection to Abortion*

For the past nine years since the court's ruling, implementation has been inconsistent and many women continue to be denied abortion services across the country (Dalén, 2013). Currently, there exist fundamental disagreements about abortion. 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 a "well-established religious conviction" (Colombian Constitutional Court, 2008). The decision outlined that physicians were legally

able to claim exemption from providing or participating in abortion care on religious, moral or philosophical grounds, and had to officially do so with documentation recognized by the Colombian government.

This decision, known as T-209/2008, made clear that institutions like hospitals and companies that provide health insurance do not have the right to conscientiously object as a unified whole, or as institutional policy (Cabal et al., 2014). T-209 specifically states that conscientious objection in Colombia applies only to physicians and excludes coverage of nurses, psychologists, and health care establishment administrators. Additionally, T-209 delineates that objecting physicians are obligated to refer a woman seeking an abortion to a provider of legal abortion services, and institutions have a duty to ensure the availability of non-objecting physicians to whom patients can be referred (Cook et al., 2009). Logically, conscientious objection presents a particularly controversial barrier to abortion services (Johnson et al., 2013).

According to a legal analysis authored by Cabal, Olaya, and Robledo, conscientious objection specifically with regards to the provision of reproductive health care services has been globally recognized and legislated. In Europe and Latin America, international human rights committees have clarified that governing bodies of individual countries must balance their obligations to the preservation of human rights, women's reproductive rights, and physician rights to conscientious objection (ICCPRa, 1996; ICCPRb, 1993; UNHRCa, 1993; UNHRCb, 2000). Several countries in Latin America have begun legislating conscientious objection, including Argentina, Uruguay, and Mexico. All three countries recognize conscientious objection as a legal right for physicians working in reproductive health care. Argentina allows both public and private health care institutional conscientious objection

(Ministerio de Salud, 2010). Uruguay allows institutional conscientious objection solely for private health care institutions, and maintains a public registry of objectors (Ibid, 2012), while Mexico City does not allow public health care institutions to conscientiously object (Malkin & Catan, 2008).

In contrast to the conscientious objection legislation enacted by these Latin American countries, Cabal et al. states that the standards set forth by Colombia's T-209/2008 offer an all-inclusive approach to conscientious objection by limiting its use to physicians directly providing abortion services, aiming to restrict negligent conduct on the part of physicians, banning conscientious objection in emergency cases, and imposing requirements for physician referral (Cabal et al., 2014).

### *Barriers to Legal Abortion Access*

Access to abortion is a legal, social and cultural issue. Colombia is a predominantly Catholic country (Conscience, 2013), and while the court decision is lauded by some, it is criticized or ignored by many (Ceaser, 2006). Attempts to regulate the provision of abortion services have been met with resistance by providers, judges, and lawmakers. While legal abortion is available at public hospitals, clinics, and non-governmental providers, there is still a high incidence of illegal abortion due to multiple access barriers (Ashford et al., 2012; Prada et al., 2011b; Roa, 2008). Abuse of conscientious objection and deliberate interference or obstruction of women's consent process act as impediments to women's legal access of abortion (Roa, 2008). Many health care institutions illegally adopt conscientious objection as institutional policy, turning away all patients from abortion services (Roa, 2008). In one infamous case, a 12-year-old girl was refused an abortion based on the doctor's deeming that

many 12-year-old girls were already mothers and the patient should be capable of motherhood as well (Conscience, 2013). Women also face barriers such as waiting periods, discrimination by providers, misinformation or lack of information from providers, and parental consent requirements (Anderson, 2003).

In Colombia, illegal abortions vary in procedure, method and safety by region and socioeconomic status (Prada et al., 2011b). The highest incidence of abortion is in Bogotá, where an estimated 65.6 abortions took place per 1,000 women of reproductive age in 2008. Though the use of misoprostol and mifepristone, the drugs used in medical abortion, is common in urban areas and greatly reduces the risk of complication, there is still a risk of hemorrhage if incorrectly dosed (Prada et al., 2011a). Also, women who are treated by an untrained or lay provider in unsuitable or dangerous settings will be unlikely to access post-abortion counseling, contraceptive services, or other care. Within the city of Bogotá, past research has shown that vulnerable populations, such as women of low socioeconomic status (Gonzalez et al., 2010), victims of intimate partner violence (Gomez, 2011), and sexually exploited minors (Pinzon-Rondo et al., 2009) are all at high risk of having an unintended pregnancy and, potentially an abortion. Varying by socioeconomic status and region, between 24-53% of illegal abortions in Colombia cause complications, with higher risk among poor women (Prada et al., 2011b). An estimated 2/5 of patients with complications will not receive any treatment for complications, potentially resulting in long-term consequences such as infertility (Prada et al., 2011b). Induced abortion is not inherently unsafe or risky but, in an illegal, unregulated setting, can be both.

In Colombia, the incidence of illegal abortions has not declined since the liberalization of abortion in 2006, despite the availability of legal abortion. In 2008, 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). This difference is egregious, as illegal abortions are often unsafe. In Latin America, unsafe abortions are responsible for 30 maternal deaths per 100,000 live births per year (Rao & Faúndes, 2006) and 95% of induced abortions in the region are unsafe (Prada et al., 2011b). The reason for the high number of illegal abortions post-C-355/2006 is unclear. Increased legal access to abortion is associated with lower incidence of unsafe abortion (Berer, 2004), yet where the law is applied unevenly, vulnerable populations may suffer most from decreased access.

The many barriers to abortion access do not fit in any one category or discipline. One important barrier to abortion access and provision of services is stigma, a barrier that is not limited to one category, event, or decision. Stigma, the process of shaming and discriminating against an individual or practice, influences abortion's legal status, a patient's access to abortion, and provider willingness to perform abortions (INROADS, 2013). Following the legalization of abortion in Mexico City in 2008, a study in Mexico found that stigma may be an important factor in a woman's decision to seek an illegal, unsafe abortion although legal abortion is available (McMurtrie et al., 2012). In Colombia, stigma is likely to be an important factor affecting both provider and patient behavior.

### **2.3 Colombia's Health Care System**

In alignment with the Colombian constitution's guaranteed right to health, Colombia employs a system of universal health care that covers over 80% of its residents (Giedion & Uribe, 2009). Within the system, Colombia's citizens participate in one of two regimes depending on income: the Contributory Regime (CR) and the Subsidized Regime (SR). The

CR covers workers and their families with monthly incomes above a minimum monthly amount (approximately \$170 USD per month), and the SR covers those identified as being poor (Giedion & Uribe, 2009). The CR is made possible via payroll taxes, and the SR is made possible via national and local taxes, as well as a payroll tax. In this way, the SR is made possible by those who finance the CR. In both regimes, people are able to choose their insurance company, known as an *Entidad Promotora de Salud* (EPS). EPS's sell health service packages to the public, and contract their services with health care-providing institutions (Giedion & Uribe, 2009; Gaviria et al., 2006). The System for the Selection of Beneficiaries for Social Programs, known as *El Sistema de Seleccion de Beneficiarios para Programas Sociales*, or SISBEN, is the national system of identification of beneficiaries for social subsidy. This system classifies Colombian citizens according to their socioeconomic level into 6 strata; stratum 0 consists of those who are homeless and/or living in extreme poverty, and stratum 6 constitutes Colombia's most affluent population. Those who need financial help are partnered with SISBEN, and are able to access health care through the support of a contracted EPS (Gaviria et al., 2006). Standing behind its stance on its citizens' right to health, if an EPS refuses to pay for a treatment or service for a Colombian citizen, the patient is entitled to contest the denial of service using a legal mechanism through the civil court known as a *tutela*. The motion must be ruled on by a judge within three days, and usually does so in favor of the patient (Colombian Constitutional Court, 1991).

## **2.4 Qualitative Research on Abortion**

Though abortion is a controversial topic, past research experiences suggest that through respectful and carefully framed questions, women are willing to participate in

surveys and in-depth interviews after accessing abortion services. In a study conducted by Olavarrieta and colleagues in Mexico City, patients were interviewed the day of an abortion appointment or in a follow-up visit about their satisfaction with the abortion services received (Olavarrieta et al., 2012). In a qualitative study by Bury and colleagues of women accessing Post-Abortion Care (PAC) in Bolivia, clinic staff helped interviewers avoid approaching women whose emotional condition rendered an invitation to participate inappropriate (Bury et al., 2012). Qualitative research on barriers to legal abortion access experienced by women in Bogotá, Colombia has yet to be published.

## Chapter III: Manuscript

### TITLE PAGE

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### **3.1 Contribution of the Student**

My contribution to this project began as part of a Summer 2014 Emory Global Health Institute Multidisciplinary Field Scholars Team in Bogotá, Colombia. I am the primary investigator and author of the study with women having accessed abortion. I conducted all data collection, with assistance in recruitment of study participants from in-country gatekeepers and reproductive health stakeholders. I designed the research question and analysis strategy as well as conducted all background research and qualitative analysis.

## **3.2 Abstract**

### ***Context***

In 2006, a landmark case in the Colombian Constitutional Court, C-355/2006, partially decriminalized abortion. However, the incidence of illegal abortion has not declined despite the availability of legal abortion. In 2008, an estimated rate of 39.2 abortions per 1,000 women ages 15-44 occurred, or 400,412 abortions, compared to only 322 reported legal abortions (Prada et al., 2011a). This study aims to qualitatively identify existing barriers to safe, legal abortion access for women in Bogotá, Colombia, and also to elucidate the ways in which these barriers impact their decision-making process with respect to access to care.

### ***Methods***

This study was conducted in Bogotá, Colombia between June and August 2014. In-depth interviews were conducted with 17 women, ages 18 and over, who had accessed abortion services in Bogotá in the 12 months preceding the interview.

### ***Results***

Educational, physical, financial, legal, emotional, and religious barriers, which led to social barriers in the form of both internalized stigma and pervasive external social stigma culminated in delays in accessing comprehensive abortion services. Social stigma appeared to be driven by religion, which manifested most powerfully in the behavior and actions of health insurance companies, hospital administrators, and health care providers. Of particular note was the way in which nurses attempted to dissuade women from having an abortion, and subsequently abused women while in the process of obtaining an abortion.

### ***Conclusions***

This research 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 how and where to access safe, legal abortion interfere with Colombian women's legal rights to safe abortion.

### **3.3 Introduction**

#### **Global Unsafe Abortion**

In many parts of the world, unsafe, clandestine abortion is a significant contributor to maternal mortality and morbidity. 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). Complications from unsafe abortions include hemorrhage, sepsis and trauma, any of which can lead to death, depending on severity (Grimes et al., 2006). In the United States, 2% of women ages 15-44 have an abortion each year and less than 0.05% end in major complications and, if performed before 8 weeks gestational age (of the fetus), only one in a million end in death (Guttmacher, 2014).

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). In Latin America, unsafe abortion causes a higher proportion of total maternal deaths than any other region worldwide, in part due to the very restrictive abortion laws in most countries (Singh, 2006; Yam et al., 2006). Recent studies in Nepal, Australia, Colombia, Mexico, the United States, Ghana, and India 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).

## **Abortion in Colombia**

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/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). For the past nine years since the court's ruling in favor of legal access to abortion, implementation has been inconsistent and many women continue to be denied abortion services across the country (Dalén, 2013). Currently, there exist fundamental disagreements about abortion. 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 a "well-established religious conviction" (Colombian Constitutional Court, 2008). This decision, known as T-209/2008, made clear that institutions like hospitals do not have the right to conscientiously object as a unified whole, or 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). Logically, conscientious objection presents a particularly controversial barrier to abortion services (Johnson et al., 2013).



According to a legal analysis authored by Cabal, Olaya, and Robledo, conscientious objection specifically with regards to the provision of reproductive health care services has been globally recognized and legislated. In Europe and Latin America, international human rights committees have clarified that governing bodies of individual countries must balance their obligations to the preservation of human rights, women's reproductive rights, and physician rights to conscientious objection (ICCPRa, 1996; ICCPRb, 1993; UNHRCa, 1993; UNHRCb, 2000). Several countries in Latin America have begun legislating conscientious objection, including Argentina, Uruguay, and Mexico. All three countries recognize conscientious objection as a legal right for physicians working in reproductive health care. Argentina allows both public and private health care institutional conscientious objection (Ministerio de Salud, 2010). Uruguay allows institutional conscientious objection solely for private health care institutions, and maintains a public registry of objectors (Ibid, 2012), while Mexico City does not allow public health care institutions to conscientiously object (Malkin & Catan, 2008).

Colombia is a predominantly Catholic country (Conscience, 2013), and, while the court decision is lauded by some, it is criticized or ignored by many (Ceaser, 2006). Attempts to regulate the provision of abortion services have been met with resistance by providers, judges, and lawmakers. While legal abortion is available at public hospitals, clinics, and non-governmental providers, there is still a high incidence of illegal abortion due to multiple access barriers (Ashford et al., 2012; Prada et al., 2011a). One of these burdens is the high use of conscientious objection. Many health care institutions illegally adopt this policy as a whole, turning away all patients from abortion services (Roa, 2008).

Globally, liberalized abortion policies are associated with lower rates of maternal mortality and morbidity due to abortion. However, in Colombia, the incidence of illegal abortions has not declined since the liberalization of abortion in 2006, despite the availability of legal abortion. In 2008, 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). This difference is egregious, as illegal abortions are often unsafe. In Latin America, unsafe abortions are responsible for 30 maternal deaths per 100,000 live births per year (Rao & Faúndes, 2006) and 95% of induced abortions, as opposed to spontaneous abortion or miscarriage, in the region are unsafe (Prada et al., 2011b). The reason for the high number of illegal abortions post-C-355/2006 is unclear. Increased legal access to abortion is associated with lower incidence of unsafe abortion (Berer, 2004), yet where the law is applied unevenly, it is likely that vulnerable populations will most suffer from decreased access.

The many barriers to abortion access do not fit in any one category or discipline. One important barrier to abortion access and provision of services is stigma, a barrier that is not limited to one category, event or decision. Stigma, the process of shaming and discriminating against an individual or practice, influences abortion's legal status, a patient's access to abortion and provider willingness to perform abortions (INROADS, 2013). Following the legalization of abortion in Mexico City in 2008, a study in Mexico found that stigma may be an important factor in a woman's decision to seek an illegal, unsafe abortion although legal abortion is available (McMurtrie et al., 2012). In Colombia, stigma is likely to be an important factor affecting both provider and patient behavior.

## **Qualitative Research on Abortion**

Though abortion is a controversial topic, past research experiences suggest that through respectful and carefully framed questions, women are willing to participate in surveys and in-depth interviews after accessing abortion services. In a study conducted by Olavarrieta and colleagues in Mexico City, patients were interviewed the day of an abortion appointment or in a follow-up visit about their satisfaction with the abortion services received (Olavarrieta et al., 2012). In a qualitative study by Bury and colleagues of women accessing Post-Abortion Care (PAC) in Bolivia, clinic staff helped interviewers avoid approaching women whose emotional condition rendered an invitation to participate inappropriate (Bury et al., 2012). However, qualitative research on barriers to legal abortion access experienced by women in Bogotá, Colombia has yet to be published.

## **Health Care in Colombia**

In order to understand the financial and social barriers described by study participants, Colombia's health care system must be explained. In alignment with the Colombian constitution's guaranteed right to health, Colombia employs a system of universal health care that covers over 80% of its residents (Giedion & Uribe, 2009). Within the system, Colombia's citizens participate in one of two regimes depending on income: the Contributory Regime (CR) and the Subsidized Regime (SR). The CR covers workers and their families with monthly incomes above a minimum monthly amount (approximately \$170 USD per month), and the SR covers those identified as being poor (Giedion & Uribe, 2009). The CR is made possible via payroll taxes, and the SR is made possible via national and local taxes, as well as a payroll tax. In this way, the SR is made possible by those who finance the CR. In both

regimes, people are able to choose their insurance company, known as an *Entidad Promotora de Salud* (EPS). EPS's sell health service packages to the public, and contract their services with health care-providing institutions (Giedion & Uribe, 2009; Gaviria et al., 2006). The System for the Selection of Beneficiaries for Social Programs, known as *El Sistema de Seleccion de Beneficiarios para Programas Sociales*, or SISBEN, is the national system of identification of beneficiaries for social subsidy. This system classifies Colombian citizens according to their socioeconomic level into 6 strata; stratum 0 consists of those who are homeless and/or living in extreme poverty, and stratum 6 constitutes Colombia's most affluent population. Those who are found to be in financial need are partnered with SISBEN, and are able to access health care through the support of a contracted EPS (Gaviria et al., 2006). Standing behind its stance on its citizens' right to health, if an EPS refuses to pay for a treatment or service of a Colombian citizen, the patient is entitled to contest the denial of service using a legal mechanism through the civil court known as a *tutela*. The motion must be ruled on by a judge within three days, and usually does so in favor of the patient (Colombian Constitutional Court, 1991).

### **3.4 Methods**

The primary author 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. The IDI guide included open-ended questions in four conceptual domains: 1) Pregnancy recognition, 2) Seeking care, 3) Reaching a medical facility, and 4) Receiving effective treatment. Examples of interview questions included: “How far along in your pregnancy were you when you suspected you may be pregnant?”, “Can you talk about any opposition that you faced while deciding to seek an abortion?”, “How did you manage the cost of the abortion?” and “How long was the time between deciding to get an abortion and the appointment you scheduled?” (See Appendices A & B). Memos were written after each interview, making note of emergent themes, and incorporated iteratively into subsequent interview questions and probes.

Upon arrival to Colombia, the IDI guide was first reviewed by the executive director of Fundación Oriéntame for accurate grammar and cultural competency. After piloting the guide, both questions and probes were refined in order to reveal information the organization would also find useful. Additionally, in-country research ethics committees at Fundación Oriéntame, Universidad de los Andes, and Profamilia reviewed the study protocol and IDI guide in order to ensure protection of vulnerable populations in accordance with Colombian Human Subjects Research laws. The IDI guide was also back-translated in English to ensure proper translation and reliability.

### ***Sample***

IDIs were conducted with 17 women who had accessed abortion services in Bogotá, Colombia. Inclusion criteria determined that interview participants be 1) female, 2) aged 18 years or older, 3) had accessed abortion in the past 12 months, and 4) exhibited proficiency in spoken Spanish. Excluded from the study population were males, females younger than

18 years old, females who had not accessed abortion services in the past 12 months, and females who did not exhibit proficiency in spoken Spanish.

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 of Oriéntame and Profamilia, psychologists, and lawyers from *La Mesa por la Vida y la Salud de las Mujeres*, or La Mesa. Women were approached by the primary author using convenience and venue-based sampling. A similar, small number of interviewees were recruited from the five sources in order to reach thematic saturation. (Table 1).

**Table 1. In-Depth Interview Participant Source and Number of Participants**

<b>Source</b>	<b># of Participants</b>
La Mesa por la Vida y la Salud de las Mujeres	3
Centro Amigable (CAMI) Suba	3
Centro Amigable (CAMI) Centro Oriente	3
Oriéntame – Teusaquillo	4
Profamilia – Piloto	4

***Study Setting & Data Collection***

This study was conducted in Bogotá, Colombia. The primary author conducted interviews in person in Spanish and recorded the interviews using an iPad and the Voice Recorder by TapMedia Ltd application. The interviews were conducted at four clinic sites in Bogotá, including Centro Amigable (CAMI) Centro Oriente, Centro Amigable (CAMI) Suba,

Oriéntame Clinic – Teusaquillo, and Profamilia Clinic – Piloto. These four clinic sites were selected via the advice of gatekeepers who explained that they were Bogotá’s four first-step abortion provision sites, meaning they make up a small network of clinics that provide abortion up to 14 weeks gestation. 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***

The interviews were transcribed verbatim by a Colombian transcriptionist who resides in Bogotá. A Colombian transcriptionist was utilized in order to preserve the cultural significance and nuances in participants’ narratives. IDI transcripts were then imported into MAXqda10 (VERBI Software, Berlin, Germany), a qualitative software package. All data analysis was performed by the primary author. 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. As the intricacies and nuances of the data contained within the conceptual framework became more eminent, grounded theory was developed. The grounded theory was validated using existing literature on the topic of induced abortion decision-making. The phenomenological approach to the thematic analysis centered on in-depth, case-based analysis of each participant’s experience in accessing legal abortion.

### ***Quality Control***

Qualitative data were anonymous; no identifying information was stored. Nevertheless, the data were password-protected to prevent use by those without permission to do so.

### ***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). (See Appendix E). 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). (See Appendices F, G, & H). 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. (See Appendices C & D). Participants were not compensated for their time.



## **3.5 Results**

### **Characteristics of Study Participants**

The 17 participants ranged in age from 18 to 39 years (median age=25 years) and had obtained an abortion in the 12 months preceding the interview. The time interval between having an abortion and participating the interview ranged from two weeks to 11 months, with a median time interval of six weeks. Of the 17 participants, about half had no children (n=8), about half had one child (age range 1-14 years, n=7), one participant had two teenage children, and one participant had three young children. Gestational age at the time of abortion ranged from 4 to 22 weeks, the median being 9 weeks. Thirty percent of participants were students, 30% were unemployed, and only 40% of had a regular income. All 17 resided in Bogotá.

Though four abortion services locations were initially visited by the 17 participants (Oriéntame, CAMI Suba, CAMI Centro Oriente, and Profamilia), a total of nine locations were ultimately utilized in order to obtain an abortion. These locations included: Oriéntame - Teusaquillo, CAMI Suba, CAMI Centro Oriente, Profamilia - Piloto, Clínica Colombia, Clínica Santa Fe, Hospital La Victoria, Hospital Maternal e Infantil, and Hospital Suba.

### **Shared Barriers to Access to Legal Abortion**

#### ***Educational Barriers***

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. One participant described what she thought she knew about the sentence, and how being in the situation where she needed an abortion, and helped by the right people, saved her life:

“I had it in perspective that if I wasn’t raped, I wouldn’t have a right to an abortion. The person who opened my eyes and understood what I was feeling and who told me that I could have an abortion, was the lawyer from La Mesa. 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.”  
– LM3

Several study participants expressed feeling powerless before knowing about their right to an abortion, and feeling fortunate to have found safe, legal services. About 75% of study participants said they had searched online for abortion in Bogotá using public search engines, and several had read about how to perform an abortion on themselves. About half of this portion of the study population tried things they had read online. One study participant described her experience with trying to self-abort:

“I read about it online, that parsley, infusions, and praying... but nothing worked... every eight days I was drinking a ton of liquor, and then I went to the doctor finally for the sonogram and they said it (the fetus) was fine, and I thought ‘Oh my God.’ Also, during the first two months, I drank a lot, I started to smoke... thinking that would hurt it and cause me an abortion, but nothing worked, not the infusions, or wearing tight belts at night... it said ride a bike, it said lift heavy things – I tried to lift the television... I stopped eating... I did everything.” – LM3

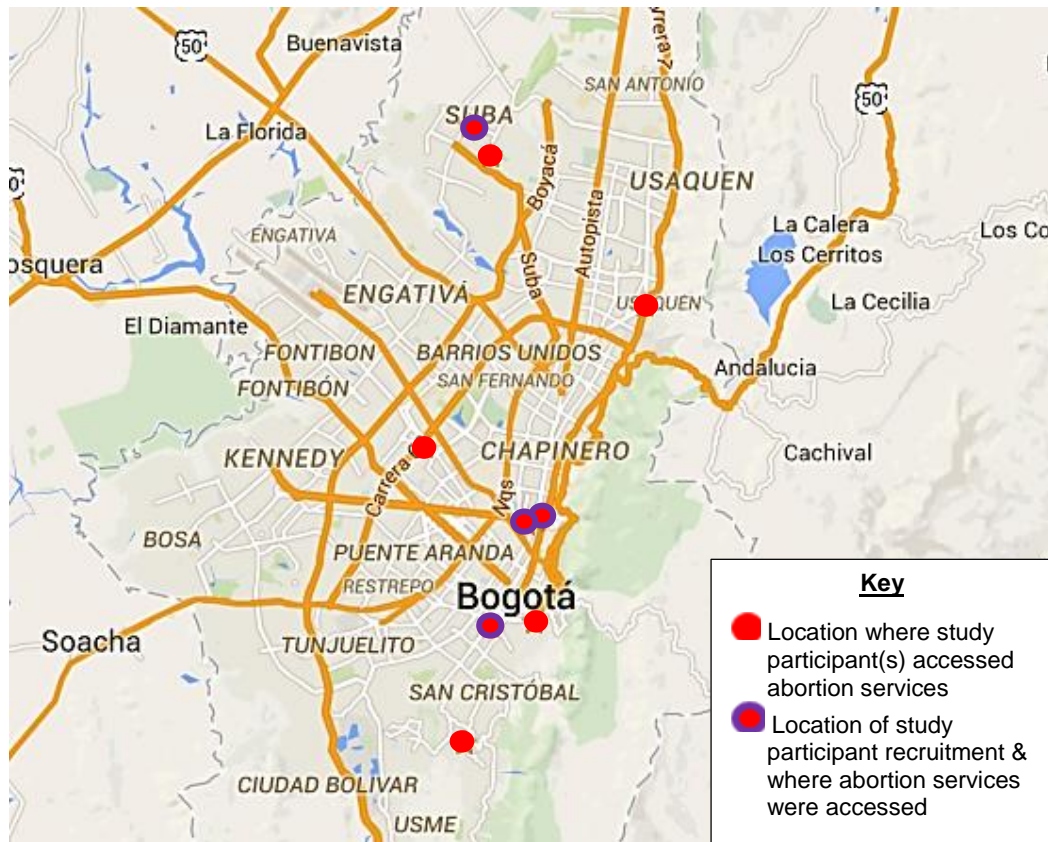
This transcript excerpt represents the experience of several interviewees who did not have access to valid, correct information, thus delaying their access to safe, legal abortion services, and subsequently their options for an abortion were much more limited due to advancement of gestational age. Several study participants expressed knowing as soon as

finding out that they were pregnant that they did not want to give birth, and not knowing about their right to an abortion, or where to obtain one, resulted in delay in access to abortion services.

### ***Physical Barriers***

About half of the study participants described difficulty in physically arriving at the location where they received abortion services, or the offices of La Mesa. Women said they would at times get lost, and complained of long wait times in the clinic, hospital, or office. Some study participants lived within 20 minutes of clinics and hospitals they visited, while others spent as long as two hours on public transit both to and from the health care establishments they visited (Figure 1).

**Figure 1. Locations of Study Participant Recruitment and Abortion Service Points of Access**



Source: Primary author, C. Brack

More often than not, the women who experienced issues with obtaining approval from their health insurance provider, or those who experienced issues in locating a physician or facility that would provide their abortion, also experienced enormous physical barriers in obtaining their abortion. Over 88% of study participants had to take time off from work or school in order to obtain their abortion, and also described this experience as being difficult and/or resulting in a delay in seeking abortion services. Additionally, about 30% of study participants had gone to a clandestine clinic before seeking abortion services at a safe, legal clinic. One participant described being approached by a representative of a clandestine clinic as being ridiculous:

“It was really funny, because this guy was there, acting all sketchy, he tried to talk to us, to get us to trust him... he had some pills and some needles, and I thought: ‘How many women are you using those couple of needles on?’ He said they charge by the week [of gestation]... and for me it would have been \$150,000, and they would do it in two minutes.” – CS3

Study participants described the representatives of the clandestine clinics as trying to lure women in with cheaper prices than well-known establishments. They promised that it would be a quick and easy procedure. Another participant recounted the deception and coerciveness of clandestine clinics:

“I looked them (Oriéntame) up in the yellow pages, the same day I called, got an appointment, I pretended I had a work interview. I came looking for the clinic, they told me it was Oriéntame. They did a sonogram for me, and said they would do my abortion for cheaper than Oriéntame, then said: ‘Call me and we’ll make the appointment, you just need to bring the towels and that’s it, it will only take an hour’ and I said: ‘No... this is NOT the place I was looking for’ and I left quickly.” – LM3

Almost all study participants knew that clandestine clinics existed. About half said they had friends who had negative experiences at illegal clinics, including near-death experiences from severe infection from unsafe abortion. One participant described accompanying a friend to a clandestine clinic, and that her friend’s experience made her afraid to have an abortion, saying:

“So, all of that left me with a lot of fear, I thought I shouldn’t have a procedure (abortion), because of the consequences that one can have after. Because it went really badly for my friend, she went to a clandestine clinic, where they charged her a lot of money. They didn’t even do any exams - no pregnancy test, no sonogram, the place was atrocious, completely unhygienic, not a single precautionary measure... those people just do it for the money. I thought that was so terrible. But because of her desperation to get out of the situation [she was in] and the pressure that a person in that position feels, she made a decision.” - CS1

The same participant also said that her friend went to this clinic because her friend’s mother and sister had gone there, and so she wondered “how many girls, how many women

are going to have abortions there and put their health at risk, their lives, everything?” Across the study population, stories were shared about what had been heard on the news about women dying from unsafe abortions in Colombia, and many participants reflected on their personal decision not to choose a clandestine clinic. Because study participants had heard of awful experiences with abortion through their social networks, the majority of them thought that their abortion experience would be similar, which contributed to an emotional barrier and a delay in seeking care.

### ***Financial Barriers***

About 60% of study participants paid for their abortions out-of-pocket, the prices of the abortion varying by service type. Those receiving pharmacological abortion were charged \$40,000 Colombian Pesos (CP) (~\$20 USD), while those who received surgical abortion were charged \$215,000 - \$500,000 CP (\$107.50 - \$250.00 USD), depending on the type of anesthesia, and what they were able to negotiate with the health care establishments. 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 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 EPS and being denied.

The 40% of women who did not pay directly for abortion services utilized their health insurance company (EPS). Half of these women said that because they had SISBEN, a phone

call was made by health care establishment staff during the appointment, and the service was processed by the insurance company with few issues, though some EPS's took as many as 14 days to process the request. Half of the women who had their abortion ultimately paid for by their EPS described extreme issues with the companies that delayed their access to abortion services. These women described being sent all over Bogotá for separate examinations and clearances by physicians and psychiatrists in order to satisfy their EPS and obtain approval. The time spent making appointments and waiting for them, taking time off from work and school, and inconsistent instructions from their EPS further delayed these women in getting approval and accessing abortion in a timely manner. Some study participants were delayed up to a month, and even two months by their EPS when trying to access abortion. Several of these women utilized the legal aid of the reproductive rights advocacy organization La Mesa in order to combat the barrier that their health insurance companies imposed. One study participant, a lawyer herself, described feeling unable to advocate for herself, and had already spent over a month being trying to access services:

“I had done what they (La Mesa) told me to do – I went to a public hospital and told them that I needed an abortion. After they refused *again*, I called them (La Mesa) and I told them: ‘Look, they wouldn’t see me, they treated me badly’ and they told me: ‘Let’s meet, I’m going to come with you to your health insurance company.’ She came with me, and immediately with the simple fact that I had a lawyer there with me, all of the services thereafter were good because of La Mesa.” - LM1

All participants, those whose services were paid for by their EPS, as well as those who could not or would not use an alternative source to pay for the abortion, stated that the cost was worth it.

## ***Legal Barriers***

Once study participants had decided to seek care, the most major delays in actually receiving care were legal barriers. Because the ability of a health care establishment to provide abortion services depended on gestational age, many study participants found that once they had arrived at the designated service, they still were unable to have their abortion.

One participant who was able to access abortion services at Oriéntame stated:

“...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 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.” - O3

Due to several other aspects of the lives of the study participants, including emotional, social, religious, physical, educational, and financial barriers, the women expressed a sense of pressure to have an abortion before the deadline, and avoid carrying the pregnancy to term. Several study participants stated that before becoming pregnant, they were unaware that gestational age would become a legal barrier to access to care. Representing the view of the 35% of the study population that faced significant legal barriers related to gestational age that delayed their access to abortion services, one study participant said:

“Because I didn’t know, that’s why my procedure took so long to have, or rather, the time got away from me, if I had known that that existed, believe me that I would have gotten [the abortion] in less than a month and it wouldn’t have been so painful and it wouldn’t have been so difficult.” - CS3

## ***Emotional Barriers***

Several women expressed difficulty in coming to the decision to have an abortion, or feeling unsure about having one after having a sonogram. Many participants described hearing the heart beat during the sonogram, and being told their due date by the physician



or technician, who in some cases already knew that the woman was having a sonogram in order to determine what type of abortion service she was eligible for. Several women described feeling selfish, which resulted in several days or weeks of wavering about their decision. One study participant described how her emotional turmoil over abortion delayed her seeking of abortion services and made it more difficult for her to have one:

“If I was delayed? Yes, due to the reaction I had, because, from the moment I found out I was pregnant I knew I didn’t want to have it, but, my mood was critical, I didn’t know what to do, that made me delay in having the procedure, because I didn’t have an urgent reaction... So that was the delay, they were going to do it for me... but after the sonogram, it wasn’t viable, because so many weeks had passed and I had to do the surgical abortion.” – P2

Across the study population, emotion as a barrier was linked to religion, and their relationships, that also appeared to be driven by religion, as described next.

## ***Religious Barriers***

### *Internalized Stigma*

Just as the majority of the women felt conflicted about having a child at that specific point in their lives and their specific situations, the majority expressed feeling conflicted about their own religious beliefs and what an abortion would mean. In this sense, the women described an internal stigma they felt about their own decision-making, which for some women led to a delay in accessing services. One participant described her experience as follows:

“Suddenly the barrier that you see most is at the moral level, and emotional level before that. I thought about how there was a living being inside of me, without regards to gestational age, but something that was growing inside of me, fruit of responsibility or irresponsibility – it had no fault, that was a confrontation I had... I cried, I asked God to forgive me for what I was doing.” – O3

Of the women who said they felt conflicted about having an abortion for religious beliefs, all cited Catholicism and Christianity as their primary faith, and that they had felt opposed to abortion before they needed one.

### *External Social Stigma*

Religion appeared to be a principal driver for the population's attitudes, beliefs, and actions toward abortion, including those of the women interviewed for this study. At the time of the interview 47% of participants had not told their partners about their pregnancy or subsequent abortion, and did not have plans to ever tell their partner. Of the nine participants who had told their partners about the pregnancy, three described feeling pressured by their partner to carry the pregnancy to term and to marry their partner. About 75% of participants had not told their families about their pregnancies or subsequent abortions, and described difficulty in maintaining secrecy from their loved ones. Only 30% of study participants had told close friends about their abortion. About 90% felt societal pressure to not disclose that they had had an abortion, specifically referencing Colombian culture and religious attitudes against abortion. Over one-third of study participants said that the only people who knew about their abortion were themselves, the hospital staff who performed and assisted with the abortion, and the primary researcher with whom they interviewed.

### *Health Care Providers – Nurses?!*

Another 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. Several women described having conversations with these individuals who would refuse to perform an abortion on them, and some women even experienced a physician's refusal to refer them to a physician who did not conscientiously object. 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?" One study participant also described how a physician brought groups of residents into her hospital room who lectured and shamed her for having a second trimester abortion. In the case of another participant, a psychiatrist brought a group of students into her hospital room who 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. Women described being questioned, harassed, and verbally abused by nurses while in a vulnerable emotional state, and while physically in their hospital beds before and after their abortions. The five study participants described overt judgment and several acts on the part of the nurses that were meant to upset the women, including intense questioning of why the women wanted to abort, what was wrong with her mentally that she would want to have an abortion, and why she hadn't used birth control correctly. 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 describes how a nurse tried to talk her out of having an abortion, and that if she did, that she would throw the child 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.” – CCO2

Another participant described being treated by hospital staff as if she had had a stillbirth:

“The doctor told me that it been expelled, and they took it, and the nurse asked me if I wanted to hold it, which seemed totally strange. In truth I was confused, I was tired, I was very sensitive. Later, another nurse came in, she had cleaned the product [of conception] and said: ‘But she came well, she didn’t have any malformations. Why?’ There, in front of me, all of them left the room and left that product there in a tub, wrapped up in gauze.” – LM2

Not only were the women treated badly in their time of need, but the treatment was abuse that continued to psychologically affect several of them. One participant described how she continued to lose sleep thinking about the way a nurse treated her: “At night I still see the images of everything that happened, the image comes to me of the nurse saying: ‘You’re a sinner,’ and then the image of her taking the bag and telling me it’s going in the trash... it all mortifies me.” – CS3

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.

### *Health Insurance Companies (EPS)*

Of the 60% of study participants who paid for their abortions out-of-pocket, the majority described seeking financial support for their abortion from their EPS and being denied. The women described how a representative from the EPS would lecture them on the morality and the wrong decision they were making:

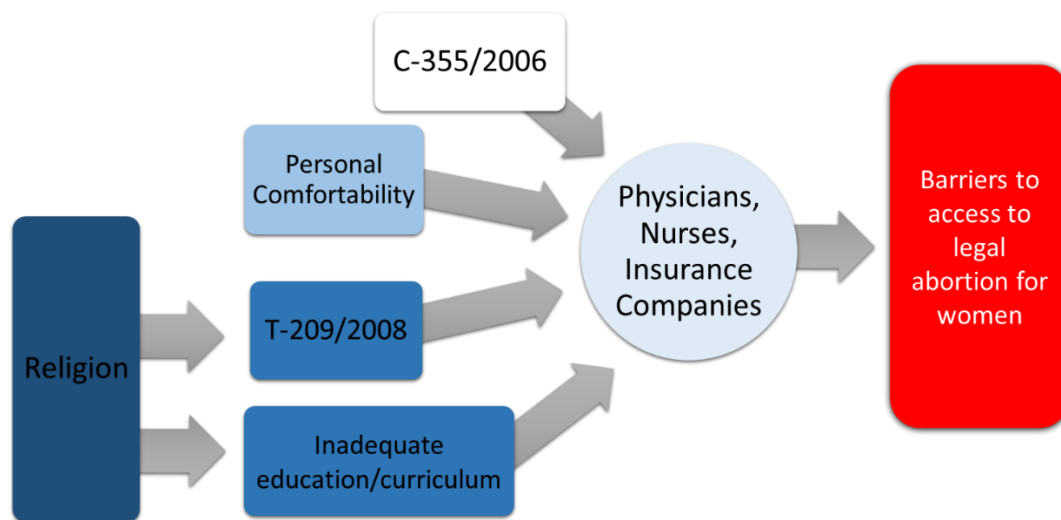
“They referred me to the EPS, which completely denied me. They told me I was making a total mistake, and asked if I was aware that I was murdering a person. I told them ‘Right now it’s not a person, because it has not been born.’ They said it had a soul, that it already had many things. They just tortured me.” – LM2

Several women also described being admitted to a hospital or clinic and trying to begin their abortion after having completed all of the requirements of their EPS, and then still being unauthorized and blockaded by their EPS. Many of the study participants who paid out-of-pocket for their abortion said that they did not seek support from their EPS because of the intense social stigma and lack of confidentiality that would come along with utilizing their EPS. One participant described the taboo of having an abortion as comparable with having a drug overdose, and how both would stay in her medical history forever, and both would be equally embarrassing and shameful. Several study participants said that their EPS called their family members while they were at the hospital and relayed to them confidential information about their procedure in efforts to cause the family to intervene.

Together, health care providers and insurance companies acted as a barrier to access of legal, safe abortion for women. As providers of health care, they are legally obligated to either perform or assist in performing an abortion, or authorize the procedure, unless they are physicians who have the legal right to object. Religion appeared to be the underlying influence on the behavior of these individuals, and ultimately these companies, types of

professionals, and health care establishments. They appeared to be attempting to balance their personal beliefs, level of comfort with abortion provision, and knowledge and understanding of both court sentences, and unfortunately failing to act in accordance with Colombian constitutional law (Figure 2).

**Figure 2. Conceptual Framework Demonstrating How Health Care Employees Acted as a Barrier to Abortion Access**



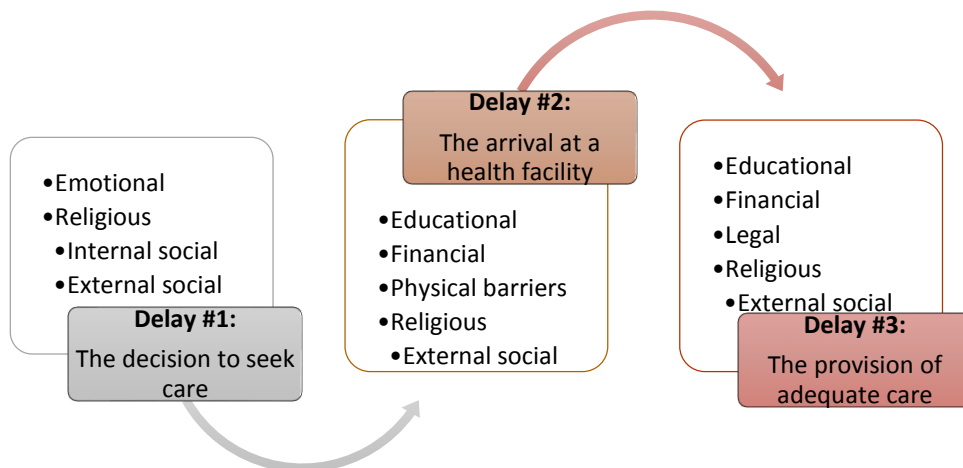
Source: Primary author, C. Brack

### 3.6 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, and pervasive, externally experienced 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) (Figure 3). This research is the first of its kind to qualitatively explore and identify the multitude of barriers experienced by Colombian women despite the passing of C-355/2006 by the Colombian Constitutional Court and inherent legal guarantee to safe, legal abortion.

**Figure 3. Barriers to Abortion Access that Resulted in Three Different Types of Delay**



Source: Primary author, C. Brack

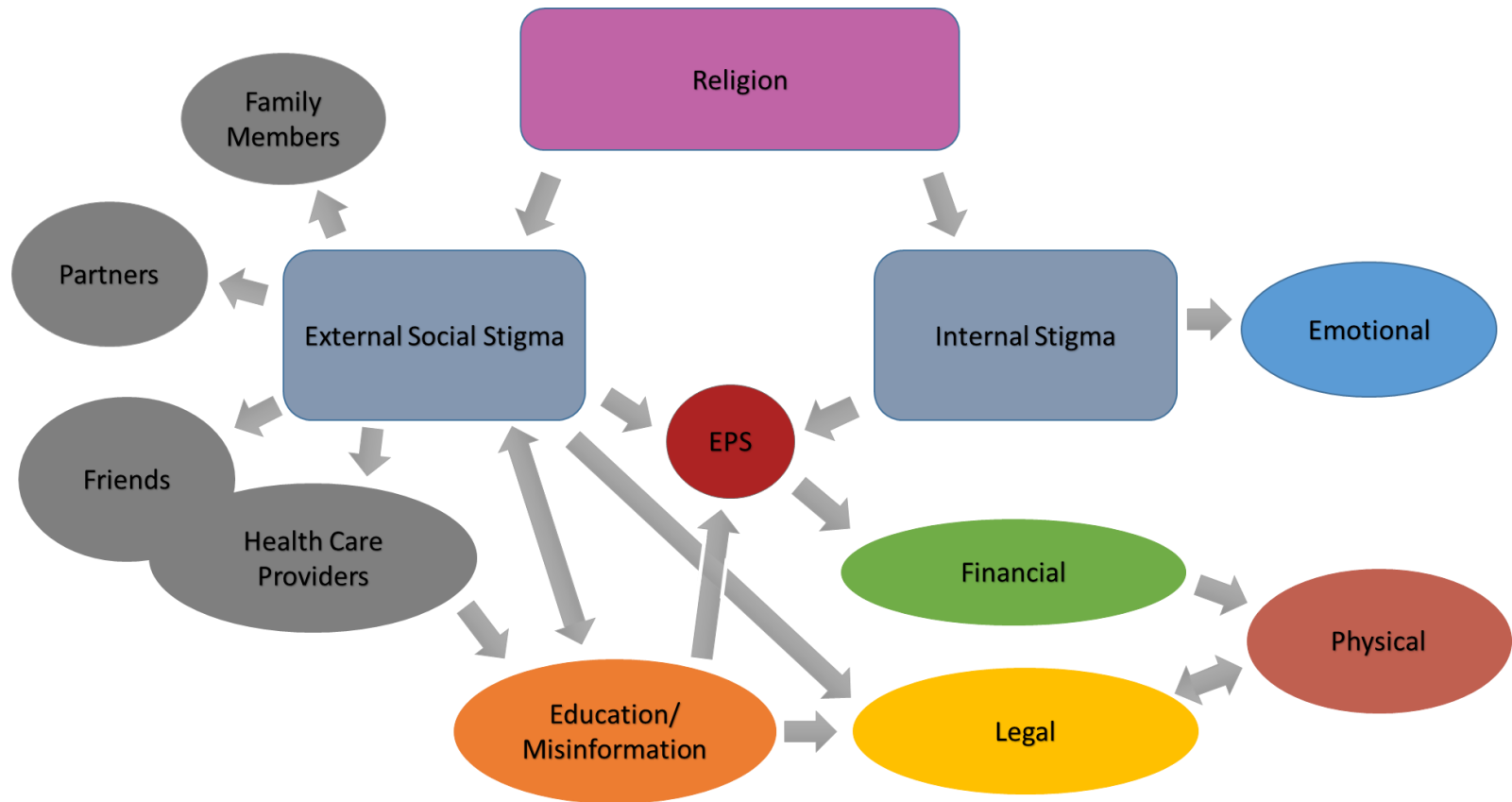
Educational, physical, financial, legal, emotional, and religious barriers, which led to social barriers in the form of both internalized stigma, and external pervasive social stigma that manifested most powerfully in the behavior and actions of health insurance companies, hospital administrators, and health care providers. The barriers experienced by women interviewed for this study appeared to be intertwined with one another, and many barriers led to or determined one another, making it difficult to parse and organize a framework

explaining experienced barriers (Figure 4). The findings suggest that when a study participant confronted at least one barrier to abortion access, she usually confronted several, and was fortunate to overcome said barriers in order to access a service that she was legally entitled to. Recent studies in Nepal, Australia, Colombia, Mexico, the United States, Ghana, and India have also found that educational, physical, financial, legal, emotional, religious and social barriers acting singularly and in tandem resulted in delays in accessing abortion (Andersen et al., 2015; Banerjee et al., 2012; Doran & Hornibrook, 2014; Prada et al., 2013; Paine et al., 2014; Peterfy, 1995; Rominski et al., 2014).

One of the most universally experienced barriers by women in this study was access to legal abortion before the pregnancy had advanced, as one study participant described as “a race against the clock.” Several other studies have also found that legal restrictions on abortion provision act as a barrier to care globally (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., 2004). This qualitative study illuminates the strict nature of abortion provision in Colombia with respect to gestational age. Women described the physical and legal inability of clinics to perform their abortion after 14 weeks gestational age. Clinics including Oriéntame, Profamilia, and the CAMI’s referred women to La Mesa, a reproductive rights advocacy organization that provides pro bono legal aid to women seeking legal abortion. Though their services were celebrated and mentioned repeatedly by the women, many women testified that knowledge about the existence of this organization would have been helpful earlier in the pregnancy, thereby reducing many of the barriers and delays experienced. This publication hopes to recognize the amazing work of La Mesa and promote the utilization of its services.



**Figure 4. Conceptual Framework Representing the Interplay and Determination of Barriers to Access to Legal Abortion Services**



Source: Primary author, C. Brack

A commonly described theme across the study population was interaction with physicians who refused to perform an abortion on them. Some women experienced refusal on the part of the physician to refer them to a physician who did not conscientiously object, which is a violation of T-209/2008. In a study published in 2015 in Malaysia, a lack of clear interpretation and understanding of the law specifically on the part of health care providers resulted in women facing difficulties accessing abortion information and services. Similarly to what was observed in Colombia, the study found that many physicians were unaware of the legal status of abortion in Malaysia and/or were influenced by their personal beliefs with regard to provision of abortion services (Low et al., 2015). Though T-209/2008 specifically outlines that the Ministry of the Health and the Superintendency of Health should investigate hospitals who are not compliant with the law should have sanctions brought against them, the law simply suggests this action. Similarly, the law states that physicians who are non-compliant with T-209 can be sued by health authorities that are liable to pay compensation for the negligence (Cook et al., 2009). At this point in time, sanctions are not regularly brought against physicians who do not uphold the obligations of legally identifying as a conscientious objector. Therefore, this research illustrates the need for the writing of a criminal code for those entities that are non-compliant with T-209, both individual and institutional.

One of the most shocking findings of this study was that of the behavior of the nurses employed by public hospitals. The treatment of women seeking abortion by nurses who disagreed with the women's choice was vindictive and cruel. The instances where study participants were purposefully shown the fetus after the abortion and shamed for having the abortion are reprehensible. Prior to this published research, descriptions of this type of

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### *Strengths & Limitations*

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had the right to stop the interview at any time for any reason. Furthermore, to ensure the confidentiality of participants, recruitment strategies and eligibility criteria were completely confidential.

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### *Conclusions*

Abortion is an individual, community, society, political, religious, and moral issue in Bogotá. Explorative studies of the process by which women in Bogotá decide to have an abortion and seeking of safe abortion care are scarce. Lamentably, 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, legal, emotional, religious, and social barriers to abortion access. Typically, the study population experienced several of these 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.

This research revealed key findings to promote changes in current legislation and expansion of medical and nursing curriculum, and to facilitate the removal of barriers to legal access of abortion services. As is demonstrated by the testimonies of the study population,

the wealth of misinformation and lack of accurate information about how and where to access safe, legal abortion interfere with Colombian women's legal rights to safe abortion.

### *Future Recommendations*

Based on this research, there exists a large knowledge gap about reproductive rights with respect to abortion in Colombia, yielding an understanding of the necessity to publicize more widely the legal conditions under which women are able to access abortions. Radio is a free and universally-accessed service in Bogotá, as opposed to internet, and could be used as a vessel for information about C-355/2006. More public advertising of accurate information about the federally protected right Colombian women have to an abortion may facilitate the removal of barriers to legal access of abortion services. Additionally, this research illustrates the need for the writing of a criminal code for those entities that are non-compliant with T-209, both individual and institutional.

Lastly, the expansion of both medical and nursing school curricula to include more information on provider legal rights and responsibilities with respect to C-355/2006 and T-209/2008 would ensure knowledge of both limits and scope, and better prepare both types of health care professionals to be compassionate providers.

### **3.7 Acknowledgements**

First and foremost, I thank the 17 incredible women who shared their stories of anguish, courage, and triumph. I will forever be thankful for their bravery, and inspired by their desire to be a vessel of information and guidance for other women.

This study was supported by the Emory Global Health Institute (EGHI) and made possible by the Global Health Multidisciplinary Team Scholarship, as well as a contribution from the Global Elimination of Maternal Mortality from Abortion (GEMMA) fund. I acknowledge Dr. Karen Stolley of the Emory Department of Spanish and Portuguese, Martha Fineman of the Emory Law School, and Suzanne Mason from the EGHI for their assistance in formulating a grant proposal.

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## **Chapter IV: Discussion, Conclusion, and Recommendations**

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## Appendices

### **Appendix A: In-Depth Interview Introduction and Guide (English)**

#### **An Analysis of Barriers to Legal Abortion Access in Bogotá, Colombia**

In-Depth Interview Guide with Recipients of Abortion Services

**STUDY ID** \_\_\_\_\_

Hello, my name is Chelsey. I am a graduate student from Rollins School of Public Health at Emory University in the US, working with the University of the Andes on a research project about barriers to getting an abortion. As a part of the project I am talking to women who have sought an abortion. Today I am particularly interested in talking to you about your experience seeking abortion services; I feel that by talking to you we will better understand possible barriers that women experience when getting an abortion.

I am going to ask you a series of questions about your experience and the sequence of events that led you to get an abortion. Some of these questions may be sensitive and personal, but your experience is very important to the project so I hope you feel comfortable to discuss these issues. I have a list of questions and topics, but I would like you to feel free to tell your story in your own words and describe anything that you feel was important. I want to let you know that your participation in this interview is completely voluntary, and if you don't feel comfortable answering a question or don't want to continue with our conversation we can stop at any time, just let me know.

The interview will be completely confidential and anything you say will not be shared with anyone in your community. Only my research team and myself will have access to what you share with me today. Also, I want you to know that all research documents relating to our conversation will not include your name or any of your personal information. If you don't mind, I would like to tape-record our discussion so that I do not miss or forget anything that we talk about. So, is it okay for me to tape-record this interview?

**Great. Before we start, do you have any questions for me?**

#### **Opening questions**

*Ok, first let's talk about your background and family.*

1. How old are you?

Age \_\_\_\_\_

2. What is your current employment status? Would you say you are...

Employed

Unemployed

Student

Other \_\_\_\_\_

3. What is your current marital status? Would you say you are...

Single

In a Relationship/Married

Separated/Divorced  
Widowed

4. Do you have any children? If she answers yes, continue with:  
How many children do you have? \_\_\_\_\_
5. What is your highest level of education?  
Primary  
Bachelor's degree  
Technical degree  
Professional degree  
Post-graduate degree
6. What are the circumstances that led to this pregnancy?

### **I. Pregnancy Recognition**

**Great. Now I would like to talk about this pregnancy.**

7. Can you describe how you found out that you were pregnant?  
Probe: - Did you miss a period?  
- Did you use a pregnancy test?
8. How far along in your pregnancy were you when you suspected you may be pregnant?  
Probe: - How many weeks since last menstrual period?
9. How did you know what to do?  
Probe: - Has this happened before?  
- Did someone advise/counsel you?

### **II. Seeking Care**

**Great. Now, I would like to talk about how you decided to seek an abortion.**

10. Can you describe what happened after you found out you were pregnant?  
Probe: - What was your thought process of deciding to get an abortion?  
- What did you do?
11. Some people try to do something themselves before coming to the clinic. What was the first thing that you did before deciding to come to the clinic?  
Probe: - Went to another abortion practitioner? Misoprostol from pharmacy? Something physical?
12. Can you talk about any opposition that you faced while deciding to seek an abortion?  
Probe: - People: partner, family, friends?  
- Religion  
- A conscientious objector/provider who did not certify you under C-355/2006?  
- Your health insurance provider?  
- How did this make you feel?



13. Can you talk about any support that you received while deciding to seek an abortion?

Probe: - From whom?

- People: partner, family, friends, judicial/legal support?
- How did this make you feel?

14.1a How did the opposition you faced while deciding whether to seek an abortion delay your getting an abortion?

14.1b How did the opposition you faced delay your decision-making in getting an abortion?

14.2 How did the support you received while deciding to seek an abortion facilitate your getting an abortion?

15. What were the main reasons that helped you to decide to get an abortion?

Probe: - How long did it take to decide to get an abortion?

- How long after you found out you were pregnant?
- Did you decide right away or did you have to think about it?
- Did you discuss with others?

### **III. Reaching a medical facility**

**Great, thank you so much for sharing that with me. Now, I would like to talk about the process of getting the abortion, making an appointment and reaching the clinic.**

16. Did you know that your situation met one (or more) of the circumstances that the law permits for obtainment of legal abortion?

Probe: - How did you know?

- What circumstance?

17. How did you learn about this facility?

Probe: - Advertisements? Referral from friend, family or person in the community, judicial/legal support?

18. Can you describe how you made an appointment at the clinic?

Probe: - What challenges did you face when you tried to make the appointment?

19. How long was the time between deciding to get an abortion and the appointment you scheduled?

Probe: - Did you get an appointment when you wanted or needed to, or when the clinic could see you?

- How much time passed between your initial inquiry and when you received your abortion?

20. How did you get to the clinic?

Probe: - Is transportation/associated costs an issue for you?

- How long did it take you to get to the clinic?

21. Did you need to make any special arrangements to attend the appointment?

Probe: - Arrangements with school? Work? Child care?

22. How did you manage the cost of the abortion?

Probe: - Did it delay your getting an abortion?

- Did you have to wait until you had the finances to make an appointment?

- Did you go into any sort of debt in order to get an abortion?
- Did your health care insurance type matter? Contributive, subsidized, linked?
- Did your partner help you in paying for your abortion?

#### **IV. Receiving effective treatment**

23. Did you receive pre-procedure counseling that included contraception/family planning options?

Probe: - Did you receive contraception?

- Method?

- Post-abortion counseling? Contraception?

24. In a couple of words, how would you describe your overall experience of getting an abortion?

#### **Closing questions**

**We are now coming to the end of our discussion; I just have one last question.**

25. Based on your experience, what is the most important advice you would give to other women experiencing an unplanned pregnancy?

26. Do you have anything else you would like to share with me on the topics that we have discussed today?

#### **Conclusion**

Thank you so much for your time and participation. Your contribution to our project is invaluable. If you have any questions or concerns, please don't hesitate to contact me to speak more.

## **Appendix B: In-Depth Interview Introduction and Guide (Spanish)**

### **Un Análisis de Barreras al Acceso al Aborto Legal en Bogotá, Colombia**

Guía de entrevista en profundidad con destino a los servicios del aborto

**Número de Identificación del estudio** \_\_\_\_\_

Hola, mi nombre es Chelsey. Yo soy una estudiante de postgrado del Rollins Escuela de Salud Pública de la Universidad Emory en los Estados Unidos. Actualmente, estoy trabajando con la Universidad de Los Andes en un proyecto de investigación sobre las barreras para conseguir un aborto. Como parte del proyecto, estoy hablando con mujeres que han buscado realizarse un aborto. El día de hoy, estoy particularmente interesada en hablar con usted sobre su experiencia al buscar el servicio del aborto; siento que al hablar con usted nosotras entenderemos mejor las posibles barreras que las mujeres enfrentan para conseguir un aborto.

Yo voy a realizarle una serie de preguntas relacionadas con sus experiencias y la secuencia de eventos que la condujeron a realizarse un aborto. Algunas de las preguntas son de carácter personal, algunas de ellas pueden generarle algo de susceptibilidad, pero su experiencia es muy importante para el proyecto por lo cual espero que usted se sienta cómoda al momento de tocar estos temas. Yo tengo una lista de preguntas y temas, pero deseo que usted se sienta libre de contar su historia en sus propias palabras y describir cualquier cosa que considere importante. Quiero que sepa que su participación en esta entrevista en profundidad es completamente voluntaria, y si usted no se siente cómoda respondiendo a alguna pregunta o si usted no desea continuar con nuestra conversación, podemos parar en cualquier momento, solamente déjeme saber.

La entrevista será totalmente confidencial y nada de lo que usted mencione será compartido con alguien conocido por usted. Únicamente mi equipo de investigación y yo tendremos acceso al contenido de la entrevista en profundidad que usted está realizando el día de hoy. Además, quiero que usted sepa que los documentos relacionados con nuestra conversación no incluirán ni su nombre ni tampoco otra información personal. Si a usted no le molesta, me gustaría grabar nuestra conversación para no perder u olvidar algo de lo que hablemos. Entonces, ¿me permite grabar esta entrevista?

**Muy bien. Antes de iniciar ¿usted tiene alguna pregunta?**

#### **Preguntas abiertas**

***Bien, primero vamos a hablar sobre sus antecedentes y sobre su familia.***

1. ¿Cuántos años tiene?

Edad \_\_\_\_\_

2. ¿A qué se dedica actualmente? Usted diría que usted está...

Empleada

Desempleada

Estudiante

Otro \_\_\_\_\_

3. ¿Cuál es su estado civil? Usted diría que usted está...

Soltera

Unida  
Separada/Divorciada  
Viuda

4. ¿Usted tiene hijos? Si contesta sí, sigue con:  
¿Cuántos hijos tiene? \_\_\_\_\_

5. ¿Cuál es el nivel educativo más alto que usted ha alcanzado?  
Prueba: ¿Primaria, bachillerato, Carrera técnica, Carrera profesional, postgrado?

6. ¿Cuáles fueron las circunstancias que la llevaron a quedar embarazada?

### **I. Reconocimiento del embarazo**

*Bien. Ahora me gustaría hablar sobre este embarazo.*

7. ¿Podría decirme como se dio cuenta de que estaba embarazada?

Prueba: - ¿No le llegaba el periodo menstrual?  
- ¿Se realizó una prueba de embarazo?

8. ¿Cuántas semanas de embarazo tenía cuando usted sospechó que podría estar embarazada?

Prueba: ¿Cuántas semanas habían transcurrido desde su último periodo menstrual?

9. ¿Cómo supo que hacer?

Prueba: - ¿Esto le había sucedido antes?  
- ¿Alguna persona la aconsejó o sugirió que hacer?

### **II. Búsqueda de cuidado**

*Bien. Ahora me gustaría hablar sobre como tomar la decisión para realizarse un aborto.*

10. ¿Podría decirme qué sucedió cuando se enteró que estaba embarazada?

Prueba: - ¿Cómo fue su proceso de tomar la decisión para realizarse un aborto?  
- ¿Ud. qué hizo?

11. Algunas personas intentan por sí mismas abortar antes de ir a una clínica. ¿Qué fue lo primero que usted hizo antes de decidir venir a esta institución clínica?

Prueba: - ¿Fue a otro proveedor de servicios?  
- ¿Consiguió misoprostol de la farmacia?

12. ¿Podría hablarme de alguna oposición (dificultad) que usted haya enfrentado mientras decidía abortar?

Prueba: - Gente: ¿compañero sentimental, familia, amigos?  
- ¿Religión?  
- ¿Proveedor de objeción/no le dio el certificado?  
- ¿EPS?  
- ¿Cómo se sintió con relación a esto?

13. ¿Podría hablarme sobre algún tipo de ayuda que usted haya recibido mientras decidía terminar con el embarazo?

Prueba: - ¿De quién, quienes?

- Gente: ¿compañero sentimental, familia, amigos, apoyo jurídico?

- ¿Cómo se sintió con relación a esto?

14.1a ¿De qué manera la oposición que usted enfrentó retrasó la consecución del aborto?

14.1b ¿De qué manera la oposición que usted enfrentó retrasó la toma de decisión de terminar el embarazo?

14.2 ¿De qué manera el apoyo que usted recibió mientras buscaba terminar el embarazo le facilitó tomar la decisión?

15. ¿Cuáles fueron las principales razones que le ayudaron a tomar la decisión de abortar?

Prueba: - ¿Cuánto tiempo le tomó decidirse a abortar?

- ¿Cuánto tiempo después de que usted supo que estaba embarazada?

- ¿Usted tomó la decisión de inmediato o le tomó algún tiempo decidirse?

- ¿Lo discutió con otros?

### **III. Acceso al servicio médico**

*Muy bien, muchas gracias por compartir esta información conmigo. Ahora, me gustaría hablar acerca del proceso de consecución del aborto, solicitud de cita, y acceso al servicio médico.*

16. ¿Usted sabía que su situación corresponde con algunas de las razones que la ley permite para obtener un aborto legal?

Prueba: - ¿Cómo sabía?

- ¿Cuál razón o circunstancia?

17. ¿Cómo se enteró sobre este servicio?

Prueba: ¿Publicidad, remisión por parte de un amigo, un familiar, un conocido en su barrio, apoyo jurídico?

18. ¿Podría decirme cómo solicitó una cita en la clínica?

Prueba: ¿Qué desafíos/retos enfrentó cuando usted intentó solicitar la cita?

19. ¿Cuánto tiempo transcurrió entre el periodo de tomar la decisión de realizarse el aborto y la cita programada?

Prueba: - ¿Usted consiguió la cita cuando quiso, cuando la necesitó, o cuando se la programaron?

- ¿Cuánto tiempo transcurrió entre su solicitud y el servicio que recibió?

20. ¿Cómo llegó a las instalaciones donde le practicaron el aborto?

Prueba: - ¿Transporte público (buses, Transmilenio, taxi, carro particular) y los costos asociados se relacionan con esto?

- ¿Cuánto tiempo le tomó a usted llegar al servicio médico del aborto?

21. ¿Usted tuvo que solicitar algún permiso especial o algún tipo de adaptación para asistir a la cita?

Prueba: ¿En el colegio? Trabajo? Con el cuidado de los niños si los tiene?

22. ¿Cómo asumió los costos del aborto?

Prueba: - ¿Los costos la retrasaron para conseguir el aborto?

- ¿Tuvo que esperar hasta que consiguió la manera de financiarse para solicitar la cita?

- ¿Tuvo que asumir una deuda para conseguir el aborto?

- Su EPS - ¿pertenece al grupo contributivo, subsidiado, vinculado?

- ¿Su pareja le ayudó a pagar los costos?

#### **IV. Recibiendo tratamiento efectivo**

23. ¿Usted recibió consejería antes de realizarse el aborto que incluyó opciones de planificación familiar/anticoncepción?

Prueba: - ¿Recibió anticonceptivos?

- ¿Cual método?

- ¿Orientación después? ¿Anticonceptivos?

24. Con un par de palabras, ¿cómo describiría su experiencia general en obtener un aborto?

#### **Preguntas de Cierre**

*Ya casi vamos a terminar nuestra conversación; tengo una pregunta para finalizar.*

25. Con base en su experiencia, ¿cuál es el consejo más importante que usted le daría a otra mujer quien esté viviendo un embarazo no planificado?

26. ¿Tiene algo más que usted quisiera compartir conmigo con respecto al tema del que hablamos el día de hoy?

#### **Conclusión**

Muchas gracias por su tiempo y participación. Su contribución a nuestro proyecto es invaluable. Si usted tiene dudas, preguntas o alguna preocupación, por favor no dude en contactarme para hablar al respecto.

## **Appendix C: Written Informed Consent Form (English)**

### **Emory University Informed Consent**

**Study Title:** Abortion Access: Colombia

**Principal Investigator:** Roger Rochat

**Funding Source:** Emory University Global Health Institute

#### **Introduction and Study Overview**

Thank you for your interest in our project. We would like to tell you everything you need to think about before you decide whether or not to join the project.

- 1) The purpose of this study is to explore Colombian women’s experiences and attitudes surrounding abortion.
- 2) The study is funded by Emory University Global Health Institute.
- 3) This study is not intended to benefit you directly, but we hope this research will benefit Colombian women in the future.
- 4) The interview will take about 45-60 minutes to complete.
- 5) If you participate, you will be asked to talk to someone about your recent experiences (within the last six months) with abortion. We will not ask you about any experiences prior to 2014.
- 6) Some questions may be sensitive or uncomfortable
- 7) Your participation in this interview is completely voluntary, and if you don’t feel comfortable responding to any questions, you are not obligated to answer those questions.
- 8) If you do not wish to continue with the interview, we can stop it or end it at any time, and you may withdraw yourself from the project at any time.
- 9) Your privacy is very important to us. We will not record your name at any point and will take all precautions to prevent anyone from finding out about your participation in this study.
- 10) Only the research team will have access to the content of this interview that you are participating in today, and after the information you share with us today has been utilized, all of the documents and recording will be destroyed.

#### **Contact Information**

If you have questions about this study, your part in it, your rights as a research participant, or if you have questions, concerns or complaints about the research you may contact the following:

**Name and Position:** Chelsey Brack, Researcher

**Phone number (Colombia):** 300-698-6199

**Phone number (USA):** +1 415-471-5338

**Emory Institutional Review Board:** 404-712-0720 or toll-free at 877-503-9797 or by email at irb@emory.edu

#### **Consent**

I have read the information provided about the study and my participation. I have received answers to any questions I had. I give my consent to participate in this study.

\_\_\_\_\_  
Name of participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Signature of participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Signature of Person Conducting Informed Consent Discussion

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

## **Appendix D: Written Informed Consent Form (Spanish)**

### **Formulario de Consentimiento Informado**

**Título de Investigación:** Acceso al Aborto: Colombia

**Investigador Principal:** Roger Rochat

**Fondos:** Emory University Global Health Institute

#### **Introducción y Resumen de Investigación**

Gracias por su interés en nuestro proyecto. Quisiéramos compartir todo lo que usted necesita saber antes de su decisión de participar o no en nuestro proyecto.

- 1) El propósito de esta investigación es explorar las experiencias y actitudes de las mujeres Colombianas sobre la interrupción voluntaria del embarazo.
- 2) Esta investigación está financiada por Emory University Global Health Institute.
- 3) Este estudio no la beneficiará directamente, pero esperamos que esta investigación beneficiará a las mujeres Colombianas en el futuro.
- 4) Esta entrevista durará en promedio 45-60 minutos.
- 5) Si decide participar, se le pedirá que hable acerca de sus experiencias recién (dentro de los seis meses anteriores) con la interrupción voluntario del embarazo. No le preguntamos de sus experiencias antes de 2014.
- 6) Algunas preguntas pueden ser sensibles o incómodas.
- 7) Su participación en esta entrevista es completamente voluntaria, y si usted no se siente cómoda respondiendo a alguna pregunta, no está obligada a contestarla.
- 8) Si usted no desea continuar con nuestra conversación, podemos parar la entrevista o terminarla y usted puede retirarse del proyecto en cualquier momento.
- 9) Su privacidad es muy importante para nosotras. Con su permiso, vamos a grabar la entrevista, pero no vamos a grabar su nombre en ningún momento y tomaremos todas las medidas posibles para evitar que alguien sepa de su participación.
- 10) Toda la información obtenida de esta entrevista estará guardada en un sistema protegido por contraseña y únicamente el equipo de investigación tendrá acceso al contenido de la entrevista que usted está realizando el día de hoy,
- 11) Después de la entrevista y el uso de la información de la entrevista para el propósito de investigación en el contexto de este proyecto, vamos a borrar todos los archivos y destruir todos los documentos que tiene que hacer con esta entrevista.

#### **Información de Contacto**

Si tiene alguna pregunta acerca de esta investigación, su participación en ella, sus derechos como participante en la investigación, o si usted tiene preguntas, inquietudes o quejas sobre la investigación, puede contactar a:

**Nombre y Posición:** Chelsey Brack, Investigadora

**Número de teléfono (Colombia):** 300-698-6199

**Número de teléfono (EEUU):** +1 415-471-5338

**Emory Institutional Review Board:** 404-712-0720 o llamada gratuita al: 877-503-9797 o por correo electrónico [irb@emory.edu](mailto:irb@emory.edu)

#### **Consentimiento**

He leído la información proveída sobre el estudio y mi participación. He recibido respuestas a las preguntas que tuve. Doy mi consentimiento para participar en este estudio.

\_\_\_\_\_  
Nombre de la participante

\_\_\_\_\_  
Fecha

\_\_\_\_\_  
Hora

\_\_\_\_\_  
Firma de la participante

\_\_\_\_\_  
Fecha

\_\_\_\_\_  
Hora

\_\_\_\_\_  
Firma de la Persona Encargada del Consentimiento Informado Discusión

\_\_\_\_\_  
Fecha

\_\_\_\_\_  
Hora



## **Appendix E: Emory University IRB Letter of Approval**



**EMORY**  
UNIVERSITY

Institutional Review Board

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TO: Kaitlyn Stanhope  
Principal Investigator  
Dean

DATE: May 23, 2014

RE: **Expedited Approval**  
IRB00073234  
An Analysis of Barriers to Access of Safe Abortion Services Among Women in Colombia

Thank you for submitting a new application for this protocol. This research is eligible for expedited review under 45 CFR.46.110 and/or 21 CFR 56.110 because it poses minimal risk and fits the regulatory category F(7) as set forth in the Federal Register. The Emory IRB reviewed it by expedited process on May 20, 2014 and granted approval effective from **5/20/2014 through 5/19/2015**. Thereafter, continuation of human subjects research activities requires the submission of a renewal application, which must be reviewed and approved by the IRB prior to the expiration date noted above. Please note carefully the following items with respect to this approval:

- **Documents included with this approval:**
  - Protocol version uploaded 4.17.2014
  - IDI Info Sheet\_Providers\_English
  - IDI Info Sheet\_Providers\_Spanish
  - IDI Info Sheet\_Women\_English
  - IDI Info Sheet\_Women\_Spanish
  - In-Depth Interview Guide\_Women\_English
  - In-Depth Interview Guide\_Women\_Spanish
  - Lawyer Info Sheet English.docx
  - Lawyer Info Sheet Spanish.docx
  - Lawyer Interview English.docx
  - Lawyer Interview Spanish.docx
  - Survey Info Sheet\_Providers\_English
  - Survey Info Sheet\_Providers\_Spanish
  - SurveyofProviders\_English.docx
  - SurveyofProviders\_Spanish.docx

SemiStructured Interview Guide.Spanish.docx  
SemiStructuredInterviewGuide.English.docx  
SSI.Info Sheet\_Women\_Spanish.docx  
SSI.InfoSheet\_Women\_English.docx

Oral consent for women in English and Spanish version 3.31.2014  
Oral consent for providers in English and Spanish version 3.31.2014

- A Waiver of documentation of consent has been granted. The participants will still need to go through the consent process but do not have to physically sign the consent form.

Any reportable events (e.g., unanticipated problems involving risk to subjects or others, noncompliance, breaches of confidentiality, HIPAA violations, protocol deviations) must be reported to the IRB according to our Policies & Procedures at [www.irb.emory.edu](http://www.irb.emory.edu), immediately, promptly, or periodically. Be sure to check the reporting guidance and contact us if you have questions. Terms and conditions of sponsors, if any, also apply to reporting.

Before implementing any change to this protocol (including but not limited to sample size, informed consent, study design, you must submit an amendment request and secure IRB approval.

In future correspondence about this matter, please refer to the IRB file ID, name of the Principal Investigator, and study title. Thank you

Brandy Covington, CIP  
Sr. Research Protocol Analyst

*This letter has been digitally signed*

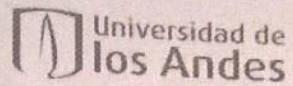
CC:

Brack	Chelsey	Public Health
Fineman	Martha	School of Law
Richardson	Kalie	Law School
Stanhope	Kaitlyn	Dean
Stolley	Karen	Spanish

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Emory University  
1599 Clifton Road, 5th Floor - Atlanta, Georgia 30322  
Tel: 404.712.0720 - Fax: 404.727.1358 - Email: [irb@emory.edu](mailto:irb@emory.edu) - Web: <http://www.irb.emory.edu/>  
*An equal opportunity, affirmative action university*

## Appendix F: Universidad de los Andes Research Ethics Committee Letter of Approval



### COMITÉ DE ÉTICA EN LA INVESTIGACIÓN Acta 352 de 2014

EL COMITÉ DE ÉTICA EN LA INVESTIGACIÓN de la Universidad de los Andes, certifica mediante la presente acta del 16 de Julio de 2014, que se revisó la propuesta denominada: **"Análisis de Barreras al Acceso al Aborto Legal en Bogotá, Colombia"**, cuyo investigador principal es Óscar Alberto Bernal Acevedo, Profesor Asociado de la Escuela de Gobierno Alberto Lleras Camargo, Universidad de los Andes.

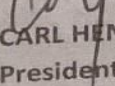
#### Concepto:

El COMITÉ DE ÉTICA DE LA INVESTIGACIÓN de la Universidad de los Andes, **aprueba el proyecto presentado**. De conformidad con la legislación vigente, este proyecto se clasifica como:

#### INVESTIGACIÓN CON RIESGO MÍNIMO.

Se expide esta certificación el 16 de Julio de 2014.

Cordialmente,

  
CARL HENRIK LANGEBAEK RUEDA  
Presidente del Comité

Nota: Los proyectos evaluados para convocatorias de COLCIENCIAS deben volver a presentarse al comité de ética una vez sean aprobados

## Appendix G: Fundación Oriéntame Research Ethics Committee Letter of Approval



### CERTIFICACIÓN A QUIEN PUEDA INTERESAR

Bogotá, Abril 10 de 2015

En mi calidad de Directora Ejecutiva de la Fundación Oriéntame en Bogotá, Colombia certifico que serví de asesora de trabajo de campo para las Investigadores Responsables: Chelsey Brack, Kaitlyn Stanhope, Lauren Fink, Kalie Elizabeth Richardson, de la Escuela de Salud Pública, Emory University Global Health Institute.

En relación con el Estudio: "Un Análisis de Barreras al Acceso al Aborto Legal en Bogotá, Colombia"

Las investigadoras sometieron a consideración del Comité de Ética de la Fundación la Propuesta de investigación, el Consentimiento Informado y la Guía de entrevista en profundidad, los cuales fueron estudiados por el comité de ética, que lo aprobó y formuló unas pocas recomendaciones que las investigadores atendieron por lo cual fueron autorizadas para realizar el estudio.]

Atentamente,

  
**CRISTINA VILLARREAL**  
Directora Ejecutiva

## Appendix H: Profamilia Research Ethics Committee Letter of Approval


Bogotá, abril 20 de 2015



A quien le interese

En mi calidad de Directora de Investigaciones de la Asociación Probienestar de la Familia Colombiana –PROFAMILIA- certifico que las Investigadoras Chelsey Brack, Kaitlyn Stanhope, Lauren Fink, Kalie Elizabeth Richardson, de la Escuela de Salud Pública, Emory University Global Health Institute, sometieron aprobación por parte de la dirección, el estudio: "Un Análisis de Barreras al Acceso al Aborto Legal en Bogotá, Colombia". Se hizo revisión y aprobación de la Propuesta de investigación, el Consentimiento Informado y la Guía de entrevista en profundidad."

Atentamente

  
**Claudia Gómez López**  
Directora de Investigaciones